NATIONAL RURAL HEALTH MISSION

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Update on the ASHA PROGRAMME

January 2013

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Update on the ASHA Programme

Eight years after the launch of the National Rural Health Mission (NRHM) working in 2005, there are now about 8.6 lakhs ASHAs across the entire country. With one ASHA covering a population of 1000 population or fewer, with most sub centres having at least one Auxiliary Nurse Midwife (ANM), and the massive increase in the number of Angawadi centres, the potential to provide comprehensive community level care is higher than ever before. Yet this promise can only be realized if a critical component, the ASHA programme now focuses its energies in the next phase on a set of key processes and outcomes. In most areas the central challenge will continue to be maternal, newborn and child health and nutrition. In some areas the high burden of communicable disease (Malaria and Kala Azar in endemic areas) will need prompt attention. In some other areas, where these challenges have been overcome, the frontline is the prevention and promotion of care for non-communicable diseases. In all these areas however certain institutional capacities and mechanisms would need to be put in place:

1. Performance Monitoring System to assess and improve ASHA functionality and effectiveness.
2. Reaching the marginalized and unreached population.
3. Setting Up effective Grievance Redressal Mechanisms for the ASHA.
4. High quality competency based training through trainer accreditation and ASHA certification.
5. Regular replenishment of drug kit, timely and regular incentive payments, and use of non monetary incentive payments to retain ASHA motivation.
6. Orientation and strengthening of existing support structures to provide onsite mentoring and support for the ASHA.

In the first phase of the NRHM, central and state efforts were largely focused on the ASHA, although the NRHM articulated a much larger canvas of community engagement. In the second phase of the NRHM, learning and experiences in the first phase, enable us to implement approaches to strengthen the Village Health Sanitation and Nutrition Committee, establish a Grievance Redressal System, strengthen community accountability mechanisms, and create a convergent platform for action on social determinants. There is also increasing recognition of the need to ensure that the ASHA plays a pivotal role in these interventions, enabling her to exercise her skills as an activist and to support people's realization of health rights. Finally there is need to engage with civil society organizations and NGOs to facilitate this process.

This issue is the seventh in the series of biannual ASHA updates produced by the National Health System Resource Centre (NHSRC) for the Ministry of Health and Family Welfare (MOHFW). We report on advances in the ASHA programme, related to training and support structures, recent policy directives, and reports of recent evaluations and reviews.

The first section reports on the evaluation of the ASHA programme in Nagaland and Karnataka. In this section we also include relevant excerpts from an external evaluation of the National Rural Health Mission commissioned by the Planning Commission of India. Section 2 reports on the findings related to the ASHA and other community processes interventions in 15 states, in which the Sixth

Common Review Mission (CRM) of the NRHM was conducted. Section 3 contains a state wise status update on the numbers of ASHA, training and support structures. In section 4 we provide an updated list of incentives mandated by the most recent approvals of the Mission Steering Group.

A striking aspect of state level implementation is the number of innovations that have surfaced as states adapt and modify programme contours and guidelines to suit local contexts, and then proceed to scale up such innovations. Finally, one new feature we have introduced in this update is to report on such innovations. We have purposively selected Odisha's Gaon Kalyan Samitis to serve as an example for other states to build on as they begin the process of strengthening the Village Health Sanitation and Nutrition Committees. This report is in Section 5.

SECTION 1

Findings from Recent ASHA Evaluation

This section carries key findings from the three recent evaluations. The first part presents findings of the ASHA programme from an external evaluation of the NRHM in seven states. This evaluation was commissioned by Programme Evaluation Organisation (PEO) of Planning Commission of India. The second and third part reports on evaluation of the ASHA programme in Karnataka and Nagaland, commissioned by the respective state governments to study the levels of functionality and outcomes of the ASHA programme.

External Evaluation Findings from ASHA Evaluation Undertaken by IEG Planning Commission

The Programme Evaluation Organization of the Planning Commission of India, commissioned a performance evaluation of the National Rural Health Mission in 2010. This was done considering the wide scope of the Mission, and the fact that it was past the midway point of implementation. The study was assigned to the Institute of Economic Growth (IEG), and was conducted by the Population Research Centre housed in the IEG.[1] One of the key objectives of the study was to study the role played by ASHAs in creating awareness on health and nutrition among the rural population.

The study used a mixed methodology approach, with quantitative and qualitative data considered most appropriate for complex interventions implemented at scale. Facility and household surveys, structured questionnaires with health personnel at different levels, detailed secondary data review including programme documents and analysis of existing secondary data, and in depth interviews with key stakeholders were used. The analysis also involved triangulation of data at different levels to provide a comprehensive understanding and multiple stakeholder perspectives. The study involved purposive sampling of states, districts, health facilities across the public health system, and households. The facility survey covered 37 District Hospitals (DHs), 74 Community Health Centers (CHCs), 148 Primary Health Centres (PHCs), 296 Sub Centers (SCs), and 296 villages spread across over 37 districts in seven states. The household survey was undertaken in 7400 households from 296 villages across 37 districts in the seven selected states. 25 households were selected from each of eight villages under the eight selected Sub Centres.

The facility survey elicited information about functioning of ASHAs in the selected sub-center service areas and the household survey provided information on their functioning in villages. This was supplemented by focus group discussions to understand their knowledge and awareness levels regarding their roles and responsibilities.

The key findings on ASHA which emerged out from the study are as follows:

a. Most ASHAs are residential and this has facilitated community rapport building.

b. ASHAs in all the states have received training and are playing all three of their primary roles: health awareness in the community, basic curative care, and facilitation of access to services from the health system. However,

1 Excerpted from Evaluation Study of National Rural Health Mission (NRHM) In 7 States Programme Evaluation Organisation Planning Commission Government of India-February 2011.

disbursements of incentives and allowances, as well as supply of medicines for their drug kits were not regular.

c. ASHA is functional in undertaking home visits which is evident from more than 65% beneficiaries confirming that ASHA visits them between 15-30 days. Higher figures of about 65-70% were reported from Jharkhand, Odisha and Assam on this aspect, while Madhya Pradesh and Uttar Pradesh performed slightly low.

d. ASHA visiting the households with drug kits was highest in Odisha, UP and MP at 80%, 70% for Assam and Jammu and Kashmir but these figures were low for Jharkhand at only 55%.

e. 80% beneficiaries reported that ASHA provided free drugs from her drug kit.

f. ASHA's role in motivating mothers to utilize public health facilities for children's complete immunizations also turns out to be significant and positive. Holding of village health and nutrition days, in which ASHA performs a major role in mobilising pregnant women and children to attend VHNDs in villages, also depict significant and positive impact on complete immunization of children.

g. A bivariate analysis on role played by ASHA in motivating pregnant women for utilization of antenatal care from public health care facilities indicated a close correlation with ASHA visits, where 60% of women who availed antenatal care services in government facility reported fortnightly visits by ASHAs. Similar analysis when extended to view the institutional delivery pattern reveals 65% beneficiaries going for institutional delivery were met by ASHAs once in fifteen days. Adjusting probabilities of women seeking Delivery Care from Public and Private health care facilities to program factors like visits by ASHAs it was found that-

> "ASHA's regular visits to households, while accounting for other predictor variables, improve the probability of utilization of public health facilities from 0.54 to 0.71. Interestingly, ASHA's visit to household becomes responsible for a significant shift from no use to use of public health facilities and depicts marginal impact on change in probability of use of private health facilities for the delivery care. So, ASHA's role in motivating women for public sector institutional deliveries turns out to extremely important."

h. Across all states majority of contraceptive users for family planning reported being motivated by ASHA. Use of contraceptive methods was reported by 56% of the couples and out of the users we found that 88% had availed government health facilities for contraception services. Interestingly majority of the users were motivated by ASHA and 46% out of 88% had reported the source of contraception to be ASHA/ANM/VHW.

i. Results of a Multinomial Logic, Regression Technique reveal that ASHA's visit to households, while accounting for other predictor variables, improves the probability of utilization of public health facilities for Post Natal Care from 0.55 to 0.66. ASHA's visit to household becomes responsible for a significant shift from no-use to use of public health facilities for the PNC. Nevertheless, ASHA's visits also depict impact on likelihood of utilization of even private health facilities for the postnatal care. So ASHA's role in motivating women for utilization of obstetric care of public health facilities turns out to be extremely important.

j. Awareness about ASHA scheme was much higher than about NRHM which clearly reflects that JSY and role of ASHA has brought much higher awareness about the NRHM initiatives.

k. In relation to payments 72% of the ASHAs reported to be paid compensation for the services rendered by them except for few ASHAs who reported being paid very low in UP (23/75) and Jharkhand (25/50).

l. While a larger percentage of ASHAs report positively on their key functions related to awareness building and providing services, and coordination with the ANM and AWW, far fewer ASHAs have positive reports on coordinating with the Gram Panchayat and playing an active role in village health planning. It is a fact that while states have invested in training the ASHA and enabled team work with the ANM and AWW, there has been less movement on working with VHSNC and village health planning. However, a bigger problem that the evaluation highlights as have other evaluations, is that the ASHAs incentive remuneration and regular supply of drugs, two important mechanisms to motivate and sustain the ASHA continue to be problematic.

Key Findings on ASHA Evaluation from States of Karnataka and Nagaland[2]

The evaluation of the ASHA programme in both states is approached combining qualitative and quantitative methods. While the methodology used in both the evaluations was largely consistent with the methodology adopted by the National Health Systems Resource Centre (NHSRC) to conduct the ASHA evaluation in eight states[3] in 2010-2011, but there were some variations. For instance, selection of three districts, inclusion of the non- beneficiaries in Karnataka and selection of 10% of the overall ASHAs in Nagaland for the study. In both the states three districts were selected but from different categories, in the state of Karnataka two districts were selected with large disadvantaged population - Kolar & Chamarajanagar and one good performing district – Haveri was selected. While in Nagaland districts were selected on the basis of performance of the ASHA Programme: a) Good performing - Dimapur, b) Medium performing - Wokha and c) Poor performing – Phek.

As part of the qualitative research, all stake holders at state, district, and sub district level were interviewed. Quantitative survey was conducted at the village level to include – ASHAs, ANMs, AWWs, PRI/VHSNC representatives and two categories of service users. User A Mothers of children up to 6 months of age who have availed services of the ASHA and User B Mothers of children between 6.1 months – 2 years with illness in last one month and utilized services from ASHA.

In addition, Karnataka included at least one non-beneficiary in each of the study villages. Non-beneficiaries were defined as – a pregnant woman who has had a home-delivery in the last 6 months OR has not received her JSY amount in the last 6 months OR Mother of a child aged 6.1-24 months currently with a child eligible for measles vaccine but has not received it OR who has had a childhood illness episode (e.g. diarrhoea or respiratory infection) but has not received ASHA services.

2 Excerpted from SHSRC Evaluation of ASHA Programme in Karnataka; 2012 (conducted by ST JOHN'S RESEARCH INSTITUTE ;St John's National Academy of Health Sciences-Bangalore) and Report of ASHA Evaluation in Nagaland; Regional Regional Resource Centre for North Eastern States (RRC-NE); Ministry of Health & Family Welfare (MoHFW); 2012.

3 National Health Systems Resource Centre, Ministry of Health and Family Welfare, Government of India; ASHA… Which way forward ….? ASHA evaluation in eight states.

Key Findings from Karnataka

Support Mechanisms

At the time of evaluation, 33750 ASHAs were working in the state. The ASHA programme is managed by one Nodal officer and one administrative assistant based within SPMU. However, the training component is managed separately by another officer working with SIHFW. ASHA mentors who are erstwhile District/ASHA trainers are expected to support the programme both at district and block levels. However in practice the programme is managed by the existing DPMU staff since trainers are mostly involved in continuous rounds of training which limits their involvement in field level supportive supervision and monitoring. At the village level also, ANMs have been designated to provide handholding and mentoring support to the ASHAs. There is no report of training of these staff in ASHA mentoring and supportive supervision.

In terms of payments of incentives, delays were reported with variable patterns across districts and blocks. On average ASHAs earned between ₹ 1000-2000 per month. Stock outs of drugs were found with most of the ASHAs interviewed since the drug kits were distributed one time with irregular replenishments. In few instances where drugs were unavailable even at PHCs, ASHAs reported being instructed to procure drug kit materials from the VHSNC untied fund.

Profile of ASHA

- The selection in all districts ensured adequate representation of the SC/ST population. Majority of the ASHAs were in the age-group of 26-35 years and about 43% were Class X pass.
- On an average ASHAs covered a population of 1000-1500 and reported working for about 3 to 5 hours on a daily basis.
- Dropout rate was within the range of 8-15% across districts. The main reported reasons for dropouts were -family issues, low incentives, lack of career progression, alternate job opportunities and problems with transport and access to services.
- Acceptance of ASHAs has increased in the community over the years and particularly after the Home-Based Neonatal Care (HBNC) services were introduced. Overall there were no caste-related barriers faced by ASHAs.

Functionality and Effectiveness of ASHAs

- Majority of ASHAs reported being functional on promoting institutional deliveries and immunization. Above 95% ASHAs reported accompanying women at the time of delivery and coordinating immunization days. 86% mentioned being active on pregnancy care and about 73% reported doing newborn visits.
- High levels of functionality and effectives were observed in terms of promotion of institutional delivery and newborn care practices across all three districts. About 85% of service users A were met by ASHA three times or more during pregnancy and over 90% received three or more ANCs. About 60% of women who had an institutional delivery quoted ASHA as the main motivator.
- 72% of the service users A were visited by ASHAs three times during the first 6 weeks after delivery, which was lowest in Chamrajanagar at 64%. About 91% women received advice on breastfeeding in Kolar and Haveri districts while it was reported by 66% women in Haveri. In terms of effectiveness over 80% service users-A in Kolar and Chamrajanagar initiated breast feeding within one hour of the childbirth as compared to 74% in Haveri.
- However functionality of ASHAs on counselling for danger sign management (post-partum haemorrhage etc.), contraceptive use and nutrition was very low with only 15%, 21% and 58% of the service users-B receiving such advice respectively.

Table-1A: Antenatal and Postnatal Care Services by ASHAs as Reported by Mothers with Children Aged <6 Months Across three Districts (Figures Reported in Percentage)

	Kolar	Chamarajanagar	Haveri	Total
Women who were met by ASHA three times or more during their antenatal period	84.4	83.4	86.5%	84.8
Women who completed three or more antenatal check-ups during their pregnancy	90.4	91.7	92.9	91.7
Women who were escorted by ASHA to a facility for delivery	80.1	78.2	72.1	76.7
Women who had an institutional delivery and reporting motivation by ASHA	55.5	69.6	56.8	60.0
Women who were visited by ASHA three times or more during postpartum period (6 weeks)	78.9	63.9	73.8	72.4
Women who received advice on breast feeding from ASHA after child birth	94.1	91.3	66.2	83.6
Women who initiated breast feeding within one hour of birth of the baby	86.6	79.9	73.5%	78.8

Table-1B: Childhood Illness Management Practices Among Mothers with Children Aged >6 Months (Beneficiary B): (Figures in Percentage)

	Kolar	Chamarajanagar	Haveri	Total
Proportion of mothers who met ASHA for any childhood illness	99.5	95.6	100	98.4
Proportion of mothers with a child aged 6 to 23 months with diarrhoea during the last one month and who received services of ASHA	66.7	69.0	73.7	71.1
Proportion of mothers with a child aged 6 to 23 months with diarrhoea during the last one month and who received ORS from ASHA	55.0	50	48.3	49.8
Proportion of mothers with a child aged 6 to 23 months with ARI during the last one month and who received services of ASHA	32.7	46.7	61.3	52.7

- Similarly low proportions of service users-B i.e., only 39% started complimentary feeding for their child at the age of 6 months.

  The low functionality is indicative of inferior training quality which could have emerged due to lack of monitoring and no on the job mentoring mechanisms.
- 98% of service users-B reported contacting ASHAs for childhood illness. This indicates a high level of acceptance of ASHAs in the community. About 71% of service users-B with children having diarrhoea received services from ASHA. However the effectiveness of ASHAs in providing ORS to these children was only 50%. Low coverage was noted on services for ARI at only 53%.
- This reflects the missed opportunity to provide appropriate community level care which could be attributed to either lack of drugs, poor training or limited support leading to lack of confidence amongst ASHAs to use their skills.
- 69% of VHSNC members reported that ASHAs are undertaking public health related services like preventive/curative care & water and sanitation and 25% said they were active on promotion of health equity or rights awareness.
- However, of the total non-beneficiaries interviewed 35% were from SC/ST households; similarly a large majority of the non-beneficiaries were from poor households (with household earnings being <1000 rupees per month). This points towards a much larger concern that ASHAs are unable to reach the most vulnerable and marginalized sections of the community.

Key Findings from Nagaland

Support Mechanisms

- At state level programme is managed by one State Nodal Officer and administrative assistant. The programme is managed by a dedicated Community Mobilizer at the block level, while the existing Staff of DPMU manages the programme at district level and there are no facilitators at the village level.
- About 30% of the ASHAs reported earning between ₹ 500-650 in one month and another 29% received between ₹ 350-500 while 12% received more than ₹ 650 in one month. Mode of payment was reported to be cash.
- Though drug kit has been distributed to all the ASHAs, refilling was found to be irregular. None of the ASHAs were maintaining the drug stock card and 36% of the ASHAs shared that their drug kits were refilled about six months back.

Profile of ASHAs

- About 76% of the ASHAs were class VIII pass, of which 18% were secondary school pass, 5% were intermediate pass while 1% were graduates.
- Selected through village meeting organized by Headman or Village Council members, maximum of ASHAs were found to be ST and Christian.
- Majority of ASHAs were devoting about 1 to 2 hours per day on their work and serving about a 1000 population. Most of the ASHAs were trained up to Module 5 and training in Round 1 of Module 6 and 7 has been conducted for about 80%.

Functionality and Effectiveness of ASHA

- 88% ASHAs reported being active on promoting institutional delivery while 70% reported accompanying pregnant women for institutional delivery. About 86% reported conducting regular household visits and 58% were functional on immunization services.
- Though high functionality of ASHAs was noted in promoting institutional deliveries and counseling for women on all aspects of pregnancy, low levels of effectiveness was observed in terms of providing maternal and newborn care services. Only 29% of the service users-A reported that ASHAs visited them at least thrice during antenatal period for counseling (highest in Dimapur – 36%) while three ANC services were received by 45% in Dimapur, followed by 35% in Phek and 29% in Wokha.
- About 62% of service users-A reported being advised by ASHA for institutional delivery. However, high home delivery figures of 60.6% indicate low effectiveness. Non-availability of transport facilities (in 35% cases), family pressure/tradition and faith on family members (in 27% cases) and low

Table-1C: Pregnancy and Newborn Care in Nagaland

	1	2	3	4	5	6	7	8
	% of service users-A who were visited at least thrice by ASHA during antenatal period	% of service users-A who received three ANCs or more	% of service users-A who went for institutional delivery	% of Service User-A who went for institutional delivery and cited ASHA as a motivator	% of service users who were counseled on post partum care	% of service user-A reporting they received advice from ASHA for early initiation of breast feeding	Help sough from ASHA in case of sick newborn	Counselling on danger signs like excessive bleeding during post natal period
Nagaland	29	37.6	39.4	31.2	34.7	69.7	47.4	12.3
Dimapur	35.9	44.6	47.3	35.1	27.7	77	50	15.4
Wokha	22.4	28.5	36.7	34.7	45.9	67.3	42.1	11.6
Phek	24	35.2	26.8	18.3	33.8	57.7	50	7.1

coverage, seems to limit effectiveness of ASHA in promoting institutional birth. Of the service users-A- who went for institutional delivery, about 35% in Dimapur and Wokha quoted ASHAs to be the main motivator as compared to 18% in Phek.

- Nearly 70% service usersA shared that ASHAs have advised them about initiation of breastfeeding/colostrum feeding and almost all service users-A initiated breast feeding within first three hours of birth. However effectiveness in ensuring no pre-lacteal feeds was seen to be low since during first three days of birth plain water was fed to baby by 59.2% mothers in Phek, 15.3% in Wokha and 10.1% in Dimapur respectively.
- Counselling on post natal care shows variable patterns as only, 12% Service users-A were advised on danger signs after delivery as compared to over 50% who were advised on early initiation of breast feeding, immunization and keeping the newborn warm.
- Interestingly, in case of a sick newborn, 42-50% of the service users-A across all districts sought ASHA's help for care of the newborn.
- Of the entire service users-B who suffered from diarrhea in last one month, 71% sought

Table-1D: Common Childhood Illness and Management

	1	2	3	4	5	6
	% of user-Bs who had diarrhea and whom ASHA helped in some way	% of user-Bs who had diarrhea and to whom ASHA gave ORS from her kit	% of user-Bs who had diarrhoea and sought treatment	% of ASHA had knowledge of making ORS	% of user-Bs who had diarrhea and to whom ASHA suggested methods of hand washing and cleanliness practices	% of user-Bs who had diarrhea and to whom ASHA advised to continue feeding the child
Nagaland	86	56.8	81.1	68.3	36.5	70.3
Dimapur	93	69	93.1	71.1	51.7	72.4
Wokha	96	60	72	68.6	40	68
Phek	65	35	75	62.2	10	70

help from ASHAs while 51% sought help from ANM and only 11% from AWW. However in over 93% cases ASHAs helped service users-B in some way in Dimapur and Wokha as compared to 65% in Phek.

- In 70% of the cases ASHAs advised the mother to continue feeding the child during illness while advice on hand washing and cleanliness practices was given to 52% service users-B in Dimapur, 40% in Wokha and 10% in Phek

- Overall about 81% of the users-B with diarrhoea sought treatment (72-75% in Wokha and Phek and 93% in Dimapur) and about 69% children in Dimapur, 60% in Wokha and 35% in Phek got ORS as part of treatment. It is important to note that in all these cases ASHAs were the only source of ORS for them.

- Over 68% of the ASHAs had adequate knowledge levels for preparing ORS at home. However only 52% of the service users-B in Wokha and 15 % in Phek were told by ASHA about the preparing ORS at home.

ASHAs in Karnataka are highly functional and effective on tasks related to promotion of institutional delivery and immunization which are also the most commonly incentivised tasks for ASHAs. Nagaland showed promising results in terms of ensuring immunization but effectiveness in ensuring three ANC and institutional delivery was seen to be low and can actually be attributed more to system failure and traditional practices. Actual counselling on danger signs of pregnancy and post-partum care was less for both the states. Irrespective of the poor supply of drugs and frequent stock outs, role of ASHAs in diarrheal cases were at modest levels in both the states while it was low in cases of symptoms suggestive of ARI. In these states ASHAs have been trained in first round of Module 6 and 7 and round two is underway. A lack of training monitoring and no post training follow-up by the support staff is responsible for the functionality gaps related to home based post natal care for mothers and newborn. These should be improved with consistent supportive supervision, regular field level mentoring and refresher training. ASHAs need to be sensitized for undertaking targeted home-visits, especially in marginalized households for better counselling on essential newborn care (feeding, temperature regulation), identification of danger signs and early referral along with nutritional counselling (appropriate complementary feeding) which could help improve neonatal and child health.

SECTION 2

Sixth Common Review Mission

Findings and Recommendations on Community Processes

In the interim between the last update issued in July 2012 and this, Sixth Common Review Mission led by the Ministry of Health and Family Welfare was undertaken in fifteen states. It studied extensively all aspects of NRHM implementation including the community processes. The section below summarizes key findings related to ASHA and community processes. Based on extensive analysis of the field level findings, important recommendations were made by the reviewers and have been captured here.

Findings Related to Community Processes[4]

ASHA

- ASHAs across all states have consistently been described in terms such as "vibrant" and "enthusiastic" etc. Most ASHAs are functional in areas of promotion of institutional deliveries, immunization and family planning services. In Kerala ASHAs are mainly facilitators for NCD services. Their role as community level care provider is limited even where training of three rounds of Module 6 and 7 has been completed. Home visits as per Home Based Newborn Guidelines are being conducted in Assam, Chhattisgarh, Odisha, Madhya Pradesh, Punjab, Manipur, Tripura and Uttarakhand.
- Selection of ASHAs is complete in all states except Delhi (88%), West Bengal (77%) and Tamil Nadu (57%) where the final selections are ongoing. Turnover rate of 1-4% was reported across states. Mechanisms of systematic replacement of non functional or drop out ASHAs are reported only from Uttar Pradesh. States of Odisha and Tripura need to plan for more ASHAs to achieve adequate coverage of one ASHA per AWC. Most common reasons for dropout were reported to be the selection of ASHAs as AWWs, Panchayat members and ASHA Facilitators etc.
- Performance monitoring based on functionality indicators has been introduced in states of Bihar, Delhi, Chhattisgarh, Odisha, Rajasthan and Uttarakhand while other states are yet to start. Detailed data base of ASHAs is maintained in Bihar, Chhattisgarh, Odisha, Uttar Pradesh, Kerala and Delhi.
- State specific adaptation of Module 6 and 7 has been made in Uttar Pradesh, Bihar, Delhi, Tamil Nadu and Chhattisgarh. In Kerala non communicable disease focused modules are proposed as Module 6 and 7. Training of Module 6 and 7 and is proceeding at a varying pace across states, the gradient being as follows – Rounds 4 for ASHAs – Gujarat, Round 3 – Uttarakhand and Manipur, Round 2 – Tripura and just initiated in Bihar, Madhya Pradesh and Odisha (in 18 high focus districts); Round 1– Bihar, Odisha, Madhya Pradesh, Punjab, Rajasthan and Tamil Nadu; TOT – Uttar Pradesh, Delhi and Haryana. Chhattisgarh has completed training of Mitanins in 16 modules with Module 14 and 15 as equivalent to Module 6 and 7.

4 Excerpted from Main Report of Sixth Common Review Mission; January 2013.

- Adhoc measures used for refilling of ASHA drug kits lead to frequent stock outs of drugs. No refilling of the drugs was reported in Uttar Pradesh and West Bengal after one time distribution. In Manipur, Tripura and Uttrakhand neither have drugs been supplied as per HBNC package nor have newborn referrals picked up. Communication kit was provided to ASHAs in Bihar.
- Support structures for the ASHA programme has been set up in states as follows: all four levels – Bihar, Chhattisgarh, Rajasthan, Uttarakhand, Tripura; at three levels – Madhya Pradesh, Assam, Manipur; at two levels – Gujarat, Odisha and Punjab; at one level – Uttar Pradesh. In the five non high focus states of Delhi, Haryana, Kerala, Tamil Nadu and West Bengal the programme is managed by existing staff. Strengthening of support structures with appropriate training has not been done in most states.
- ASHAs met across states reported incentive range from ₹ 500- ₹ 2500. Lowest amount was reported from Chhattisgarh and Manipur where ASHAs have been selected at 300-400 population. Highest incentive is reported in Odisha which can rise up to ₹ 5000. In Uttar Pradesh some ASHAs with large population coverage also make similar amounts. Rajasthan and Kerala have an assured monthly compensation of ₹ 1100 and ₹ 500 respectively. Delays in payments and irregular payments are a problem in many states.
- Many states have provided non monetary incentives. Best performer in this area is Assam which provided uniform/sari, umbrella, torch, ID card, radio and mobile sets. Assam has introduced a medical insurance scheme for ASHAs while Chhattisgarh has a more elaborate welfare programme. Radio programme for ASHAs has been initiated in Assam, Manipur, West Bengal and Chhattisgarh. Rest rooms for ASHAs were available at DH and SDH level only in Odisha and Assam while in Uttar Pradesh ASHAs are expected to use the rest rooms built for patient relatives.
- A formal mechanism for Grievance Redressal was reported from Chhattisgarh and Assam with a dedicated help line. Madhya Pradesh, Odisha and Manipur are in the process of setting up grievance mechanisms for ASHAs. Reports of grievances being addressed through an informal process during monthly meetings were shared from Odisha, Tripura and Uttar Pradesh. Rajasthan has also started a helpline for complaints related to payment but the awareness about helpline was low among ASHAs.
- Chhattisgarh has a sponsorship programme for ASHAs to enter ANM training schools and Bihar has supported about 1000 ASHAs to clear the Class Xth exam through National Institute of Open Schooling (NIOS).

VHSNC

- States which have shown an active VHSNC are Chhattisgarh, Odisha, Uttar Pradesh, Punjab, Kerala, Tamil Nadu and Tripura. The best practice in this area is clearly Chhattisgarh where VHSNCs maintain birth and death records for their own information and monitor access to services on a list of 24 items and take remedial steps where needed. States like Odisha, Rajasthan, West Bengal, Uttarakhand, Uttar Pradesh, Tamil Nadu and Tripura have had training for VHSNC.
- Most states report improving utilization of VHSNC funds. ASHAs were reported to be member secretaries of VHSNC in only Assam, Madhya Pradesh and Uttar Pradesh. However irrespective of the membership status of ASHAs, the functionality of VHSNCs was seen to be dependent on ASHA's engagement and participation. In states where ASHAs are trained and supported to provide leadership roles to VHSNC, the VHSNCs are performing better. In West Bengal and Uttarakhand transfer of VHSNC funds to rural development department was observed but the outcome of this convergence was reported to be poor.
- Four of the fifteen states visited had Community Based Monitoring programme, these are Chhattisgarh, Odisha, Uttarakhand and Bihar.

Role of PRI

Rogi Kalyan Samitis (RKS) has been constituted in over 97% of the facilities in all states. PRI are member of RKS and DHS in all states. However the level of participation varies. At one end they are the chairpersons as in Tripura and Kerala and at the other end they do not participate in meetings as seen as Tami Nadu. Their ability to influence

critical issues like better fund utilization of user fees and lower exclusion seems to be limited. There are no training programmes for PRIs to enhance their participation.

Recommendations

- Most states have made 95% selection of ASHAs against the set targets. However findings of various reviews and monitoring visits highlight that the areas where ASHAs are yet to be selected are usually the most critical areas with high proportion of vulnerable population or difficult geographic terrain. States should therefore complete the ASHA selection to ensure that all vulnerable areas have an ASHA even if it means reducing the population norm.
- Though states have set up support structures at various levels, training of support structures has lagged behind. States must expedite the training of Handbook for ASHA facilitators to strengthen the support structures especially ASHA facilitators. ASHAs and ASHA facilitators need to be sensitized and trained in Reaching the unreached brochures to ensure adequate coverage.
- Gaps in quality of trainings have been identified and need to be corrected through periodic refresher rounds with better establishment of training structure and ensured availability of equipment and modules during training. Recognition of the need to improve training quality must now progress to specific strategies of choosing and accrediting training sites as well as trainers. Special emphasis to ensure that books, equipment and communication kits are in the hands of trainers and trainees would also improve quality of trainings. Creating career opportunities for ASHAs is essential and can be achieved through certification of their skills and supporting them in education programmes as seen in Chhattisgarh and Bihar.
- There is a need to move from adhoc mechanisms to well-oiled systems for–a) Performance Monitoring systems; b) Drug kit replenishments; c) Payment efficiency; d) Grievance redressal mechanisms and e) ASHA Welfare schemes. There are some best practices from the states visited in these areas which can be analyzed, generalized and replicated in other states. For instance Chhattisgarh is an exemplar for setting up grievance redressal system and ASHA Welfare schemes, Odisha and Assam for incentive payment processes. However states are still grappling with issues of setting up drug kit replenishment system and performance monitoring system. States should ensure one fixed day payment process for all ASHAs irrespective of the mode of payments to eliminate delays in payments.
- There is a need to formulate a clear National Guideline and a best practice compendium for VHSNC for use as a minimum package for training the VHSNCs. Involvement of NGOs is essential to build additional capacity required for training of VHSNCs. States should now endeavour to reposition the ASHA and her support structure to play a leadership and capacity building role for the VHSNCs and enable both to work in close coordination with PRIs.
- For implementing and scaling up community based monitoring across states and districts additional technical capacity of NGOs is essential.

SECTION 3

Progress of the ASHA program

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

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

The matrix also provides information on modes of payment to the ASHA, and drug kits. We have used the data reported by the states for the ASHA Matrix, upto the period of December 2012.

Section 3.1: Selection and Recruitment

Based on the recent data 95% of selection target has been achieved for the entire country. Amongst the High Focus States, Chattissgarh, Madhya Pradesh, Odisha and Uttar Pradesh have revised the proposed number of ASHAs according to 2011 Census data, while Jharkhand, Rajasthan and Uttarakhand have retained their primary target. Thus, in most high focus states except Rajasthan and to a little extent in Bihar and Madhya Pradesh, the required number of ASHAs are already in place. All North Eastern (NE) states continue with their primary targets, and as per that have selected 99% ASHAs.

Only 90% selection target has been achieved for Non-High focus states as five of these eleven states- Jammu and Kashmir, Gujarat, Haryana, Maharashtra and West Bengal have increased their proposed figures for number of ASHAs. As per the revised norms, only Maharashtra has achieved nearly100% selection and others are in process of selecting new ASHAs. In states retaining original target, Andhra Pradesh has completed selection while Delhi, Kerala and Punjab are very close to achieving complete selection. Karnataka is facing a high-turnover of ASHAs and has initiated the process for fresh selection.

Table-3.1 A: Status of ASHA Selection in High Focus States (December, 2012)

State	Proposed No. of ASHAs	No. of ASHAs Selected	% of ASHA Selected
Bihar	87135	84365	97
Chhattisgarh	66023	66023	100
Jharkhand	40964	40964	100
Madhya Pradesh	56941	56019	98
Odisha	43530	43373	99.63
Rajasthan	54915	51500	94
Uttar Pradesh	136174	136094	99.94
Uttarakhand	11086	11086	100
Total	**496768**	**489424**	**99**

Table-3.1B: Status of ASHA Selection in North East States (December 2012)

State	Proposed No. of ASHAs	No. of ASHAs Selected	% of ASHA Selected
Arunachal Pradesh	3862	3757	97.28
Assam	29693	29172	98.24
Manipur	3878	3878	100
Meghalaya	6258	6258	100
Mizoram	987	987	100
Nagaland	1700	1700	100
Sikkim	666	666	100
Tripura	7367	7367	100
Total	**54411**	**53785**	**98.85**

Table-3.1C: Status of ASHA Selection in Non High Focus States (December 2012)

State	Proposed No. of ASHAs	No. of ASHAs Selected	% of ASHA Selected
Andhra Pradesh	70700	70700	100
Delhi	5357	4913	92
Gujarat	35046	30970	88
Haryana	17000	13843	81
Jammu and Kashmir	12000	***10683***	89
Karnataka	39195	29979	76
Kerala	32854	31868	97
Maharashtra	58945	58855	99.8
Punjab	17360	16383	94
Tamil Nadu	6850	3905	57
West Bengal	61008	47402	77
Total	**356315**	**319501**	**90**

Table-3.1D: Status of ASHA Selection in Union Territories (December 2012)

Union Territory	Proposed No. of ASHAs	No. of ASHAs Selected	% of ASHA Selected
Andaman and Nicobar Islands	407	407	100
Dadra & Nagar Haveli	250	208	83
Lakshadweep	85	83	97.65
Daman & Diu*	119	98	82
Total	**861**	**796**	**91.75**

*Daman and Diu has recently started ASHA program, while Union Territory Chandigarh has withdrawn its ASHA programme.

Grand Total for All States and Union Territories			
Total	**908355**	**863506**	**95%**

Table-3.1E: Density of ASHA in High Focus States

Name of the State	Proposed No. of ASHAs	ASHAs Selected so far	Rural Population as per 2011 Census	Current Density of ASHAs
Bihar	87135	84365	9,20,75,028	1/1091
Chhattisgarh	66023	66023	1,96,03,658	1/297
Jharkhand	40964	40964	2,50,36,946	1/611
Madhya Pradesh	56941	56019	5,25,37,899	1/938
Odisha	43530	43373	3,49,51,234	1/806
Rajasthan	54915	51500	5,15,40,236	1/1001
Uttar Pradesh	136174	136094	15,51,11,022	1/1140
Uttarakhand	11086	11086	70,25,583	1/634

Table-3.1F: Density of ASHA in North East States

Name of the State	Proposed No. of ASHAs	ASHAs Selected so far	Rural Population as per 2011 Census	Current Density of ASHAs
Assam	29693	29172	2,67,80,516	1/918
Arunachal Pradesh	3862	3757	10,69,165	1/285
Manipur	3878	3878	18,99,624	1/490
Meghalaya	6258	6258	23,68,971	1/379
Mizoram	987	987	5,29,037	1/536
Nagaland	1700	1700	14,06,861	1/828
Sikkim	666	666	4,55,962	1/685
Tripura	7367	7367	27,10,051	1/368

Table-3.1G: Density of ASHA in Non High Focus States

Name of the State	Proposed No. of ASHAs	ASHAs selected so far	Rural Population as per 2011 Census	Current Density of ASHAs
Andhra Pradesh	70700	70700	5,63,11,788	1/796
Delhi*	5357	4498		
Gujarat	35046	30159	3,46,70,817	1/1150
Haryana	17000	13755	1,65,31,493	1/1202
Jammu and Kashmir	12000	9904	91,34,820	1/922
Karnataka	39195	29979	3,75,52,529	1/1253
Kerala	32854	31868	1,74,55,506	1/548
Maharashtra	58945	58855	6,15,45,441	1/1046
Punjab	17360	16383	1,73,16,800	1/1057
Tamil Nadu**	6850	3905		
West Bengal	61008	46818	6,22,13,676	1/1329

*Delhi has selected 1ASHA per 2000 population in certain identified clusters
** ASHAs have been selected only in the tribal areas

Table-3.1H: Density of ASHA in Union Territories (UTs)

Name of the State	Proposed No. of ASHAs	ASHAs Selected so far	Rural Population as per 2011 Census	Current Density of ASHAs
Andaman and Nicobar Island	407	407	244411	1/601
Dadra and Nagar Haveli	250	208	183024	1/880
Lakshadweep	85	83	14121	1/170
Daman & Diu	119	98	60331	1/616

Section 3.2: Training of ASHA

More than 80% of ASHAs in most high focus and nearly all in North East states have been trained up to Module 5. Although training of Module 5 in Madhya Pradesh started much later than rest of the High Focus states, it has trained 76% of its ASHAs. About 67% ASHAs have completed training in Module 5 for Rajasthan. To expedite the process of completing Module 5 training in Bihar contents of Module 5 have been merged with Module 6 and 7, and the length of the training has been increased from 20 days to 24 days, to be conducted in four rounds of six days each. Except for Karnataka and Punjab, where Module 5 training is complete, it is still underway in all non- high focus states.

Most of the states are now planning to train their newly inducted ASHAs, in one consolidated Module. This module largely captures the content of previous five modules and is to be transacted in eight days.

Module 6 and 7 has been rolled out in all states, except in Kerala, where the state will develop state specific skill training modules for ASHA. In the last six months, states have made considerable headway in strengthening training sites and expanding ASHA trainer pools. Training of State trainers in Round 1 and Round 2 for Modules 6 and 7 is complete in almost all states. All states have also completed Round 1 TOT for ASHA Trainers. Total Number of qualified state trainers in Round 1 are 277 and for Round 2 are 208. Overall, 7192 District/ASHA trainers are available and have also been accredited.

The number of ASHAs Trained in the first two rounds of Modules 6 and 7 shows a steady increase. Round 1 ASHA Training is underway in all the high focus states, except Uttar Pradesh. 80% ASHAs from Jharkhand and 50% from Bihar, MP and Odisha have been trained in first round. All these states have also initiated Round 2. Comparatively, Rajasthan shows a slow progress of training. Uttarakhand has completed training of ASHAs in three rounds and has also recently undertaken a refresher TOT for its State and ASHA Trainers.

The state of Uttar Pradesh is on the verge of launching training of ASHAs in an adapted version of Module 6 and 7 to avoid duplication of the content covered in Comprehensive Child Survival Programme (CCSP) training. District Trainers training is underway in the state.

All North Eastern states except Assam have completed two rounds of Module 6 and 7. Round 3 training of ASHAs has been completed in Manipur and Sikkim and is underway in Meghalaya and Tripura.

In Non-High Focus states only Jammu and Kashmir, Delhi and Haryana are yet to initiate ASHA training in module 6 and 7. Haryana has trained its ASHAs in two phases in a HBPNC module. This training was under taken in support with Norway India partnership initiative. A substantial progress has been observed in Andhra Pradesh, Gujarat, Karnataka, Maharashtra and West Bengal which are in various stages of trainings in Round 1 and Round 2. The first two states have actually completed training 85% ASHAs in Round 1, Karnataka has trained 72% in first two rounds while West Bengal has trained 48% in Round 1.

All ASHAs in Punjab have been trained in the first two rounds while Round 3 and Round 4 is underway in Gujarat and Karnataka.

The past six months also witnessed initiation of ASHA training in Modules 6 and 7 in Tamil Nadu, Union-Territories of Andaman and Nicobar Islands and Dadra and Nagar Haveli.

Table-3.2A: Training Status for High Focus States

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Bihar	84365	52859 (63 %)	52859 (63 %)	❖ 23 state trainers trained in Round 1 and 17 trained in Round 2 ❖ 4 State Training sites and 14 District Training sites established with NGOs ❖ 802 District Trainers trained in Round 1 ❖ Module 5 Training of 4 days merged with 4 rounds of Module 6 & 7 training, making it 4 Rounds of 6 days each, Round 1 training of 6 days completed for 48822 ASHAs (58%) and 8381(10%) ASHAs trained in Round 2. ❖ Roll out of ASHA Facilitators training started	
Chhattisgarh	66023	60092 (91%) Mitanins trained in Module 1 to 12.		❖ 55630 Mitanins (84.2 %) trained on 13th module ❖ 54100 Mitanins (81.86 %) trained on module 14th and 15th module ❖ 52200 Mitanins (80 %) trained on revision Round Module 16	
Jharkhand	40964	39214 (95.73%)	35675 (87.09%)	40964 (100%)	❖ 13 State trainers trained in Round 1 and Round 2 ❖ 407 District Resource Persons trained in Six days state TOTs ❖ 32945 Sahhiya (80.4%) trained in Module 6A ie. – first Round of Module 6 and 16191(39.5%) Sahhiya trained in Module 6B ie. – second Round of Module 6. ❖ Training of Sahhiya Sathi is on
Madhya Pradesh	56019	47022 (83.93 %)	45777 (81.71%)	42405 (75.69 %)	❖ 31 state trainers trained in Round 1 and 27 in Round2 ❖ 586 district trainers trained in Round 1 ❖ 29075 (51.9%) ASHAs trained in Round 1 and 8776 (15%) ASHAs trained in Round 2
Odisha	43373	43372 (99.6%)	43373 (99.6%)	41560 (95.8 %)	❖ 16 state trainers trained in Round 1 and 12 in Round 2 ❖ 290 District Trainers trained ❖ 22824 (52.43%) ASHAs trained in Round 1 and 10254 (23.56%) Trained in Round 2.

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Rajasthan	51500	34776 (67.5 %)	45110 (87.6 %)	34664 (67.6 %)	❖ 11 state trainers in Round 1 and Round 2 ❖ 669 District Trainers trained in Round 1 ❖ 5905 ASHAs (8%) trained in Round 1
Uttar Pradesh	136094	129150 (95%)	129150 (95%)	121580 (89.3 %)	❖ 22 State Trainers Trained in Round 1 ❖ District TOTs are underway and ASHA trainings are being planned
Uttarakhand	11086	11086 (100%)	11086 (100%)	8978 (81%)	❖ 6 state trainers trained in Round 1 and 5 in Round 2 ❖ 231 District trainers trained in Round 1 and 203 in Round 2 ❖ 544 out of total 550 (99%) ASHA facilitators trained in Round 1 and 2 (7 Days) & 539 trained in Round 3 ❖ 10313 ASHAs (93%) trained in Round 1, 10064 (91%) in Round 2 & 10209 (92%) in Round 3 of five days each ❖ Refresher Training of Trainers for Round 1 and 2 completed

Table-3.2B: Training Status for North Eastern States

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Assam	29172	28544 (97.85%)	28497 (97.7%)	28422 (97.43%)	❖ 17 State trainers trained in round 1 and 14 trained in Round 2 ❖ 153 District trainers trained in Round 1 ❖ 15193 (52%) ASHAs trained in Round 1 ❖ ASHA Facilitators trained in 15 districts
Arunachal Pradesh	3757	3559 (95%)	3606 (96%)	3635 (97%)	❖ 3 State trainers trained in Round 1 and 4 trained in Round 2 ❖ 28 District trainers trained in Round 1 ❖ 3627 ASHAs (96%) trained in Round 1 and 2027 (73%) trained in Round 2

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Manipur	3878	3878 (100%)	3878 (100%)	3878 (100%)	❖ 3 State trainers trained in Round 1 and 2 ❖ 62 District trainers trained in Round 1 and 2 ❖ 3878 (100%) ASHAs trained in Round 1, 2 and 3
Meghalaya	6258	6250 (99.9%)	6250 (99.9%)	6250 (99.9%)	❖ 3 State trainers trained in Round 1 and 2 ❖ 66 District Trainers trained in Round 1 ❖ 5891 (94%) ASHAs trained in Round 1, 5861(93%) in Round 2 and 1400 (23%) in Round 3 ❖ 282 ASHA Facilitators trained in Round 1 & 274 in Round 2 and 158 in Round 3
Mizoram	987	987 (100%)	987 (100%)	987 (100%)	❖ 3 State trainers trained in Round 1 and 2 ❖ 28 District Trainers trained in Round 1 ❖ 987 (100%) ASHAs trained in Round 1 and Round 2
Nagaland	1700	1700 (100%)	1700 (100%)	1700 (100%)	❖ 3 State trainers trained in Round 1 ❖ 60 District Trainers trained in round 1 ❖ 1576 (91.6%) ASHAs trained in Round 1 & 1571 (92.4%) in Round 2
Sikkim	666	666 (100%)	666 (100%)	666 (100%)	❖ 3 State trainers trained in Round 1 and 4 trained in Round 2 ❖ 20 District Trainers trained in Round 1 ❖ 666 (100%) ASHAs trained in Round 1, 2 and 3
Tripura	7367	7367 (100%)	7367 (100%)	7367 (100%)	❖ 5 State trainers trained in Round 1 and 2 ❖ 89 District Trainers trained in Round 1 ❖ 7257 (98.5%) ASHAs trained in Round 1; 7009 (95%) in Round 2 and 3883 (53%) trained in Round 3

Table-3.2C: Training Status for Non High Focus States

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andhra Pradesh	70700	30 days training as the programme preceded NRHM, but covered women's and children's health			❖ 12 State trainers trained in Round 1 and 11 in Round 2 ❖ 654 District Trainers trained in Round 1 ❖ 59824(84.6%) ASHAs trained in Round 1
Delhi	4913	Module 1-4 clubbed as Module 1, 2, 3 – 2962 (60%) ASHAs trained Module 5 as Module 4 – 3266 (66.48%) ASHAs trained			❖ State has adapted training modules and trained: Trainers for the state and district level
Gujarat	30970	26890 (87%)	26596 (86%)	26553 (86%)	❖ 4 state trainers and Five trainers from Deepak Charitable Foundation trained in Round 1 and 2 ❖ 160 district trainers trained in Round 1 ❖ 26371 ASHAs (85%) trained in Round 1, 21455(69.2%) trained in Round 2 ❖ 159898 ASHAs (51.3%) trained in Round 3, 12893 (42%) in Round 4
Haryana	13843	13730 (99.2%)	13289 (96%)	11112 (80.3%)	❖ 12038(87%) ASHAs trained in 2 days training of HBPNC module - Phase 1 and 11331(81%) trained in Phase 2; (This training is supported by NIPI) ❖ 9 state trainers trained for Module 6 & 7
Jammu and Kashmir	10683	9500 (90%)	9000 (84.24%)	8300 (77.6%)	❖ 6 State Trainers trained in Round 1 and 2 ❖ 225 District Trainers trained in Round 1 ❖ 461 second ANMs of the sub-centre synonymous with ASHA Facilitators trained
Karnataka	29979	Up to Module 5 - 33750 ASHAs were trained			❖ 15 State Trainers trained in Round 1 and 10 trained in Round 2 ❖ 240 District Trainers trained in Round 1 ❖ 21500 ASHAs (72%) trained in a combined ten days training of Round 1 and 2 ❖ 7450(22%) trained in a combined training of Round 3 and 4
Kerala	31868	28205 (88.5%)	25673 (80.56%)	22992 (72.1 %)	❖ State is planning to train ASHAs in a state specific module
Maharashtra	58855	56923 (96%)	55792 (90.7%)	50434 (85.6%)	❖ 15 state trainers trained in Round 1 and 13 trained in Round 2 ❖ 412 District trainers trained ❖ 66 BCMs and 910 Block Facilitators trained ❖ 15288 ASHAs (26%) trained in Round 1 & 8565 (14.55%) trained in Round 2 and 3391(5.76%) trained in Round 3

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Punjab	16383	16375 (99.9%)	16375 (99.9%)	16403 (100.12% including drop out ASHAs)	❖ 7 State trainers trained in Round 1 and Round 2 ❖ 326 District Trainers trained in Round 1 ❖ 16483 ASHAs (100%) trained in Round 1 and Round 2
Tamil Nadu	3905	2650 (68%)	2650 (68%)	2650 (68%) Module 1-5 trainings done only in tribal districts	❖ 1464 ASHAs (37%) trained in adapted version of Module 6 and 7
West Bengal	47402	42211 (89 %)	39163 (82%)	37577 (79.27%)	❖ 17 State Trainers trained in Round 1 and 13 trained in Round 2 ❖ 780 District trainers trained in Round 1 ❖ 22741 ASHAs (48%) trained in Round 1 & 5364 (11.2%) trained in Round 2

Table-3.2D: Training Status for Union Territories (UTs)

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andaman and Nicobar Island	407	100%	100%	100%	State has trained 53 ASHAs in Modules 6 and 7
Dadra and Nager Haveli	208	87 (41%)	87 (41%)	87 (41%)	68 ASHAs have been trained in Round 1 and 45 trained in Round 2. Additionally, orientation of 81 ASHAs on HBNC (through state specific mechanism) done for three days
Lakshadweep	83	83	-	-	No data available
Daman and Diu	ASHA programme was introduced in the state last year and trainings for FY-2013-14 are being planned				

Section 3.3: Support Structures

Box 2: Support structures as per Guidelines on Support Mechanisms for ASHAs[1]

At the ***state level*** the programme is expected to be supported by an ASHA Resource Centre with a team of Programme Manager, Deputy Project manager, communications and documentation officer, training officer regional or zonal coordinators, statistical assistant, data assistant and office attendant. State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organisations will provide policy guidance and programmatic oversight.

At the ***district level,*** a unit of a District Nodal Officer supported by a District Community Mobiliser and data assistant is expected to manage the programme in districts.

At the ***block level***, a Block Nodal Officer supported by ASHA facilitators (appointed at a ratio of 1:20 ASHA) are expected to provide support and supervision.

The National ASHA Mentoring Group (NAMG) provides input to the NHSRC and the MOHFW on key policy matters related to the ASHA programme. The beginning of the second phase of NRHM also saw the reconstitution of the NAMG in November 2012. This new group will continue to strengthen the existing ASHA programme by providing policy inputs and supportive supervision to various states, and will also contribute towards shaping newer roles for ASHA for the twelfth plan and ahead. Like before, the group will meet on a biannual basis to review the programme and provide policy inputs. NHSRC will continue to function as the secretariat for the National ASHA Mentoring Group.

The supportive institutional network at state level and below (Tables 3A to 3D) has expanded rapidly in the past year, as states have increasingly become cognizant of the necessity of a strong support structure to enhance the community processes component.

Most high focus states have established support and supervisory mechanisms at state, district, block and sub block levels. While, Uttar Pradesh has no state ASHA Resource Centres, there is a dedicated team, which undertakes the functions related to the ARC. Though selection of District Community Mobilizers is still pending for MP, it has constituted and trained District MGCA for undertaking supportive supervision related to community processes. Odisha is in process of selecting block community mobilizers.

In North East, state level support mechanisms are in place across all states except Mizoram and Sikkim. At the district level, only Sikkim is managing the programme with its existing structures, while other states have already established them. All these states except Nagaland are yet to put in place the block level support mechanisms. However considering small numbers of ASHAs, management by existing structures appears to suffice.

With programme evolution states have recognized the importance and need for having ASHA facilitators. Most of the high focus states have placed ASHA Facilitators and selection process is underway even in UP and MP. Bihar, Jharkhand and Uttarakhand have started training them in performance monitoring and supportive supervision of ASHAs to achieve better programme outcomes. All the North East states, except Nagaland have engaged facilitators and will soon initiate their training.

The Non high focus states like Punjab, tribal districts of Maharashtra, and Gujarat have district level support structures and have even appointed ASHA facilitators. Others have no support systems below the state and not even at the state in several cases, but are using the existing programme structures to manage and support the ASHA programme.

For achieving better programme outcomes, all states should target building capacities of support structures at all levels in performance monitoring and supportive supervision of ASHAs. Performance monitoring enables identifying causes of non-functionality and should lead to actions for improvements. These actions could involve improving support to ASHAs through increased mentoring, refresher trainings, improving supplies of drugs and equipments, and ensuring regular payments etc.

Table-3.3A: Status of ASHA Support Structure in High Focus States

Status of Support Structure for ASHA				
High Focus States	**State Level**	**District Level**	**Block Level**	**Sector Level**
Bihar	❖ AMG constituted, last meeting held in Feb. 2011 ❖ ARC established, registered as a separate society accountable to State Health Society ❖ Seven Divisional ASHA Coordinators in position	❖ 23 out of 38 DCMs and ❖ 31 out of 38 DDAs are in place	❖ 421 out of 504 BCM are in place	❖ 3948 out of 4150 ASHA Facilitators (one per 20 ASHA) are in place ❖ Training of Facilitators on Handbook for ASHA Facilitators has been initiated
Chhattisgarh	❖ AMG proposed ❖ ARC is working under SHRC	❖ 35 District Coordinators in place in 27 districts	❖ 438 Block Coordinators in place	❖ 3000 Mitanin trainers - 1 per 20 (ASHA Facilitators) in place
Jharkhand	❖ AMG constituted, Only meeting held so far was on 25 May, 2011 ❖ VHSRC established under SHRC	❖ 24 District Programme Coordinators in place	❖ 875 Block Trainers & DRPs in place	❖ 2157 Sahiyaa Saathi selected and trained. ❖ Sahiya Sathis are being trained on Handbook for ASHA facilitators
Madhya Pradesh	❖ AMG merged with MGCA to from MGCA, last meeting in April 2012. ❖ MGCA members allocated districts for monitoring and handholding ❖ State Nodal officer & six consultants in position, working as ARC team	❖ DCM in place in 3 districts ❖ 50 District MGCAs formed & being trained	❖ 174 BCMs in place in 43/50 districts; ❖ 313 Block MGCAs formed and training is underway	❖ ASHA Facilitator selection is underway
Odisha	❖ AMG constituted, last meeting in July 2008 ❖ CPRC in place	❖ District AMGs constituted ❖ DACs in place in all districts	❖ Selection of BCMs underway	❖ 1226 Community Facilitators (ASHA Facilitators selected)

Status of Support Structure for ASHA				
High Focus States	State Level	District Level	Block Level	Sector Level
Rajasthan	❖ AMG constituted, last meeting in Sep. 2011 ❖ ARC working under SPMU presently	❖ 25 DACs in place ❖ DPMs have additional charge in other districts	❖ 237 BACs selected ❖ 100 in position presently	❖ 1076 PHC ASHA Supervisors (1 per PHC) in position presently, (1321/1503 were selected)
Uttar Pradesh	❖ AMG constituted, last meeting in Jan. 2013 ❖ No separate ARC, Nodal officer- ASHA & 3 consultants (supported by NHSRC) in place	❖ 58/75 DCMs are in position ❖ 72 District AMGs constituted	❖ Existing staff (Block PMUs)	❖ ASHA Facilitator selection is underway in 17 districts
Uttarakhand	❖ AMG constituted, last meeting in June 2012 ❖ ARC is outsourced to NGO – HIHT	❖ District ARCs outsourced to NGOs in all 13 districts	❖ 47 BCs placed (one coordinator per 2 blocks) ❖ In urban areas four BCs have been selected	❖ 550 ASHA facilitators (1 for 15-20 ASHAs) ❖ In urban areas-30 ASHA Facilitators have been selected ❖ Training of 550 ASHA Facilitators on Handbook for ASHA Facilitators has been completed

Table-3.3B: Status of ASHA Support Structure in North East States

Status of Support Structure for ASHA				
NE States	State Level	District Level	Block Level	Sector Level
Arunachal Pradesh	❖ AMG constituted & last meeting held on 15th Oct. 2012 ❖ ARC formed	❖ DCM and DDA placed in all districts	❖ Existing BPMU	❖ 348 ASHA Facilitators
Assam	❖ AMG constituted and last meeting held in July 2011 ❖ ARC housed in SPMU (1 Program Executive in place. Recruitment process of State ASHA program Manager and SCM is on process	❖ DCM placed in all 27 districts and managed by ARC	❖ Existing BPMU (Recruitment of Block Community Mobilizer is on process)	❖ 2838 ASHA Facilitators placed (one for 10 ASHAs)

Status of Support Structure for ASHA				
NE States	State Level	District Level	Block Level	Sector Level
Manipur	❖ AMG constituted and last meeting held on 1st August 2012 ❖ ARC formed way	❖ DCMs in place in all districts	❖ Existing BPMU	❖ 194 ASHA Facilitators (one for 20 ASHAs)
Meghalaya	❖ AMG formed and last meeting held in Aug. 2011) ❖ ARC established	❖ DCPC (district Community Process Coordinator) placed in all	❖ Existing BPMU	❖ 312 ASHA Facilitators (one for 15-20 ASHAs)
Mizoram	❖ AMG formed and last meeting held in Sept. 2010 ❖ ARC not established (one Medical Officer-Community Process assigned)	❖ 6 district out of 9 has District ASHA Coordinator (other 3 yet to be recruited)	❖ (No system of Block unit for program management/ health)	❖ 48 ASHA Mobilizer/ Facilitator in placed out of 66 to be recruited
Nagaland	❖ AMG formed & last meeting held on 29th Nov. 2012 ❖ ARC functional under Directorate of Health services	❖ DCMs placed in all 11 districts	❖ 66 Block ASHA Coordinators in place	❖ This is taken care directly by BAC (Block ASHA Coordinator)
Sikkim	❖ AMG formed and last meeting held in Nov. 2011 ❖ ARC does not exist	❖ Existing staff of DPMU	❖ Existing Staff	❖ 70 ASHA Facilitators
Tripura	❖ AMG formed and last meeting held on 25th Aug. 2012 ❖ ARC constituted	❖ Four ASHA Programme Managers and 11 Sub divisional ASHA Programme Managers support the program	❖ None (No block level unit for program management/ health)	❖ 387 ASHA ❖ Facilitators

Table-3.3C: Status of ASHA Support Structure in Non- High Focus States

Non high Focus States	Status of Support Structure for ASHA			
	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	❖ AMG constituted ❖ Indian Institute of Health and Family welfare designated as ARC	❖ Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO) involved	❖ Existing staff	❖ ANM & Health Supervisors at PHC level involved in ASHA support
Delhi	❖ AMG formed, meeting to be held in Feb. 2013 ❖ ARC established; One State level Nodal Officer, 2 Data Assistants and 1 Account Assistant	❖ Existing Staff of DPMU but ❖ District Mentoring Group in place	❖ One unit per 100,000 population. 103 ASHA Units in place. Each unit has Unit Mentoring Group composed of 04-5 members, which includes MOIC, PHN, NGO representatives and ANM as facilitator	
Gujarat	❖ AMG Constituted last meeting in Nov. 2012 ❖ ARC established with a team of 2 consultants	❖ 24 Districts have constituted AMG ❖ DPM for ASHA program are placed in 12 Tribal Districts ❖ In other non-tribal districts managed through existing staff	❖ Existing staff	❖ 2775 out of 3669 ASHA Facilitators (one for ten ASHAs)in position
Haryana	❖ AMG not constituted ❖ ARC not established- One state NGO coordinator & 2 MOs working under SPMU	❖ Existing staff	❖ Existing staff	❖ Existing staff
Jammu & Kashmir	❖ ARC and AMG not established ❖ 1 ASHA Nodal Officer in place	❖ Existing staff	❖ Existing staff	❖ Existing staff

Non high Focus States	Status of Support Structure for ASHA			
	State Level	District Level	Block Level	Sector Level
Karnataka	❖ AMG constituted ❖ ARC established	❖ District ASHA Mentor	❖ One District Trainer also called as ASHA Mentor supervises ASHAs of two blocks	❖ Existing staff (Sub-Centre ANM)
Kerala	❖ AMG constituted, last meetings in Jan. 2012 ❖ ARC established under SHSRC	❖ Existing staff	❖ Existing staff	❖ Existing staff
Maharashtra	❖ AMG constituted ❖ One Nodal Officer-ASHA & on consultant work as ARC team	❖ DCMs appointed in all 33 districts ❖ District AMG formed in 15 tribal and 18 Non –tribal districts	❖ Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks	❖ 941/984 facilitators (one for 10 ASHAs) in tribal districts ❖ 1431/1496 (at PHC level) in non- Tribal districts
Punjab	❖ AMG not constituted ❖ ARC not established, team of two consultants working from SPMU for ASHA Program	❖ DCMs in all 20 districts	❖ Existing staff	❖ 865 ASHA Facilitators in position at cluster level
Tamil Nadu	❖ AMG not formed, but NGOs involved in ASHA support ❖ Institute of Public Health Poonamallee is working as ARC	❖ Existing staff	❖ Existing staff (Community Health Nurse)	❖ Existing staff (Sector Health Nurse)
West Bengal	❖ AMG formed ❖ ARC outsourced to CINI	❖ Existing staff (Dy CMHO, DPHNO)	❖ Existing staff	❖ Existing staff (Health Supervisor posted at GP level)

Table-3.3D: Status of ASHA Support Structure in Union Territorises (UTs)

	Status of Support Structure for ASHA			
State Name	State Level	District Level	Block Level	Sector Level
Andaman & Nicobar Island	❖ AMG does not exist ❖ ARC doesn't exist and SPMU manages the programme	❖ Existing staff	❖ Existing staff	❖ Existing staff
Dadra and Nagar Haveli	❖ AMG and ARC do not exist ❖ SPMU is managing the ASHA Programme	❖ Existing staff	❖ Existing staff	❖ Existing staff
Lakshadweep	❖ AMG and ARC do not exist ❖ Medical officer is in-charge of Island is the nodal officer for the Programme	❖ Existing staff	❖ Existing staff	❖ Existing staff
Daman and Diu	❖ AMG and ARC do not exist ❖ SPMU is managing the ASHA Programme	❖ Existing staff	❖ Existing staff	❖ Existing staff

SECTION 4

Updated List of ASHA Incentives

This section is in continuation with the list provided in the July 2012 issue, consisting of incentives to ASHAs which have been approved at the National level. This compilation has been prepared using minutes of the past Mission Steering Group Meetings and orders and guidelines issued by the Ministry of Health and Family Welfare. An important addition in the list includes a uniform financial package for ASHA under JSY. This incentive has been linked to performance of ASHA in achieving important outcomes of complete ante natal care and institutional delivery. For ensuring both the components, ASHAs will receive ₹ 600 and ₹ 400 respectively in rural and urban areas. The second incentive which has been added pertains to the Maternal Death Review (MDR). An important strategy under NRHM-RCH framework, MDR has been institutionalized across the country to improve the quality of obstetric care and reduce maternal mortality. The basis of enhancing this incentive from ₹ 50 to 200 is to encourage the frontline workers such as ASHA to report all such deaths.

Table-4: ASHA Incentives

Sl. No.	Heads of Compensation	Amount in ₹/case	Source of Fund and Fund Linkages	Documented in
I	**Maternal Health**			
1	**JSY financial package (NEW uniform package)**			MOHFW Order No. Z 14018/1/2012/-JSY
	For ensuring antenatal care for the woman	300 for Rural areas 200 for Urban areas	Maternal Health-RCH Flexi pool	JSY-section Ministry of Health and Family Welfare -6th Feb. 2013
	For facilitating institutional delivery	300 for Rural areas 200 for Urban areas		
2	Reporting Death of women (15-24 years age group) by ASHA to Block PHC Medical Officer **(New Revised incentive)**	200 for reporting within 24 hours of occurrence of death by phone	Health Sub-Centre Un-tied Fund	MOHFW-OM -120151/148/2011/ MCH; Maternal Health Division; 14th Feb. 2013
II	**Child Health**			
1	Undertaking six (in case of institutional deliveries) and seven (for home deliveries) home- visits for the care of the newborn and post-partum mother[5]	250	Child Health-RCH Flexi pool	HBNC Guidelines – August 2011

5. 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.

Sl. No.	Heads of Compensation	Amount in ₹/case	Source of Fund and Fund Linkages	Documented in
III	**Immunization**			
1	Social mobilisation of children for immunization during VHND	150/session	Routine Immunization Pool	Order on Revised Financial Norms under UIP- T.13011i01/2077-CC- May 2012
2	Complete immunization for a child under one year	100.00		
3	Full immunization per child upto two years age (all vaccination received between 1st and second year age after completing full immunization after one year	₹ 50	Routine Immunization Pool	Order on Revised Financial Norms under UIP- T.13011i01/2077-CC- May 2012
4	Mobilizing children for OPV immunization under Pulse polio Programme	75/day	IPPI funds	
IV	**Family Planning**			
1	Ensuring spacing of 2 years after marriage	500	Family planning Compensation Funds	Minutes Mission Steering Group meeting- April- 2012
2	Ensuring spacing of 3 years after birth of 1st child	500		
3	Ensuring a couple to opt for permanent limiting method after 2 children	1000		
4	Counselling, motivating and follow up of the cases for Tubectomy	150	Family Planning Sterilization compensation funds	Revised Compensation package for Family Planning- September 2007- No-N 11019/2/2006-TO-Ply
5	Counselling, motivating and follow up of the cases for Vasectomy/NSV	200		
6	Social marketing of contraceptives- as home delivery through ASHAs	1 for a pack of three condoms 1 for a cycle of OCP 2 for a pack of ECPs	Family planning Fund	Detailed Guidelines on home delivery of contraceptives by ASHAs-Aug-2011-N 11012/3/2012-FP
V	**Adolescent Health**			
1	Distributing sanitary napkins to adolescent girls	Re 1/pack of 6 sanitary napkins	Menstrual hygiene-ARSH	Operational guidelines on Scheme for Promotion of Menstrual Hygiene Aug. 2010
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	50/meeting	VHSNC Funds	
VI	**Nirmal Gram Panchayat Programme**			
	Motivating households to construct and use a toilet	75/Toilet constructed	Funds for IEC activities under District Project Outlay under TSC	Minutes MSG- Meeting April 2012; DO No. W-11042/7/2007/-CSRP-Part

Sl. No.	Heads of Compensation	Amount in ₹/case	Source of Fund and Fund Linkages	Documented in
VII	**Village Health Sanitation and Nutrition Committee**			
	Facilitating monthly meetings of VHSNC followed by meeting with women and adolescent girls	150/meeting	VHSNC Untied Fund	MOHFW Order Z-18015/12/2012-NRHM-II
VIII	**Revised National Tuberculosis Control Programme**			
	Being DOTS Provider (only after completion of treatment or cure)	250	RNTCP Funds	Revised Norms and Basis of Costing under RNTCP
IX	**National Leprosy Eradication Programme**			
1	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	300	NLEP Funds	Guidelines for involving ASHAs under NLEP
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	500		
X	**National Vector Borne Disease Control Programme**			
1	Preparing blood slides	5/slide	NVBDCP Funds for Malaria control	NVBDCP Guidelines for involvement of ASHAs in Vector Borne Diseases-2009
2	Providing complete treatment for RDT positive Pf cases	20		
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen	50		

Gaon Kalyan Samitis in Odisha

The Village Health Sanitation and Nutrition Committee along with ASHA are key interventions under the "communitization" strategy of the National Rural Health Mission, designed primarily to facilitate active community participation in the health systems. The main objective of establishing Village Health and Sanitation committees in every village was to offer a platform for convergent action on social determinants and increase access to health care services specifically for vulnerable sections of community. VHSNCs were also expected to act as a medium for improving the role of Panchayat in accountability of health care facilities and functionaries and ensuring access to public services. And finally, the other key objective was to initiate Community based monitoring to enable community and community-based organisations become equal partners in the planning process and increase the community participation for improved functioning of the public health system.

These objectives led to the constitution of VHSNCs across the country and under the same spirit took the form of Gaon Kalyan Samitis in Odisha. The concept behind the changed nomenclature was to highlight their broadened scope of work and focus on representation of weaker section of community. Odisha is one among the few states which has undertaken action towards strengthening the functioning of VHSNCs and to a great extent tried to streamline mechanisms for their constitution, capacity building and monitoring. They included some innovations in the processes of achieving this and some of them have been mentioned in the section below.

Constitution of GKS

From the very beginning, strategic planning has governed the GKS programme implementation. The entire process of formation was well facilitated and closely monitored to ensure community involvement. The State issued comprehensive guidelines detailing criteria for selection and steps of formation. Right from the initiation of this process, convergent meetings were held between different departments such as Health, Panchayati Raj, Rural Development, Women and Child Development to ensure active involvement of their field functionaries. The State ensured orientation meetings were conducted with block functionaries at district level and with field functionaries at block level. During the block level meetings, responsibilities were assigned to field functionaries and detailed plans were laid out for conducting village level consultations. GKS were constituted through this consultative process which was mandatorily to be attended by a minimum

Photograph displaying the mobilization campaign used for constituting GKS

of 50 persons. This assured effective participation of the community in formation of their GKS. Prior to this, a three month, state wide campaign utilizing mass media, massive IEC activities, folk media was done. A team was put in place to conduct the process and monitor process activities. Self Help Groups, community based organizations, Non-Governmental Organizations working at village level were extensively used in creating basic awareness at the community level on roles and responsibilities of GKS.

This resulted in the formation of 46000 GKS at revenue village level across the state. Their bank accounts were opened subsequently and are headed by the Ward member as the Chairperson, AWW as convener, and ASHA as its Facilitator. Representative from Self Help Group, Community Based organization and each hamlet from villages are included as member.

Building Partnerships

After the constitution, the next challenge for the state was to ensure support to GKS- through effective supervision and capacity development of its members. To achieve these and for ensuring effective programme implementation, additional technical resources and capacities were roped in for the existing structures. Government decided to involve NGOs with strong presence in the community to enable them to reach out to the marginalized sections of the community more effectively and use their additional technical capacities for programme management. Thus, with the full support and supervision of the Mission Directorate, the Community Processes Resource Centre entered into partnerships with other support organizations like- Care and Action Aid. They have been identified as the Nodal Agencies, which further select NGOs for undertaking tasks related to supportive supervision, monitoring and training of GKS. An advisory group for selection has been set up by the state at District level and includes representatives from Nodal agencies and District Administration. This committee decides the set of criteria for selection of NGOs. Process of selection is transparent, well defined, open and accountable. Scoring criteria have been developed through which selection is undertaken. After selection- based on geographical area, initial verification and mandatory field level validation, an MOU is signed between District Administration, Nodal Agency and NGO. As on today, 83 NGOs are engaged in supporting GKS all across Odisha. Each NGO is given three-four blocks for undertaking the set of tasks mentioned above. Fund release to these NGOs is done from the District Administration.

GKS Capacity Building and Training

The identified Field level NGOs then conducted a two days non-residential training programme. A set of core members such as - President, Convener, Facilitator and representatives from SHG/ Community Based Organizations of each GKS were trained. The venue of training was kept close to the community to reduce the travel time and address issues of inaccessibility. Standard training module was used and training was imparted in local language. GKS guideline, GKS register and other IEC materials formed a part of the training aids distributed. They were also provided and oriented on a *User manual* for filling the GKS register. The training strengthened the knowledge of GKS members in the utilization of untied fund– Do's and Don'ts, disaster management, financial monitoring, enhancing the knowledge of GKS convener on record keeping and preparing the Village Health Plan. More than 1.7 lakh GKS members have been trained and the state has now created a cadre of local Resource persons.

Support and Supervision for GKS

Block specific strategy has been developed to monitor and support the functioning and operationalization of GKS. A Supportive and Supervision Committee has been formed at the block level which is responsible for GKS operationalization. All difficulties and bottle necks faced by GKS with regards to local issues, functioning and financing are sorted out by this committee. It ensures timely submission of reports and monitors implementation activities undertaken by GKS. For each block six persons, both from NGO and government, have been included in this committee. Government support cadre includes sector Medical officers, CDPO, ICDS Supervisor, Block Extension Educator, Junior Engineer, Male and Female Health worker.

Field level monitors in the form of Male Health Worker, LHV and local NGO personnel provide handholding and support for-preparing village health plan; enabling fund utilization based on set of activities decided and finally ensuring monthly submission of reports at Block level. These monitors assess the functioning and carry out grading of GKS on a prescribed set of 15 activities. Functions of GKS are assessed under Excellent, Moderate and Low performing GKS.

The information is shared during bi-annual conventions organized at Block and District level.

Motivational Mechanisms for GKS

In 2011, Health and Family Welfare Department, Govt. of Odisha, under National Rural Health Mission (NRHM) announced *"Sustha Gaon Puraskar"* for those GKS which promote their village as healthy village based on certain criteria. The following objectives are intended to be achieved by this ward.

- Increased participation of the community members in addressing health related issues pertaining to their village.
- Appropriate steps by GKS for maximum utilization of health services and provisions.
- Increased resource mobilization through GKS to address health and other related problems of the community.
- GKS maintaining appropriate integration and coordination with service providers and field functionaries.
- Finally, promote GKS as a self- sustaining and cohesive unit.

Each GKS qualifying for *"Sustha Gaon Puraskar"* receives an additional amount of ₹ 10,000/- as cash award in the form of AC payee cheque, Certificate of recognition and token of appreciation to the GKS members.

Work and Activities of GKS

The GKS guideline issued by the state has laid out a set of activities which could be or could not be undertaken by the committee. Along with this list of wide range activities which could be undertaken by the GKS, a prescribed expenditure limit has also been provided. All activities undertaken and expenditure incurred by GKS need to adhere to the prescribed financial norm. Through this approach, the government is not really directing GKS un-tied fund utilization and is merely providing them with the guidance and flexibility to choose amongst a set of prioritized actions.

The work and activities of GKS include preparation of village health plan, organizing village health camp, facilitating referral of needy patient, cleanliness drive, organizing *Gaon Swasthya Diwas,* installing information board, displaying of emergency telephone number on the board, welcome board, First Aid provision, repairing of defunct tube wells, provision of drinking water during summer (JALCHHATRA), disinfection of water sources, awareness generation on social security measures and distribution of long lasting insecticide treated nets to community, capacity building of PRI members, *Gram Sabha Shasktikaran* with integration of *Panchayati Raj* Department and managing village pipe water scheme under close co-ordination with Department of Rural Development.

Gaon Kalyan Samitis organize Gaon Swasthya Diwas in last Thursday of every month.

For these activities, the state Utilization of Untied Fund was 72% during 2011-12 and a reasonable 55% was utilized by Dec. 2012.

Table-5: Achievements of GKS

Sl.No.	Major Activities	Achievement
1	No. of GKS involve in distribution of Long Lasting Insecticide treated Nets (LLIN)	12530
2	No. of GKS involved in IRS campaign	20000
3	Total Number of cleanliness drive conducted by the GKS	187000
4	No. of Waste disposal dustbin placed at villages	14582
5	No. of tube wells repaired by GKS	48837
6	No. of Platform area of tube well repaired by GKS	28152
7	No. of Health Camp and Shishu Mela organized by GKS	4902
8	No. of Swasthya Kantha campaign conducted by GKS	31882
9	No. of Jalchhatra organized by GKS	90000
10	No. of GKS organized village contact drive and folk media show prevention of Malaria and Diarrhea	8000

Swasthya Kantha

"Swasthya Kantha"- is an interactive health information bulletin board of the GKS displaying tips on health, information about name of the members of the GKS, their responsibility and schedule of the activities to be undertaken by GKS on a monthly basis for information of the people. This is considered as a hallmark of the GKS as a grassroots level structure on community health. It also includes *"Swasthya Barta",* which are messages promoting change in the health seeking behaviour of the rural community and build awareness on people's right to health. The objective of the messages is to educate the community and encourage them for taking actions in addressing issues related to health and sanitation. Convener ASHA of the GKS writes health messages in the *Swasthya Kantha,* which is displayed on walls of the Anganwadi Centre, school, community centre or in any prominent location from where it is clearly visible. The funds to meet the required expenditure are met from the GKS untied fund.

ASHA Writing Health Bulletin Board of GKS

Challenges

Gaon Kalyan Samitis in Odisha have evolved but more convergence and integration with all departments is needed for them to achieve their full potential. Limited involvement and ownership of Ward members for GKS is the key limiting factor in improving their effectiveness and functionality. Even in the current scenario, it is difficult to deploy specific support provisions for the GKS located in difficult inaccessible areas and hard to reach habitations. More effort on capacity development of GKS members in village planning is needed for ensuring local level community action on the specific health issues.

Abbreviations and Equivalent Terms

Abbreviations	Equivalents
AMG – ASHA Mentoring Group	MGCA- Mentoring Group For Community Action
ARC- ASHA Resource Centre	VHSRC- Village Health Sahiya Resource Centre CPRC- Community Processes Resource Centre
ASHA Facilitators	ASHA coordinator Mitanin trainers PHC ASHA Supervisor Sahiyaa Saathi
BC- Block Coordinators	
BCM- Block Community Mobiliser	BAC- Block ASHA Coordinators BF- Block Facilitators BTT- Block Training Team
BPM- Block Programme Manager	
DCM- District Community Mobiliser	APM - ASHA Programme Managers DAC - District ASHA Coordinators DNO- District Nodal Officer DPC-District Programme Coordinators
DDA – District Data Assistant	
DPM- District Programme Manager	
DRP – District Resource Person	
SHRC – State Health Resource Centre	

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