NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Update on the ASHA PROGRAMME

July 2013

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Since the first ASHA update was launched in August 2009, about four years ago, the programme has made many strides, and has evolved in many ways. The number of ASHAs in the country increased from 4,04,451 at that time to nearly 8,70,089 as of July 2013. There are few parallels to this anywhere in the world in terms of scale. Over the last eight years, the ASHA has gained in visibility and has been the focus of attention ranging from the romantic to the cynical. In 2010 a large scale evaluation in eight states[1] demonstrated, inter alia, that the ASHA represents a significant missed opportunity for contributing to health outcomes, and that where the ASHA is well supported, she is effective in the tasks she undertakes. This evaluation combined with sustained advocacy and technical inputs, enabled states to strengthen their support mechanisms for the ASHA. While in terms of programme maturity progress is variable across and within states, there has been substantial forward movement.

The NRHM's vision of communitization envisaged a broader engagement with the community, and this engagement needed to include the Village Health, Sanitation, and Nutrition Committees, platforms of public participation in health facilities- such as the Rogi Kalyan Samitis, and Community Monitoring. These interventions are yet to reach the scale and scope that was envisioned. Over the next few years community institutions will need to be strengthened if the vision of active community involvement is to be realized. Experience from Odisha and Chhattisgarh tells us that an active ASHA is an effective facilitator of community institutions such as the VHSNC. This is the direction in which the programme must move from now on. In order to emphasise this, in June this year, the MOHFW issued a revised set of guidelines, titled: "Guidelines for Community Processes[2]", which include three sets of guidelines: for the ASHA, VHSNC, and support structures, to reinforce the message that these three components must work in synergy to enable active community involvement.

This issue is the eighth in the series of biannual updates produced by the National Health Systems Resource Centre (NHSRC), for the Ministry of Health and Family Welfare (MOHFW). This issue has five sections. In Section 1 we report on evaluations of the VHNSC from Chhattisgarh, Manipur Meghalaya and Tripura, and an evaluation of the ASHA programme in Meghalaya.

1 ASHA... Which Way Forward?, An evaluation of the ASHA programme, National Health Systems Resource Center, New Delhi, India, 2010.

2 Guidelines for Community Processes, National Rural Health Mission, Ministry of Health and family Welfare, Government of India, June 2013.

The Chhattisgarh evaluation uses a creative methodology combining record review, individual in depth interviews (with VHSNC office bearers, and community members) and group discussions. The VHSNC evaluations for the three states of Meghalaya, Manipur and Tripura conducted by the North East Regional Resource Centre (NERRC), used interviews with VHSNC members, ASHA, and programme officials at various levels. The Chhattisgarh evaluation demonstrates a higher level of functionality of the VHSNC, a result of the duration of the programme, and a well thought out capacity building programme. The VHSNC in the NE states have a substantial road to traverse, before they become effective village level bodies capable of undertaking monitoring and developing village health plans.

Section 2 includes a summary report on a series of regional trainer conventions organized early this year. This summarizes the insights and experiences of trainers involved in training and supporting ASHA training. Apart from serving as a platform to share and exchange experiences these conventions helped build solidarity among trainers and provided useful programmatic feedback.

Section 3 contains a state wise list of numbers of ASHA, a report on training progress and on the status of support structures. The progress on this last front is impressive, but now the challenge is to build the capacity of the support structures to provide the leadership and support role to the community processes interventions. NHSRC has supported the states in conducting such orientation workshops over the last few months.

Section 4 is the section on innovations. Three innovations are discussed in detail. The first, from the state of Punjab captures the role of the ASHA in cancer detection and referral, the second is from the state of Kerala, where ASHAs were the first port of call for a programme on Gender Based Violence, and a third innovation reports on training ASHA in Participatory Learning and Action, (PLA) to promote community involvement in Jharkhand. This section also briefly lists innovations reported from other states at the trainer conventions referred to above.

Finally, in **Section 5,** we provide a report on component wise spend for the same year. The results are illuminating and correlate with the programme on the ground. We also provide data on expenditures from FY 08 to the present. The increasing trend in spending demonstrates the growing maturity of the programme.

Section- I

Findings from Recent Evaluations

In this section we present findings and conclusions from recent evaluations of VHSNC and ASHA programme. It includes findings of- VHSNC evaluation from states of Chhattisgarh, Manipur, Meghalaya and Tripura and of ASHA evaluation for Meghalaya.

1. Village Health Sanitation and Nutrition Committees (VHSNCs) in Chhattisgarh

The evaluation was commissioned by State Government to assess strengths and challenges of VHSNCs. The State Health Resource Centre, Raipur was assigned the responsibility of conducting a sample assessment.

The study covered 8 randomly selected districts (Durg, Dhamtari, Raigarh, Korba, Sarguja, Jashpur, Kanker and Bastar) from each administrative division. In each district four blocks were randomly selected and from each block, ten VHSNCs were selected following systematic random sampling. A total of 320 VHSNCs were studied in detail. Information was collected from VHSNC records and questionnaires were administered to VHSNC office bearers (Mitanin, Ward Panch, Mitanin Trainer), members and other VHSNC members and residents of sampled villages. Data Collection was done by teams of Swasth Panchayat Coordinators, who undertook the survey in a district other than their own.

KEY FINDINGS

- **Formation:** 95% of the villages in the state have a VHSNC and all of them have a bank account.
- **Membership:** Most VHSNCs have 6 to 15 members. VHSNC membership has adequate representation of women and SC/ST communities. 56% of VHSNC members are women. 62% of VHSNC members are either ST or SC.
- **VHSNC Meetings:** 86% of VHSNCs have a fixed day for meeting and 75% of VHSNCs reported regular monthly meetings. Most of the meetings had more than 50% of members present. Participation of Mitanin, Ward Panch and Anganwadi worker is quite regular in VHSNC meetings, with lower attendance of ANM and Sarpanch.
- **Monitoring of Health and Related Issues by VHSNCs:** 60% of VHSNCs are filling Village Health monitoring registers, which enable them to monitor services and behaviours related to around 25 indicators of health, nutrition and sanitation. 69% of VHSNCs are recording deaths taking place in their villages and community reported probable causes. 47% of VHSNCs base their village planning process on the gaps identified through monitoring registers.

- **Village Health Planning and Action by VHSNC:** 74% of VHSNCs are carrying out village health planning. They were helped by the MT in writing the Village Health Plan. In terms of issues taken up in Village Health Planning, almost equal attention paid to Health (25%), Nutrition (25%), Sanitation (21%) and Miscellaneous (29%) issues. For 55% of issues identified in Village Health Plans, collective action was undertaken to resolve the problem. Mitanins and PRI members played a leadership role in organizing action to address the gaps. 52% of VHSNCs had organised some form of shram-daan (voluntary labour contribution) – usually for sanitation and malaria prevention. 47% of VHSNCs had either met local officials or written complaints to them for resolving health gaps.
- **Record Keeping:** Around 80% of the VHSNCs are maintaining the required records. However, the quality of record keeping especially of cash books needs improvement.
- **Availability of Support to VHSNCs:** The existing Mitanin Support Structure with addition of one VHSNC specialist coordinator at block level has provided effective support to at least two-third of VHSNCs.
- **Utilisation of Untied Grant by VHSNCs:** VHSNCs utilised 79% of the funds received by them by June 2012. 77% of VHSNCs had written evidence of securing signed consent of more than 50% of membership for their last withdrawal/expenditure (as mandated by guidelines). The key items of expenditure have been DDT Spray Wages, Cleanliness, ANC Tables/curtains in Anganwadis, Handpump repair and Wall Writing of Health messages. There is a tension between spending on items mandated by Government orders and on health or nutrition related needs identified locally by the community.
- Gaps were noted in the fund flow. As of June 2012, only 10% of VHSNCs had received the amount meant for 2011-12.
- Around two-third of the VHSNCs are performing well in areas of health monitoring, local planning and action.
- VHSNCs have involved PRIs, especially women ward Panchs in health action.
- Swasth Panchayat Yojana inputs have been effective in improving VHSNC performance.
- The Utilisation rate of Untied Grant by VHSNCs was adequate and in accordance to the guidelines.

2. Assessment of Village Health Sanitation and Nutrition Committees (VHSNCs) in Manipur, Meghalaya and Tripura

NERRC undertook an assessment of VHSNCs in the states of Manipur, Meghalaya and Tripura. Three districts were selected from each state based on the status of programme implementation and geographical representation. In states of Tripura and Manipur, 10% of the VHSNCs were studied from the selected districts while in state of Meghalaya 5% of the VHSNCs were studied. VHSNCs were selected using systematic random sampling in each district and a total of 301 VHSNCs were covered across three states Table No. 1.1 shows the districts and the sample of VHSNCs covered in the assessment. Interviews were conducted with members of each VHSNC specifically with ASHAs and with State, District and Block level officials.

Table -1.1:

State	District	VHSNCs
Manipur	Chandel	55
	Imphal West	33
	Thoubal	52
Meghalaya	Jaintia	22
	South Garo Hills	29
	West Khasi Hills	53
Tripura	Tripura (North)	23
	Tripura (South)	34

KEY FINDINGS

1. Constitution of VHSNCs

Constitution of VHSNCs in Meghalaya and Tripura is based on the number of revenue villages but

in two districts of Manipur i.e. Imphal West and Chandel, constitution of VHSNCs is based on the number of ASHAs. In Thoubal district of Manipur, VHSNCs were formed in accordance with the number of villages; (but not revenue village), thus the number of VHSNCs is more than the number of ASHAs in the district and one ASHA is member secretary of more than one VHSNCs. More than 78% of VHSNCs in Manipur were constituted in 2006-2007. In Meghalaya, most VHSNCs (47.12%) were formed during 2008-2009 followed by 34.61% VHSNCs constituted during 2007-2008. In the case of Tripura maximum VHSNCs (43.85%) were constituted during 2007-2008, and 21.05% VHSNCs were not aware of the year of its constitution. All the VHSNCs in Meghalaya and Tripura have bank accounts except the 22 VHSNCs which are from Chandel district in Manipur. In Meghalaya and Manipur, ASHAs along with the PRI member/Headman are joint signatories of the bank account while in Tripura, AWW is the joint signatory as AWW is the member secretary of VHSNCs instead of the ASHA.

2. Untied Fund

In last three financial years 118 out of 140 VHSNCs from Manipur, received funds in last three years, and 22 VHSNCs from Chandel district have never received any funds since their formation. Of these 118 VHSNCs which have received funds, 8 VHSNCs (5.71%) (from Imphal West) received Rs. 8000 every year as untied fund instead of Rs. 10000/-. This was explained by the fact that both districts have more number of VHSNCs than the number of revenue villages since VHSNCs were formed based on number of ASHAs. This led to non release of funds to 22 VHSNCs in Chandel district and sharing of untied fund by all VHSNCs in Imphal West. All the VHSNCs of Chandel district received funds through cash because of poor availability of bank services in the district.

Formation of VHSNCs was done in phases in Tripura and thus fund release was also done in phases but some delays were observed in fund release specifically for the year 2007-08. Out of 57 VHSNCs, 6 VHSNCs (10.52%) never received any fund, where as 7 (12.28%) VHSNCs received fund in 2006-07, 19 (33.33%) of the VHSNCs received fund in 2007-08, 42 (73.68%) VHSNCs received fund in 2008-09, 46 (80.70%) VHSNCs received fund in 2009-10 and 2010-11. In the initial phase the untied fund was released in cash in the district but now all funds are release through cheques.

Similar to Tripura, VHNSCs were constituted in phases in Meghalaya. However mlore delays were observed in the first time fund release, for instance 36 VHSNCs were formed in 2007-08 but none of the VHSNCs reported fund release for FY 2007-08. Thus, 46 VHSNCs (44.23%) out of 104 VHSNCs received untied fund in year 2008-2009, while remaining 58 VHSNCs (55.77%) did not receive any fund. About 28 VHSNCs (26.92%) from Jaintia Hills and South Garo Hills districts reported receiving Rs. 20000 as untied fund in 2010-2011.

3. Capacity Building

One day orientation of one member from each VHSNC was reported from all districts except South Tripura district where no orientation was done. Across all districts only existing guidelines were shared with the members during this orientation and no training modules /material were developed for the training. State officials from Tripura shared the plan for training of one day for VHSNCs during 2011-12. A training module and three day training of trainers was completed by Public Health foundation of India in the year 2010-11.

4. Activities

Monthly meetings of VHSNCs in all the three states were found to be irregular as meetings were conducted as and when required. Major activities conducted by the VHSNCs included; VHND, construction of urinal site/toilet, repairing of well/pond, purchase of furniture and weighing machine for AWC, health awareness campaign, community cleaning, road repairing/approach roads, loan to poor/BPL families, erection of hoardings and signboard with health messages and construction of wooden bridge etc. In Meghalaya, most VHSNCs of West Khasi Hills have used VHSNC fund for setting up hoardings to communicate health issues. The IEC campaign of VHSNCs in Tripura especially in South Tripura district could be taken as a best practice. Fund generation from other sources was reported by few VHSNCs in Thoubal and Imphal West Districts only.

5. Support

In Meghalaya, State's ASHA Resource Centre also manages the VHSNCs. There is follow up and supportive mechanism from State to district, district to Block (in relation to VHSNCs) through regular meetings, though it needs further strengthening. Effective supportive supervision of VHSNCs was observed in state of Meghalaya especially by Block level officials (BPMU). Systems/mechanism of supportive supervision at all levels were found to be weak in Tripura, and is almost absent in Manipur.

The evaluations although they used different methodological approach show high functionality of VHSNCs in Chhattisgarh as compared to the three North Eastern states in terms of regular meetings, identification of issues of local priority, development of village level plans and higher levels of fund utilization. Likely contributing factors include a mature community processes programme, enabling the Mitanin (ASHA) to be the key facilitator, utilizing an existing training system with substantial experience in training and a dedicated state and district level support structures.

3. ASHA Programme Evaluation Survey For Meghalaya

Meghalaya has 6258 ASHAs working across the state. The programme at the state level is managed by an ASHA Resource Centre. The district level support is provided by a District Community Processes Coordinator in all districts and an ASHA Facilitator at the sub-block level for every 20 ASHAs.

The evaluation of the ASHA programme was commissioned by State Health Department and conducted by IIM, Shillong. The three districts selected for the survey are – East Khasi Hills, RiBhoi and West Garo Hills District. The evaluation used a mix of qualitative and quantitative methods

KEY FINDINGS

Across all districts studied 40-52% of the ASHAs had completed education up to Class Xth and above and almost all the ASHAs were tribals. Given the hilly terrain of the state, about 30% of the ASHAs from East Khasi Hills and RiBhoi district reported covering less than 500 population. This figure was highest in West Garo Hills where 67% ASHAs covered less than 500 population. The average monthly incentives earned by the ASHAs for all activities was found to be lowest in East Khasi Hills and RiBhoi districts where 60% earned up to Rs. 400 in a month as compared to 21% in West Garo Hills. Higher range of monthly incentive i.e, Rs. 601 -900 was reported by 25-33% ASHAs in East Khasi Hills and RiBhoi districts whereas none of the ASHAs from West Garo Hills got an incentive higher than Rs.600 in a month. Interestingly highest number of ASHAs i.e, 43% from West Garo Hillssiad that they were satisfied with the incentive amount earned by them. This figure was only 18% and 27% in East Khasi hills and RiBhoi district respectively. Delays in payments of ASHAs incentives were found in all districts. Incentive for JSY was reported to be the most regular incentive while delays were reported in payments of other incentives such as TB and immunization. Low incentive amounts were reported by officials as the reason for ASHA dropout in RiBhoi and West Garo Hill districts.

All the ASHAs studied in the three districts said they found the training in Module 6 & 7 very useful. One time receipt of drug kit was reported by all the ASHAs. Regular refilling was reported by 100% ASHAs only in West Garo Hills as compared to 45% in RiBhoi district and 22% in East Khasi Hills.

The findings show that ASHAs escort function was not restricted only to delivery cases and she was escorting Malaria and fever cases as reported by 54% ASHAs in West /Garo districts, 45% in RiBhoi district and 22% in East Khais Hills.

VHSNCs have been constituted in all villages studied and a high proportion i.e., 76-80% from East Khasi Hills and RiBhoi district and 34% from West Garo Hills reported preparing some sort of village level health plan.

Key issues related to the ASHA programme relate to issues of drug replenishment and delayed payments. The state has an adequate support mechanism in place and could do more by way of supporting and motivating the ASHA.

Section- 2

Report from Trainers Conventions to Share State Experiences on ASHA Training

Background

Since the inception of the programme training of the ASHA has been considered an integral feature of the programme. Overall, states have expended 35.64% of the budget under the head of selection and training in the FY 2012-13. A substantial amount of this expenditure would have been on training as most states have nearly completed the selection of ASHAs. In the past eight years there has been a huge emphasis on creating training systems, developing curricula and training state and district trainers. To strengthen the understanding of the training systems followed in different states, the National Health Systems Resource Centre organized four Regional Nodal Officer Review meetings cum Trainers Convention between February to March 2013 in (Guwahati, Delhi, Bodhgaya and Hyderabad). Nodal officers for ASHA programme and trainers from 253 states shared their experiences on the training of ASHA with a focus on Module 6 & 7 training at state and district levels. All participants expressed that what distinguished this phase of ASHA training was the systematic and rigorous approach to the process, and the relevance of the content of the training to the existing health issues in the community. In this section we provide an update on the status of training, and discuss state level experiences with regard to establishing and strengthening training systems for the future.

(a) **Institutional Arrangement for Training:** Bihar, MP and Uttarakhand shared their experiences on the positive impact of the NGO's role in the training. Bihar team shared that state has been able to expedite the roll out of Module 5, 6 & 7 training with the innovative training strategy of partnering with NGOs to establish 4 state training sites and a network of 14 district training sites. However challenges in smooth fund release for the partner organizations still remained in few districts. Uttarakhand highlighted its strong partnership with NGOs and shared that both state ARC and district level ARCs are run by local NGOs and function in close coordination with the State officials. MP has also made extensive use of collaborative NGOs and has involved members of its state ASHA mentoring group as additional resources for monitoring logistics for ASHA trainings. It has kept the state training sites within the health system, but has outsourced district level responsibilities to NGOs for organising ASHA Module 6&7 training.

3 List all states – Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, Arunachal Pradesh, Assam, Mizoram, Meghalaya, Manipur, Nagaland, Sikkim, Tripura, Andhra Pradesh, Gujarat, Haryana, Karnataka, Maharashtra, Punjab, West Bengal.

Odisha however expressed the fact that there were delays in getting NGOS to participate with the programme.

(b) **Training Strategy:** Though most states followed the training strategy of Module 6 & 7, some states reported making modifications at state level. States like Punjab and Karnataka where round 1&2 of Module 6 & 7 training were done as 10 days combined training, though the schedule and content. Training duration of round one was reduced from 5 days to 4 days in Mizoram, In Gujarat the role of NGOs in ASHA training was negligible and training was rolled out as per the old cascade model used for training of Module 1-4 with the introduction of two additional levels of trainers. Training to ASHAs was provided by Medical officers, ANMs and LHVs from Block CHC and PHC this led to variations in duration and schedule in every district. While the states reported developing training calendars, this schedule was often disrupted. In some states, management problems and other operational roadblocks have led to delays in training roll-out, leading to gaps after the state trainers and district trainers have received the training. This has led to loss in retention of the training content among the trainers and also reduced confidence levels on training methods and skill based practice sessions.

(c) **Trainer Retention:** Retention of both State and ASHA Trainers, is a challenge faced by Andhra Pradesh, Bihar, Madhya Pradesh, Arunachal Pradesh, Assam, Manipur and Meghalaya. One reason of trainers drop-out is related to trainers from among the government functionaries, many of whom, opt out of the training process as they get transferred while trainers from NGOs also opt out due to professional mobility or change of responsibilities. Another cause is related to inordinate delays in conduct of ASHA training batches. States of Odisha and Maharashtra, have reduced the drop outs of trainers by adhering to a fixed calendar of training and avoiding long gaps between the training rounds.

Maharashtra and Haryana shared their already established or upcoming web-based ASHA programme database and monitoring systems, which are also being linked to the tracking of the ASHA training progress. In states where the permanent cadre of trainers has been engaged either from state/regional health and family welfare training institutes or NGOs, as reported from Chhattisgarh, West Bengal Rajasthan, Odisha and Jharkhand; the retention of trainers is much higher. This highlights that one possible solution for addressing trainers drop out could be to merge the training and support and supervisory functions and use a dedicated cadre as in case of Chhattisgarh.

(d) **Training Adaptation for ASHAs with Low Literacy Levels:** Conducting ASHA training in local dialect was found to be very effective as reported by Chhattisgarh, where a separate training batch for Mitanins having low literacy levels is organized and training is conducted in dialects commonly spoken in that particular hamlet/block. Jharkhand has also developed a separate training Module for Sahiyas belonging to Primitive Tribal Groups. Assam shared its experience of organising special classes for illiterate ASHAs. West Bengal highlighted an innovation adopted during their ASHA training rounds, by display of "AMAR PROSNO" – which means "My queries". Any ASHA who needs to clarify her doubts related to training content, can write them on a board displayed at the training venue.

(e) **Training Evaluation:** States have faced challenges in ensuring a systematic evaluation for ASHA trainers, at the state level TOTs and for ASHAs during their training rounds. Rajasthan's trainer team shared their experiences of adopting the same questionnaires and steps of evaluation process as adopted at national training site, but also made suggestions that different passing scores/percentages should be followed for different sessions, based on the nature of sessions and its

content. This is an area that needs review, given the plans for the ASHA certification.

(f) **Refresher Training:** Some states where three rounds of ASHA training are either completed like – Uttarakhand, Manipur and Sikkim or is near completion such as in Meghalaya, Mizoram and Tripura highlighted the need for organising the Round 3 TOT for state trainers. Participants also felt that refresher training for ASHAs should be planned since this would help in reinforcing the skills of ASHAs. Tripura and Nagaland shared their strategy of using ASHA monthly meetings for refresher trainings based on a systematically planned calendar while Uttarakhand has proposed for a separate refresher training round for all trainers and ASHAs. A persistent challenge is to ensure that all ASHA obtain the requisite competencies. While it is not possible for all to achieve these, the problem is in ensuring that these ASHAs are enabled to attend repeat training rounds until they master the competencies. The other challenge is to support the ASHA to practice the skills and competencies gained in one round given the paucity of skilled ASHA facilitators on the ground. States reported challenges in adopting the right mechanisms for follow-up or refresher rounds for ASHAs who do not make the mark in the evaluation. States of Odisha, Maharashtra, Chhattisgarh and MP shared their strategies to address this issue. For instance, Odisha and Maharashtra have ensured intensive support and hand-holding to such ASHAs in the field after the training round and subsequently a repeat of evaluation process at the time of next round of training. Madhya Pradesh on the other hand ensures that such ASHAs attend the same training round again.

(g) **Systemic Issues Affecting Training:**

- **Printing and Distribution of Modules:** States of Punjab and Jharkhand reported tendering issues which hindered printing and distribution of the modules during the ongoing training rounds of Module 6&7 for certain batches of ASHAs. Among the North East states, all have printed the module after translation in local language as per the requirement and distributed, some states even having translated in up to three locally spoken languages, Eg – Sikkim translated the module in Nepali, Bhutia and Lepcha. However, all the states have completed the translation of the modules.
- **Procurement and distribution of HBNC equipment kit:** This was reported as a challenge by Maharashtra, Punjab, Rajasthan, Bihar and Jharkhand and states took time in overcoming this. Mizoram shared that some ANMs kept the weighing machine and digital thermometer meant for ASHAs. States like MP and Haryana could overcome this challenge by using an efficient procurement processes. Thus for instance MP procured the equipment using the TNMSC and Haryana was able to procure good quality equipment through United Nations Office for Project Services at reasonable rates. Trainers raised concerns about quality of equipment in many states particularly regarding digital watches and thermometers and highlighted the need to plan for review and replacement of non-functional equipment with all ASHAs.
- **Other Training Support:** States like Maharashtra highlighted that limited availability of training aids such as audio visual tools, hampers demonstration of critical issues like - danger signs in new born. Haryana also shared that these aids despite made available to the trainer teams, were not used adequately. Some states shared the challenge of limited availability of infrastructure at district or block level for residential training of ASHAs. Eg – In Meghalaya, school buildings had to be used in many blocks for conducting ASHA trainings,

and in such cases training calendar had to be adjusted as per the school holidays, which becomes a major limitation.

(h) **Challenges of States Related to Supportive Supervision and Training Monitoring:** One challenge reported by the states was dilemma of coordinating training and field level supportive supervision of ASHAs. States like Punjab and Rajasthan shared that the trainers have not been involved in the monitoring of either the field trainings or on the job support to ASHAs. But several states have tried to overcome this issue. Madhya Pradesh has a comprehensive training monitoring strategy in place. All ASHA trainings are conducted in close supervision of State Trainers and the state MGCA members. Karnataka is now trying to integrate the two roles of conducting trainings and providing supportive supervision, by using their cadre of contractual ANMs, named as ASHA mentors, dedicated for ASHA programme. Maharashtra has followed a differential planning, and has put in place one AF for every 10 ASHAs in tribal areas, and one AF for every PHC in non-tribal areas, who are being involved mainly in supportive supervision and monitoring. West Bengal shared that it has started a block level performance monitoring system for the BMOH/BPHN to initiate monitoring of the ASHA programme. An analysis of the ASHA Performance Report and the monthly HMIS Report is also being done to map her functionality. In Chhattisgarh training and supervisory functions have been merged. The state has a robust and integrated support system for Mitanin & VHSNC. i.e, two block community mobilizers and two district community mobilizers for large districts supported by one Mitanin trainer or facilitator for every 20 Mitanins.

In Maharashtra, Block Community Mobilisers analyse the HBNC forms being submitted by ASHAs and information such as, new-borns visited and details of ASHA initiated referral for different new-born illnesses is also captured and uploaded on the web.

(i) **State Specific Training Innovations in Light of Changing Priorities:** Many states revealed a change in pattern of disease burden and emergence of new health care challenges in different states. North East and non- high focus states in particular flagged the issue of reduced burden of RCH and requested guidance for equipping ASHAs to deal with the other health care challenges such as NCDs. Tamilnadu shared their experience of training ASHAs to deal with area specific problems for each district/blocks such as -Home based new born care, Leprosy, Malaria, Blindness etc. Andhra Pradesh has also trained ASHAs in a Community based breast examination program being implemented in Hyderabad district with 800 ASHAs. ASHAs in Visakhapatnam District have been trained on Community based Eye Examination, through Shankar Netralaya Foundation. Some of the NE states also reported training ASHAs to undertake new roles. Uttarakhand reported training ASHAs in solving Gender issues to overcome declining Sex Ratio.

Section- 3

Progress of the ASHA Program

This section provides data on three major areas related to the ASHA Programme. The primary source of this data is the ASHA progress monitoring matrix, a quarterly 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

We have used the data reported by the states for the ASHA Matrix, up to the period of June 2013.

Section 3.1 Selection and Recruitment

With a total of 8,70,089 ASHAs selected across 31 states and union territories, the programme has achieved well above 93% selection as against the target set by states. High Focus States, show 94% selection against the numbers proposed. Majority of these except Jharkhand and Uttarakhand have revised their target for selection according to the 2011 population census data. Most of these states have also been able to select their requisite number of ASHAs as per the revised target. The revision of target has been huge for Uttar Pradesh from 1.36 Lakh to 1.59 Lakh, and explains the gap in selection at 85%. Rajasthan has achieved 94% selection, as per the increased target to match the number of ASHAs with the number of rural Anganwadi centres.

The North East states except Nagaland, continue with their primary targets and have achieved 99% selection. Nagaland recently raised its target and has even shown good progress by attaining 98% selection.

91% selection has been achieved in Non-High Focus states. Among these, Haryana, Jammu and Kashmir, Maharashtra, Gujarat, West Bengal and Delhi have revised their selection target. Most of these states except Maharashtra are in process of selecting new ASHAs to achieve the proposed target. In states which have retained the original target- Andhra Pradesh has completed selection while Punjab and Kerala are very close to attaining their proposed number of ASHAs. West Bengal has selected 79% ASHAs and shows gradual progress due to adopting a phase wise selection. Karnataka is facing a high turn-over and is another state with only 79% ASHAs in position. The four UTs have achieved 92% selection, with Daman & Diu having recently started the ASHA programme.

In terms of density of ASHAs, among the high focus states, UP & Bihar, at 1140 & 1090 respectively, have density above the 1000 population norm. The lowest density within the group is in Chhattisgarh at 297, but Jharkhand the state with similar

tribal and outreach populations has a density of 611 ASHAs. All NE states have density well below 1000, ranging between 284 to 918. In the Non High Focus group, average density is over 1000 for all states except: Andhra Pradesh, Jammu and Kashmir and Kerala.

Table -3.1 A : STATUS OF ASHA SELECTION IN HIGH FOCUS STATUS

State	PROPOSED No. of ASHAs	No. of ASHAs SELECTED	% OF ASHA SELECTED
Bihar	87135	84501	97
Chhattisgarh	66092	66092	100
Jharkhand	40964	40964	100
Madhya Pradesh	56941	56188	99
Odisha	43530	43374	99.64
Rajasthan	54915	51624	94
Uttar Pradesh	159482	136094	85
Uttarakhand	11086	11086	100
Total	**520145**	**489923**	**94**

Table -3.1 B : STATUS OF ASHA SELECTION IN NORTH EAST STATES

State	PROPOSED No. of ASHAs	No. of ASHAs SELECTED	% OF ASHA SELECTED
Arunachal Pradesh	3862	3761	97
Assam	29693	29172	98
Manipur	3878	3878	100
Meghalaya	6258	6258	100
Mizoram	987	987	100
Nagaland	1887	1854	98
Sikkim	666	666	100
Tripura	7367	7367	100
Total	**54598**	**53943**	**99**

Table - 3.1 C: STATUS OF ASHA SELECTION IN NON-HIGH FOCUS STATES

State	PROPOSED No. of ASHAs	No. of ASHAs SELECTED	% OF ASHA SELECTED
Andhra Pradesh	70700	70700	100
Delhi	5616	5216	93
Gujarat	35237	31841	90
Haryana	17000	14972	88
Jammu and Kashmir	12000	10960	91
Karnataka	39195	30979	79
Kerala	32854	31868	97
Maharashtra	58945	58897	99.92
Punjab	17360	16383	94
Tamilnadu	6850	5405	79
West Bengal	61008	48185	79
Total	**356765**	**325406**	**91**

Table - 3.1 D : STATUS OF ASHA SELECTION IN UNION TERRITORIES

Union Territory	PROPOSED No. of ASHAs	No. of ASHAs SELECTED	% OF ASHA SELECTED
Andaman and Nicobar Islands	412	407	99
Dadra & Nagar Haveli	250	208	83
Lakshadweep	110	110	100
Daman & Diu	119	92	77
Total	**891**	**817**	**92**
Grand Total For All States and Union Territories			
Total	**932399**	**870089**	**93.3**

Table - 3.1 E: 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	84501	92,075,028	1/1090
Chhattisgarh	66092	66092	19603658	1/297
Jharkhand	40964	40964	25,036,946	1/611
Madhya Pradesh	56941	56188	52,537,899	1/935
Orissa	43530	43374	34,951,234	1/806
Rajasthan	54915	51624	51,540,236	1/998
Uttar Pradesh	159482	136094	155,111,022	1/1140
Uttarakhand	11086	11086	7,025,583	1/634

Table - 3.1 F : 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	26,780,516	1/918
Arunachal Pradesh	3862	3761	1,069,165	1/284
Manipur	3878	3878	1,899,624	1/490
Meghalaya	6258	6258	2,368,971	1/379
Mizoram	987	987	529,037	1/536
Nagaland	1877	1854	1,406,861	1/758
Sikkim	666	666	455,962	1/685
Tripura	7367	7367	2,710,051	1/368

Table - 3.1 G : 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	56,311,788	1/796
Delhi*	5616	5216		
Gujarat	35237	31841	34,670,817	1/1089
Haryana	17000	14972	16,531,493	1/1104
Jammu and Kashmir	12000	10960	9,134,820	1/833
Karnataka	39195	30979	37,552,529	1/1212
Kerala	32854	31868	17,455,506	1/548
Maharashtra	58945	58897	61,545,441	1/1045
Punjab	17360	16383	17,316,800	1/1057
Tamilnadu**	6850	5405		
West Bengal	61008	48185	62,213,676	1/1291

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

Table - 3.1 H: DENSITY OF ASHA IN UNION TERRITORIES

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	412	407	244411	1/601
Dadra and Nagar Haveli	250	208	183024	1/880
Lakshadweep	110	110	14121	1/128
Daman & Diu	119	92	60331	1/656

Section 3.2: Training of ASHA

More than 85% ASHAs in majority high focus states and nearly all ASHAs in North East States have been trained up to Module 5. Madhya Pradesh started its Module five training much later than other states and has completed training its 82% ASHAs. Rajasthan has trained about 71%. To expedite the progress on Module 5 training in Bihar, contents of Module five have been merged with the Module 6 and 7 Training and the total duration of training has been increased from 20 to 24 days. Among the Non High Focus states except Andhra Pradesh, Punjab and Karnataka most of the other states are in process of completing training of ASHAs in Module 5.The states are now planning to train their newly selected ASHAs in Induction Module, which is an integrated module, developed by consolidating the contents of Module One to Five. This module is to be transacted in eight days.

The trainer pool for ASHA training has been effectively strengthened. 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 is 3 11 and for Round 2 it is 229. Overall, 7342 District/ ASHA trainers have undergone training and have successfully passed the evaluation bench mark.

Module 6 and 7 training for ASHAs has now been rolled out all across the country except in Haryana, where it is due to begin soon. The last six months witnessed initiation of this training in Kerala, Delhi and Jammu and Kashmir. In the High Focus states, Uttarakhand has completed up to Round 3 with 90 to 93% coverage. Progress in Jharkhand is close with 90% and 83% ASHAs trained in Round 1 and 2 and 20% in Round 3. Progress on training has been substantial even in the remaining states (except Rajasthan), as about 75% ASHAs have completed training in Round 1 and 45-50% in Round 2. Odisha has recently started Round 3. Rajasthan has been able to train only 36% ASHAs in Round 1.Uttar Pradesh has elected to train those ASHAs trained in Comprehensive Child Survival Programme (CCSP) in a modified version of Module 6 and 7 called "Skills That Save Lives". The training is underway. The state has also selected 40 state trainers through an open advertisement, followed by an interview process which was facilitated by the National Health Systems Resource Centre.

North East States have covered major ground. Four states namely- Manipur, Mizoram, Meghalaya and Tripura have trained 94% to 100% ASHAs in Round 1 and Round 2. In these states Round 3 training is also over except in Meghalaya where 67% ASHAs have been trained in Round 3. Arunachal Pradesh and Assam have completed training ASHAs in Round 1. While Arunachal has completed training 85% in Round 2, Assam has started its second round training for ASHAs.

In the Non high focus states Punjab, being an early starter has trained all its ASHAs in Round 1 and 2. The other states are showing a steady increase in number of ASHAs being trained in various rounds of Module 6 and 7. Karnataka has trained more than 91% ASHAs in Round 1 and 2 and 71% in Round 3 and 4. Gujarat has trained 90% and Andhra Pradesh and West Bengal have trained more than 70% ASHAs in Round 1. A reasonable progress is also observed for Round 2 training in these states. Gujarat has commenced training in both Round 3 and Round 4 and West Bengal and Maharashtra has recently initiated Round 3. In Delhi and Tamilnadu 30-35% ASHAS have been trained in Round 1 of the state specific version of Module 6 and 7. Andaman and Nicobar Islands and Dadra and Nagar Haveli have initiated Module 6 and 7 training for the ASHAs.

Table - 3.2 A: TRAINING STATUS FOR HIGH FOCUS STATES

State Name	No. of ASHAs selected	Less than Module 4	Training Status Number of ASHAs Trained in		
			Up to Module 4	Module 5	Module 6 and 7
Bihar	84501	52859 (63 %)	52859 (63 %)	▸ 19 state trainers trained in Round 1 and 14 trained in Round 2 ▸ 4 State Training sites and 14 District Training Agencies are functional and run by NGOs. ▸ 736 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 66608 ASHAs (79%) and 36854 (44%) ASHAs trained in Round 2. ▸ ASHA Facilitators being trained	
Chhattisgarh	66092	60092 (91%) Mitanins trained in Module 1 to 12.		55630 Mitanins (84 %) trained in Module 13. 54100 (82 %) trained in Module 14 and 15 57701 (87 %) trained in Round Module 16 (mainly a refresher round)	
Jharkhand	40964	39214 (96%)	35675 (87%)	40964 (100%)	▸ 14 State trainers trained in Round 1 and2 ▸ 407 District Resource Persons trained in Module 6A; 417 trained in Module 6B and 474 trained in Module 7A ▸ 36717 Sahiya (90%) trained in Module 6A equivalent to Round 1 of Module 6&7 and 33801 (83%) Sahhiya trained in Module 6B equivalent to Round 2. ▸ 8267 (20%) trained in Module 7A equivalent to Round 3 ▸ 2097 Sahhiya Sathi (ASHA Facilitators trained in first two rounds of Module 6 and 7; Round 3 Training is underway
Madhya Pradesh	56188	47022 (84 %)	45777 (81%)	45885 (82 %)	▸ 39 state trainers trained in Round 1 and 20 in Round2 ▸ 870 district trainers trained in Round 1 ▸ 41623 (74%) ASHAs trained in Round 1 and 24265 (43%) ASHAs trained in Round 2
Odisha	43374	43027 (99%)	43014 (99%)	43027 (99 %)	▸ 22 state trainers trained in Round 1 and 15 in Round 2 ▸ 312 District Trainers trained in Round 1 ▸ 34432 (79 %) ASHAs trained in Round 1 ▸ 22354 (51%) Trained in Round 2, ▸ 4576 (11%) Trained in Round 3.

State Name	No. of ASHAs selected	Less than Module 4	Training Status Number of ASHAs Trained in		
			Up to Module 4	Module 5	Module 6 and 7
Rajasthan	51624	34776 (67 %)	45110 (87 %)	36703 (71 %)	▸ 11 state trainers in Round 1 and Round 2 ▸ 800 District Trainers trained in Round 1 ▸ 18661 ASHAs (36%) trained in Round 1
Uttar Pradesh	136094	129150 (95%)	129150 (95%)	121580 (89.3 %)	▸ 22 State Trainers Trained in Round 1 ▸ 878 District Trainers trained in Round 1 ▸ 7207 ASHA (5%) trained in Skills that Save Lives.
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 ▸ 10313 ASHAs (93%) trained in Round 1, 10064 (91%) in Round 2 & 10209 (92%) in Round 3 of five days each. ▸ 544 out of total 550 (99%) ASHA facilitators trained in Round 1 and 2 (7 Days) & 539 trained in Round 3 ▸ Refresher Training of Trainers for Round 1 and 2 completed

Table - 3.2 B: TRAINING STATUS FOR NORTH EASTERN STATES

State Name	No. of ASHAs selected	Less than Module 4	Training Status Number of ASHAs Trained in		
			Up to Module 4	Module 5	Module 6 and 7
Assam	29172	28544 (98%)	28497 (98%)	28422 (97%)	▸ 17 State trainers trained in round 1 and 14 trained in Round 2 ▸ 437 District trainers trained in Round 1 ▸ 29116 (99.80%) ASHAs trained in Round 1 ▸ 6892 (23.62%) ASHAs trained in Round 2 ▸ All 2838 ASHA Facilitators trained in Round 1
Arunachal Pradesh	3761	3559 (95%)	3606 (96%)	3635 (97%)	▸ 4 State trainers trained in Round 1 and Round 2 ▸ 32 District trainers trained in Round 1 ▸ 3632 ASHAs (96.57%) trained in Round 1; ▸ 3303 (87.82%) ASHAs trained in Round 2, 2220 (59%) trained in Round 3. ▸ 348 ASHA Facilitators (100%) trained in Round 1
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 ▸ 194 ASHA Facilitators (100%) trained inRound 1.

State Name	No. of ASHAs selected	Less than Module 4	Training Status Number of ASHAs Trained in		
			Up to Module 4	Module 5	Module 6 and 7
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 (94%) in Round 2 and 4199 (67%) in Round 3. ▸ 303 ASHA Facilitators trained in Round 1 & 274 in Round 2 and 288 in Round 3.
Mizoram	987	987 (100%)	987 (100%)	987 (100%)	▸ 3 State trainers trained in Round 1 and2 ▸ 28 District Trainers trained in Round 1 ▸ 987 (100%) ASHAs trained in Round 1 and Round 2 & Round 3
Nagaland	1854	1700 (91.60%)	1700 (91.60%)	1700 (91.60%)	▸ 3 State trainers trained in Round 1 & 2 ▸ 66 District Trainers (who are also Block ASHA Coordinator) trained in Round 1 and 2 ▸ 1576 (85%) ASHAs trained in Round 1 & 1571 (85%) in Round 2.
Sikkim	666	666 (100%)	666 (100%)	666 (100%)	▸ 4 State trainers trained in Round 1 and Round 2 ▸ 20 District Trainers trained in Round 1 and 2 ▸ 666 (100 %) ASHAs trained in Round 1, 2 and 3. ▸ All ASHA Facilitators trained in three rounds of Module 6 & 7
Tripura	7367	7367 (100%)	7367 (100%)	7367 (100%)	▸ 3 State trainers trained in Round 1 & 2 ▸ 89 District Trainers trained in round 1 ▸ 7257 (98.5%) ASHAs trained in Round 1; 7009 (95%) in Round 2 and 6962 (94%) trained in Round 3 ▸ ASHA Facilitator training in Round 1 is underway.

Tab - 3.2 C: TRAINING STATUS FOR NON HIGH FOCUS STATES

State Name	No. of ASHAs selected	Less than Module 4	Training Status Number of ASHAs Trained in		
			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 ▸ 386 District Trainers trained in Round 1 ▸ 53967 (76%) ASHAs trained in Round 1 ▸ 36755 (52%) ASHAs 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
Delhi	5216	Module 1-4 clubbed as Module 1, 2, 3 – 3744 (74%) ASHAs trained Module 5 as Module 4 – 3744 (74%) ASHAs trained			▸ State has adapted Module 6 and 7 to suit local context which is to be completed in two separate rounds of five days each. ▸ 70 state and district trainers trained. ▸ 1846 (35%) trained in Module 6 ▸ 367 (7%) trained in Module 7
Gujarat	31841	27763 (87%)	27447 (86%)	26933 (85%)	▸ 4 state trainers and Five trainers from Deepak Charitable Foundation trained in Round 1 and 2 ▸ 160 district trainers trained in Round 1 ▸ 28540 ASHAs (90%) trained in Round 1, 25635 (81%) trained in Round 2 ▸ 21517 ASHAs (68%) trained in Round 3, 18636 (58.5%) in Round 4
Haryana	14972	13730 (92%)	13289 (90%)	11112 (75%)	▸ 19 state trainers trained for Module 6 & 7 ▸ 12038 (81.35%) ASHAs trained in 2 days training of HBPNC module - Phase 1 and 11331 (76%) trained in Phase 2
Jammu and Kashmir	10960	9500 (87%)	9000 (82%)	8300 (75%)	▸ 6 State Trainers trained in Round 1 and 2 ▸ 225 District Trainers trained in Round 1 ▸ 461 second ANMs of the sub-centre who play the role of ASHA Facilitators trained ▸ 6618 (60%) ASHAs trained in Round 1
Karnataka	30979	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 ▸ 28291 (91%) ASHAs trained in Round 1 and 2 ▸ 21958 (70.8%) ASHAs trained in Round 3 and 4.
Kerala	31868	28946 (91%)	29043 (91%)	27732 (87 %)	▸ State has developed a 4 days state specific module for ASHAs covering the issues covered in Module 6&7 ▸ 20000 ASHAs (63%) ASHAs trained in state specific version of Module 6 and 7
Maharashtra	58897	57308 (97%)	56425 (96%)	51695 (88%)	▸ 14 state trainers trained in Round 1 and 13 trained in Round 2. ▸ 1398 District trainers trained in Round 1 and 292 trained in Round 2 (only in tribal areas) ▸ 24365 (41%) ASHAs trained in Round 1 & 8627 (15%) trained in Round 2 and 3644 (6%) trained in Round 3 ▸ 1986 Block Facilitators trained in Round 1 and 692 trained in Round 2 (in tribal areas)

State Name	No. of ASHAs selected	Less than Module 4	Training Status Number of ASHAs Trained in		
			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)	▸ 5 State trainers trained in Round 1 and 7 trained in Round 2 ▸ 326 District Trainers trained in Round 1 ▸ 16483 ASHAs (101%) trained in Round 1 and Round 2.
Tamilnadu	5405	2650 (49%)	2650 (49%)	2650 (49%) Module 1-5 trainings done only in tribal districts	▸ State has trained ASHAs in an adapted version of Module 6 and 7. ▸ 1614(30%) ASHAs trained in Round 1, 1046 (19%) ASHAs trained in Round 2 and 171(3%) trained in Round 3
West Bengal	48185	40165 (83 %)	39163 (81%)	37577 (78%)	▸ 17 State Trainers trained in Round 1 and 13 trained in Round 2 ▸ 780 District trainers trained in Round 1 ▸ 33663 (70%) ASHAs trained in Round 1 &19922(41%) trained in Round 2. 2150(4%) trained in Round 3.

Table - 3.2 D: TRAINING STATUS FOR UTS

State Name	No. of ASHAs selected	Less than Module 4	Training Status Number of ASHAs Trained in		
			Up to Module 4	Module 5	Module 6 and 7
Andaman and Nicobar Island	407	407 (100%)	407 (100%)	407 (100%)	State has trained 53 ASHAs in Modules 6 and 7
Dadra and Nager Haveli	135	135 (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: COMPOSITION OF SUPPORT STRUCTURES FOR ASHA AND COMMUNITY PROCESSES

At the state level the programme is to be supported by the State ASHA and Community Processes Resource Centre consisting of a Team Leader, Programme Managers and consultants for ASHA Programme/VHSNC/Communication and Documentation/Training& Regional coordinators. This team is supported by team of State Trainers. The state nodal officer with his/her small team located separately in SPMU ensures effective operationalization of the programme by issuing relevant orders and guidelines, enabling fund release and collection of utilization certificates, undertaking contract management for ARC, financing state training sites, undertaking reviews etc. These structures at state level are further supported by an advisory group in the form of State ASHA and Community Processes Mentoring Group. It consists of representatives from NGOs Civil society, academicians, representatives of training institutions and research organizations and provides policy guidance and programmatic oversight.

At the district level, there is district coordination committee for ASHA and community processes, which is convened by District Nodal Officer and functions through a full time District Community Mobiliser. District ASHA and Community Processes Team includes DCM and data assistant and is supported by District Trainers.

At the block level, a Block Nodal Officer and Block Community Mobilizers extend support for the programme.

At Sub-block level ASHA facilitators (one AF for 10 to 20 ASHAs) are expected to provide on the job mentoring and supervision.

The recently revised guidelines envisage that these support structures at all levels will support ASHA, VHSNC and all other community processes.

Creation and capacity building of support structures across four levels viz-state, district, block and sub-block is vital for strengthening ASHA and community processes. The current status of support structures across the states indicates an increased sensitization and action of the programme managers towards developing support mechanisms.

All high focus states show good progress in creating a dedicated support team at state, district, block and sub-block level. In the high focus states a dedicated team has been established in all the states either within ARC or otherwise to manage the programme at the state level. District Community Mobilizers are in place in all states except MP, where DCM selection is still underway. Block level support through a full time BCM is present in all states except Odisha and Uttar Pradesh. Odisha and MP are also about to complete the selection of ASHA Facilitators.

All North East states have state level support mechanisms. These states have DCMs at the district level, except in Sikkim (where existing structures manage the programme). A dedicated mechanism for Block level support does not exist in these states except in Nagaland and would suffice considering the small size of their districts and lesser numbers of ASHAs. ASHA Facilitators are in place in all NE states except Nagaland, where Block ASHA Coordinators extend direct field support for ASHAs and have also been trained to undertake these functions.

In the Non-High Focus States, only Maharashtra and recently Haryana have created support structures at all four levels having full complement of support personnel in the form of functional ARC, DCMs, BCMs and ASHA Facilitators. Punjab and Karnataka have support structures at three levels but are yet to place a dedicated support for block and sub-block level respectively. Delhi and Gujarat have established support mechanisms only at two levels, which is State and District for Delhi and State and Sub-block for Gujarat. The remaining states -Andhra Pradesh, Jammu & Kashmir, Kerala, Tamilnadu and West Bengal have programme specific support structure only at state level.

In the last six months about 150 personnel from the High Focus, North East and Non High Focus states (except Kerala, Tamilnadu and Jammu and Kashmir) were trained to undertake training of support staff at various levels in-Performance Monitoring of ASHAs, data base management and on all the aspects of supportive supervision. This allowed training of ASHA Facilitators to be initiated in all High Focus states except Rajasthan. Uttarakhand and Jharkhand have completed training of facilitators in Handbook for ASHA Facilitators. In North East, five states out of eight have completed this training for their facilitators while it is underway in Assam and Arunachal Pradesh. In the Non- High Focus states Punjab has accomplished training of facilitators in the Handbook. Other non-high focus states are in process of orienting their support structures to conduct this training at sub-block levels.

Table - 3.3 A: STATUS OF ASHA SUPPORT STRUCTURE IN HIGH FOCUS STATES

Status of Support Structure for ASHA - High Focus States				
	State Level	**District Level**	**Block Level**	**SectorLevel**
Bihar	AMG constituted, last meeting held in Feb 2011. ARC established and functional, registered as a separate society accountable to State Health Society.	28 out of 38 DCMs and 31 out of 38 DDAs are in place. Regional ASHA Coordinators in 7/9 divisions	421 out of 504 BCM are in place.	▸ 3983 out of 4150 ASHA Facilitators (one per 20 ASHA) are in place. ▸ 3250 Trained in Handbook for ASHA Facilitators.
Chhattisgarh	AMG proposed ARC is working under SHRC	35 District Coordinators in place in 27 districts	438 Block Coordinators in place	▸ 3000 Miltanin trainers (AFs) - 1 per 20 (ASHA are in place.

Status of Support Structure for ASHA - High Focus States				
	State Level	District Level	Block Level	SectorLevel
Jharkhand	AMG constituted, only meeting held so far was in May, 2011. VHSRC established under SHRC.	24 District Programme Coordinators in place	875 Block Trainers & DRPs in place	▸ 2157 Sahiyaa Saathi selected at 1 per 20 Sahiyas. ▸ All trained in Handbook for ASHA facilitators
Madhya Pradesh	AMG merged with MGCA to form MGCA, last meeting in April 2012. MGCA members allocated districts for monitoring and hand holding State Nodal officer & six consultants in position and working as ARC team	DCM in place in 3 districts 50 District MGCAs formed & being trained	269 BCMs out of targeted 313 are in place 313 Block MGCAs formed	▸ 2000 / 3800 ASHA Facilitators selected ▸ 1500 trained in Handbook for ASHA Facilitators
Odisha	AMG constituted, last meeting in July 2008 CPRC in place	District AMGs constituted DACs in place in all 30 districts	Selection of BCMs underway	▸ 862 Community Facilitators (ASHA Facilitators selected) out of 1228
Rajasthan	AMG constituted, last meeting in Sep 2011 One ASHA consultant working in SPMU. SIHFW extending support for rolling out ASHA Training.	25/34 DACs in place, DPMs have additional charge in other districts	249 BACs selected 100 in position presently	▸ 1076 PHC ASHA Supervisors (1 per PHC) are in position. Originally (1321were selected out of 1502.)
Uttar Pradesh	AMG constituted, last meeting in Jan 2013 No separate ARC, Nodal officer- ASHA, one consultant (supported by NHSRC) and 2 additional consultants in place presently	58/75 DCMs are in position 72 District AMGs constituted	Existing staff (Block PMUs)	▸ 1030 ASHA Facilitators selected out of 1776 in 17 districts. ▸ 879 AFs have been trained in Handbook for ASHA Facilitators.
Uttarakhand	AMG constituted, last meeting in February 2013. State has one Nodal Officer in SPMU who works closely with ARC. 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 are in place. ▸ Training in Handbook for ASHA Facilitators has been completed.

Table - 3.3 B: 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. ▸ Training on Handbook for ASHA Facilitators is underway in 7 out of 17 districts

Status of Support Structure for ASHA				
NE States	**State Level**	**District Level**	**Block Level**	**Sector Level**
Assam	AMG constituted and last meeting held in 22nd Nov 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) ▸ Training of ASHA Facilitators in Handbook for ASHA for ASHA Facilitators is underway
Manipur	AMG constituted and last meeting held on 26th March 2013 ARC formed	DCMs in place in all districts	Existing BPMU	▸ 194 ASHA Facilitators (One for 20 ASHAs) ▸ All facilitators have been trained in Handbook for ASHA Facilitators
Meghalaya	AMG formed and last meeting held in Aug 2012) ARC established	DCPC (District Community Process Coordinator) placed in all districts	Existing BPMU	▸ 312 ASHA Facilitators (one for 15-20 ASHAs) ▸ 281 ASHA Facilitators (90%) trained in Handbook for ASHA Facilitators
Mizoram	AMG formed and last meeting held in 28th June 2013 ARC not established (One Medical Officer-Community Process assigned)	All 9 Districts have District ASHA Coordinator	(No system of Block unit for program management / health)	▸ 66 ASHA Mobilizer/ Facilitator
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) ▸ All Block ASHA Coordinators have been trained in Handbook for ASHA Facilitators
Sikkim	AMG formed and last meeting held in Nov. 2011 ARC does not exist (designated State ASHA Nodal Officer in place)	Existing staff of DPMU	Existing Staff of BPMU	▸ 70 ASHA Facilitators ▸ All trained in Handbook for ASHA Facilitators
Tripura	AMG formed and last meeting held on March 2013 ARC constituted (1 state ASHA Programme Manager)	8 (District ASHA Programme manager in Place) and 11 Sub divisional ASHA Programme Managers support the program	None (No block level unit for program management/ health)	▸ 387 ASHA ▸ Facilitators ▸ All trained in Handbook for ASHA Facilitators

Table - 3.3 C: 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 Functions of ARC are managed by a small team based in SPMU, Directorate and Indian Institute of Health and Family Welfare.	Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO) involved	Existing staff of BPMU	ANM & Health Supervisors at PHC level involved in ASHA support
Delhi	AMG formed, last meeting held in March 2013 ARC established; One State level Nodal Officer,1 Data Assistant 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 which includes MOIC, PHN, NGO representatives and 5 ANMs as facilitators/mentors	
Gujarat	AMG Constituted last meeting in Nov 2012. ARC established under the office of Rural Health Department under Commissionerate of Health Office.	24 Districts have constituted AMG Data Assistant for ASHA programme placed in all districts	Existing staff	2748 out of 3669 ASHA Facilitators (one for ten ASHAs) in position
Haryana	AMG not constituted ARC in place	DACs in place in 19/21 districts	BACs in place in 83/104 blocks	399 ASHA in place Facilitators out of targeted 438, orientation done
Jammu& Kashmir	ARC and AMG not established 1 ASHA Nodal Officer in place	Existing staff	Existing staff	Existing staff
Karnataka	AMG constituted Programme is managed by One ASHA Nodal Officer based in Directorate and another Nodal Officer for ASHA Training based within SIHFW.	District ASHA Mentor	One District Trainer also called as ASHA Mentor supervises ASHAs of two blocks	Existing staff
Kerala	AMG constituted, last meeting in Jan 2012 State ASHA Team with one Nodal Officer and consultant based within SPMU	Existing staff	Existing staff	Existing staff
Maharashtra	AMG constituted One Nodal Officer-ASHA & one consultant work as ARC team based within SPMU	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 in SPMU	16 DCMs in place out of 20 districts	Existing Staff	860 ASHA Facilitators in position at cluster level and have been trained in Handbook for ASHA Facilitators.
TamilNadu	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 - 3.3 D: STATUS OF ASHA SUPPORT STRUCTURE IN UTs

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

Section- 4

State Specific Innovations and Best Practices Related to ASHA

In the first phase of NRHM implementation, efforts of the states and districts were directed at stabilizing the Community Processes programmes. There is now substantial progress, albeit variable on key parameters such as selection, training and creation of support mechanisms. In the attempt to make local adaptations, innovations related to ASHA and VHSNC have emerged. Several of these innovations have come out of the efforts by impalements. Thus they are not often designed to go to scale, since they are aimed to solve or address a particular problem. However, even here there are lessons to be drawn for scaling up.

States like Punjab and Kerala have experimented with enabling ASHA to undertake action for cancer screening and gender based violence respectively. Effort on synergizing new approaches with existing interventions is seen in Jharkhand, where ASHAs are being trained in Participatory Learning and Action (PLA) as part of Module 6 and 7 training, to better undertake community level meetings. Some states have also implemented innovations to ensure motivation of ASHAs. It is best demonstrated in case of Chhattisgarh, which has a multiple welfare programmes for ASHAs and has also increased avenues for their career progression by ensuring sponsorship in ANM training schools.

This section describes the key features of ASHA related innovations from the states of Kerala, Punjab and Jharkhand.

A. Role of ASHAs in State-wide Cancer Awareness and Symptom Based Household Level Early Detection Campaign in Punjab

BACKGROUND

Over the last few years Cancer has emerged as a major public health problem in the state of Punjab. It is seen primarily among men and women in the age group 35-60 years, in prime of their lives. To enable early detection of new cancer cases and to ascertain the number of existing cases, the government launched a massive door to door campaign covering the whole population–(more than 2.77crore). The programme was led by Department of Health & family Welfare, Government of Punjab in collaboration with Department of Medical Education and Research, which

provided inputs for planning and implementing the campaign.

PROCESS

The salient features of this initiative are as follows:

- A separate Cancer Control Cell was established within the health directorate with representatives from medical fraternity and public health departments/ institutions.
- Objectives of the campaign were to increase community awareness on cancer control and prevention and also promote early self- detection. Given that the ASHA enjoys a close rapport with the community she was used as a key resource. ASHAs played a major role in conducting household survey and enabling self- detection of suspected cases.
- Systematic capacity building of ASHAs, ASHA Facilitators, ANMs & MPWs, and Nursing Students, as well as Medical and Para Medical Manpower, was undertaken. A guide book was also developed for the field workers.
- IEC/BCC material and training modules were designed in Punjabi for health workers. Two formats were developed, one was used for household listing while the second one was used for detection of cancer cases and included a set of 12 symptoms, profile of patient, and details of treatment.
- This campaign was first piloted in Faridkot district in October, 2012. The outcomes were studied through an external evaluation. The inputs gathered from the evaluation also enabled contouring of programme design and tool modification for scaling up the initiative across the state.
- Subsequently, the main campaign was scaled up in the entire state from December 2012 to 14 January, 2013. 40,813 Field Workers, (23,007 for rural areas and 17,806 for urban Areas) including ASHAs, ASHA Facilitators, ANMs, Multipurpose Health Worker (M) and Nurses were trained to participate in the campaign.
- In addition, 7524 Medical Officers, Block Extension Educators (BEEs), Lady Health Visitors (LHVs), Supervisors and other staff including Faculty of Nursing Institutes, were oriented to the campaign. The campaign was conducted in two phases.
- Phase 1 comprised of a community level assessment. During this each field worker was allotted a population of 800- 1000 or 150-200 houses. They conducted a household survey to identify the suspected cases and confirmed cases of cancer. A basic screening was done by using the indicators provided in Format A. On an average each worker visited ten houses every day, thus completing the task in 20 days in their allotted area.
- The second phase of the campaign involved facility level Medical Examination of every suspected case and even of the already identified case, first at PHC /Civil Dispensaries (CDs) / Civil Hospitals (CHs), and subsequently by specialists at CHCs or SDHs. The District Hospitals were involved in diagnosis and treatment of the patients, but the final diagnosis and treatment was done by the tertiary care institutes; the State Medical Colleges and PGIMER Chandigarh.
- Every ASHA was paid Rs. 200 from VHSNC fund of her village for taking part in this campaign. An incentive of Rs. 300 was paid to ASHA for follow up for cases of cancer detected from her surveyed area.

  Software for analysis of data has also been developed for data management and routine monitoring.

Format A

Indicators used for Awareness and Early Detection

1. Lump in the breast/recent nipple retraction/ blood stained discharge
2. Post- coital bleeding/purulent vaginal discharge/excessive menstrual bleeding/inter- menstrual bleeding, dyspareunia
3. Non-healing Ulcer/ bleeding in ulcer in mouth, gum, palate/tongue, nodule on tongue
4. Difficulty in Swallowing of short duration/ Persistent hoarseness of voice or persistent cough/ Haemoptysis
5. Persistent Jaundice with lump in abdomen, loss of weight & appetite, itching
6. Painless blood in the stool/ unexplained weight loss/Severe Anaemia/Sudden change in bowel habit
7. Un-explained bleeding from any natural orifice/Un-explained Fever for more than three months
8. Painless Excessive blood in urine/Difficulty in Urination/Frequent nocturnal urination in male of more than 50 years age
9. Sudden change in size/colour of wart/mole or bleeding from wart/ mole
10. Hard Swelling (lump) of testicle
11. Unexplained persistent Headache and convulsions

OUTCOME

The campaign covered a population of 2,70,67,539 and reached about 96% of the households. It enabled identification of about 87,403 suspected cases of cancers and enlisting of 24,659 as confirmed cancer cases in the second phase. About 34,430 deaths in the last five years due to cancer were also recorded. ASHAs proved to be the most critical and effective human resource in reaching all sections of the community and provided extensive support in escorting suspected cases to facilities for check-ups. State Government's pre-existing Mukhya Mantri Cancer Rahat Kosh (Chief Minister Cancer Relief Fund), under which financial support of upto Rs. 1.5 lakh is provided to cancer patients, was modified after the campaign to make it more patient friendly and provide cancer drugs at cheaper rates.

The Punjab model offers lessons on involving ASHAs in increasing community awareness on cancer and other non-communicable diseases. It shows how community level health education facilitated by well trained ASHAs can enable vigilance of cancer signs and symptoms and ensure early detection or identification of suspected cases. An important aspect of this model is a conscious effort by the state in-ensuring referral linkages for detection and appropriate services for treatment which is also supplemented with financial assistance and follow up services.

B. Involving ASHAs to Overcome Gender Based Violence in Kerala

BACKGROUND

Violence against women both within homes and in public spheres is now recognized as major public health problem. Multiple community based studies by NGOs and other institutions show that amongst all cases of violence against women, a very high proportion of 60-65% is attributed to domestic violence. The recent report of World Health Organization on Gender Based Violence issued in collaboration with the London School of Tropical Medicine and South African Medical Council, describes the situation of Gender Based Violence as a global health problem of epidemic proportions. It has severe impact on physical and mental health of women. Apart from the more visible manifestations in the form of physical injuries, there are other underlying serious problems observed such as- complications during pregnancies or low birth weight babies. Women who suffer abuse are also more likely to

suffer from depression and sexually transmitted infections.

PROCESS

The Government of Kerala in 2009 launched special centres called "Bhoomika" to provide Medical Care for Victims of Gender Based Violence or Social Abuses. These centres were established in all District hospitals and selected hospitals at block level. The funding for the programme came from the State Plan Fund and supported by NRHM.

The programme design involved appointing one female counsellor or coordinator at the Gender Based Violence Management Centres to provide immediate medical assistance and counselling services for the victims. Trust and confidentiality are two important parameters in managing GBV. State factored in these parameters by using the position of ASHAs as a community's representative in enabling community level care for GBV victims. Around 10,000 ASHAs have been trained to address GBV concerns at the community level. The training enabled ASHAs to develop communication skills in discussing gender issues with community, developed their competencies to support women in breaking silence about the violence and helped them to identify women at risk and initiate referrals of GBV victims to GBVMC.

State also trained a total of 2036 doctors, 2798 staff nurses, 7464 field staff (Health Supervisors, Lady Health Supervisor, Health Inspector, Lady Health Inspector, Junior Public Health Nurse, and Junior Health Inspector). This strategy allowed integrating assessment and treatment of Gender Based Violence (GBV) into reproductive health services.

These centres were linked with legal cells, police, probation officers of Social Justice Department, NGOs etc. which proved effective in leveraging any additional support needed for the referred cases.

Another important effort targeted at community level for addressing GBV was creation of the Jagrata Samithy at ward levels. Anganwadi worker is the convenor, the ward member is the chairman and ASHAs are the members of this committee. These committees provide a community level platform to the women to report any form of violence. Even here ASHAs plays a crucial role in making women aware about these committees and encouraging them to report such cases in situations where they do not want to access facility based GBVMC.

OUTCOME

From 2009 onwards 8912 cases have been addressed by these centres and in each case a minimum of 3-7 follow ups have also been ensured. Among this 20 % of cases were referred by ASHA. An increased reporting of these cases in the last two years by using ASHAs has allowed service providers to extend better medical, psychological, and social support for these victims.

All the Bhoomika Centers have now been upgraded and are functioning as One Stop Crisis Centers (Bhoomika- OSCC) since March 2013.OSCC is situated in the hospitals where at the first point of contact itself the victim will get all the services like legal help from legal department, protection from social justice, medical help from health department and the police support.

This is another important innovation to expand the role of the ASHA for the states having good RCH indicators.

C. Implementation of Participatory Learning and Action through Sahiyas in Jharkhand

BACKGROUND

Participatory Learning and Action"(PLA) is a strategy for enabling community mobilization to improve health outcomes. Ekjut a Jharkhand NGO, between 2005- 2008 undertook a trial in which women's groups were guided by a trained woman facilitator from the local community through acycle of activities, spanning 20 monthly meetings using PLA. During this women identify, prioritize and analyze local maternal and neonatal health problems and subsequently devise local strategies and take action to address them.

The PLA encompasses four phases: Identify Problems, Plan Strategies, Act together and Evaluate together.

Ekjut Trial focussed on using PLA for maternal and new born health. The study demonstrated significant impact in terms of reduction in neonatal mortality and maternal deaths. In three years (2005-08) the newborn mortality rate in the areas where the participatory learning and action cycle was implemented with 244 women's groups had fallen by 45 per cent. Another significant finding was that during 2008 to 2011 the 244 groups who had already achieved a newborn mortality reduction were able to sustain the reduction. These outcomes inspired the Jharkhand state to implement PLA through Sahiyas in Santhal-Paragana region in the year 2011-12. This region is predominantly inhabited by tribes (Santhals, Paharia and Mundas) with low utilization of health services and poor health indicators on account of difficult geographic terrain, low literacy, poor socio-economic status, poor health seeking behaviour amongst the tribal community and left wing extremism. The project was initiated in six districts (Dumka, Deogarh, Pakur, Jamtara, Godda and Sahebganj) from the Santhal -Pargana region in December 2011. Twelve blocks each from 6 districts with 150 women's groups in each block were selected.

PROCESS

- The project was initiated with the objective of using PLA to build awareness on maternal and new born health problems and also about the health rights and entitlements related.
- The central programme strategy and different form Ekjut's model was to harness the potential of Sahiyas (synonymous with ASHAs in other states) as the community's representative. The rationale for this was-' Sahiyas act as an important resource for their community, are already working at 500-800 population in these rural and remote areas and could facilitate the PLA meeting cycle with the existing women's groups in their respective villages.
- The proposal was funded by the Ministry of Health and Family Welfare in May 2011 as- "Innovations in Tribal Areas" under NRHM.
- In many areas already existing women's group were brought together to meet the purpose and in few villages groups were formed by Sahiyas. These groups are also open up to non- members during these monthly PLA meetings.
- Ekjut provided technical support and hand holding. Training modules, picture cards developed by Ekjut were used for the training.
- 24 state level participants including-representatives from State Training Team, District Programme Coordinators and Regional Coordinators have been oriented on this process. 40 members from Block Training Team have been trained who in turn build capacity of Sahiyas Sathees/ Sahiya to conduct the women's group meetings.

In the first phase, a two day training of 2021Sahiyas from the six districts has been undertaken. This training prepared Sahiyas to conduct eight monthly meetings.

Actual monthly meetings with women's group by Sahiyas, using PLA approach began in January 2013.

OUTCOME

State has completed five meetings for approximately 1900 women's groups in five districts out of the selected six. The pilot is still being closely monitored and documented to assess the larger impact. Its initial process related findings from the field based on feedback from Sahiyas, District Programme Coordinators and other stakeholders are encouraging. Programme managers highlighted that this approach has strengthened skills of Sahiyas on interpersonal and community mobilization. Sahiyas are now able to organize the monthly meetings more systematically and message transaction has become interesting. An increase participation of women, adolescent girls in group meetings has been noted because the processes, tools and games used are attractive incentive to mobilize villagers. These aids also enable women to

better comprehend cause and effect relationship of various health issues. Sahiyas shared that- various games like 'power walk game', 'voting game', used in this approach are useful and stimulating.

For the FY-2013-14, Jharkhand NRHM has decided to integrate the training of Sahiyas on PLA led community mobilization in the curriculum of ASHA Modules 6 and 7.

The intervention has a significant potential for scale, given that it uses community collectives like women's self -help groups (which have been formed in large numbers across the country) and ASHAs, who are present in every hamlet and village. The challenge is to ensure that this intervention receives high levels of support and follow up to allow conformity to training standards and similar outcomes.

In addition to the three best practices described in detail above, some other innovations related to ASHA programme were gathered from different states and have been enlisted below:

- Bihar's innovative scheme for knowledge building of ASHAs using Mobile Kunji. There is another initiative of the state which four ASHAs from each block are supported to enhance their education level through National Open School.
- Multiple support initiatives for ASHAs from Chhattisgarh's comprising of: career opportunities to Mitanins by reservation of seats in ANM schools, welfare packages like Mitanin Sahyata Kosh, (insurance benefits for mitanin families), providing funds and ensuring benefits to Mitanins under National Pension Scheme (NPS-Swawalambhan Yojna), scholarships for the children of ASHAs and financial support for Mitanins who are interested in upgrading their education levels.
- Maharashtra's pilot initiative in Thane district, of linking incentive payment to ASHAs with Central Plan Scheme Monitoring System (CPSMS). Here payments are done through Micro ATM and promotes smart card, Biometric system and Adhar Card usage amongst ASHAs.
- Chhattisgarh pilot for ASHA incentive payments through Gram Panchayat.
- Launch of ASHA Kiron Scheme in Assam for ASHAs and ASHA Facilitators. This has provisions for Medical benefits up to Rs. 25,000 in one calendar year and Life cover benefits up to Rs. 1 Lakh in cases of normal or accidental deaths.
- Introduction of a fixed incentive of Rs. 1300/- to ASHAs every month from state funds, by West Bengal.
- Meghalaya's benefit scheme for ASHA in which state provides its own funds, matching grants to ASHAs over and above the incentives earned by them in the whole year.
- Similar scheme of Tripura where 33% additional incentives are provided to ASHAs over and above the incentives earned by them.
- ASHA Radio program of Nagaland.
- Sikkim State government providing Rs. 3000 per month to all ASHA as fixed incentive.

Section- 5

Expenditure Analysis for ASHA and VHSNC Programme

ASHA guidelines issued by the Ministry of Health and Family Welfare in July 2006, laid out the operational guidelines, including financial flows and budgets for the ASHA programme. The financial norms under NRHM as followed till now, provided for a budget provision of up to Rs. 10,000 per ASHA per year. In our July 2012 Update on ASHA programme, we had reported on funds released and expenditures incurred on ASHA programme across states, which is being updated here for the period of FY 05-06 to FY2012-13 in the Tables 5.1 to 5.4 presented in the later part of the chapter. The steadily rising percentage of expenditure across the states shows an overall strengthening of the programme.

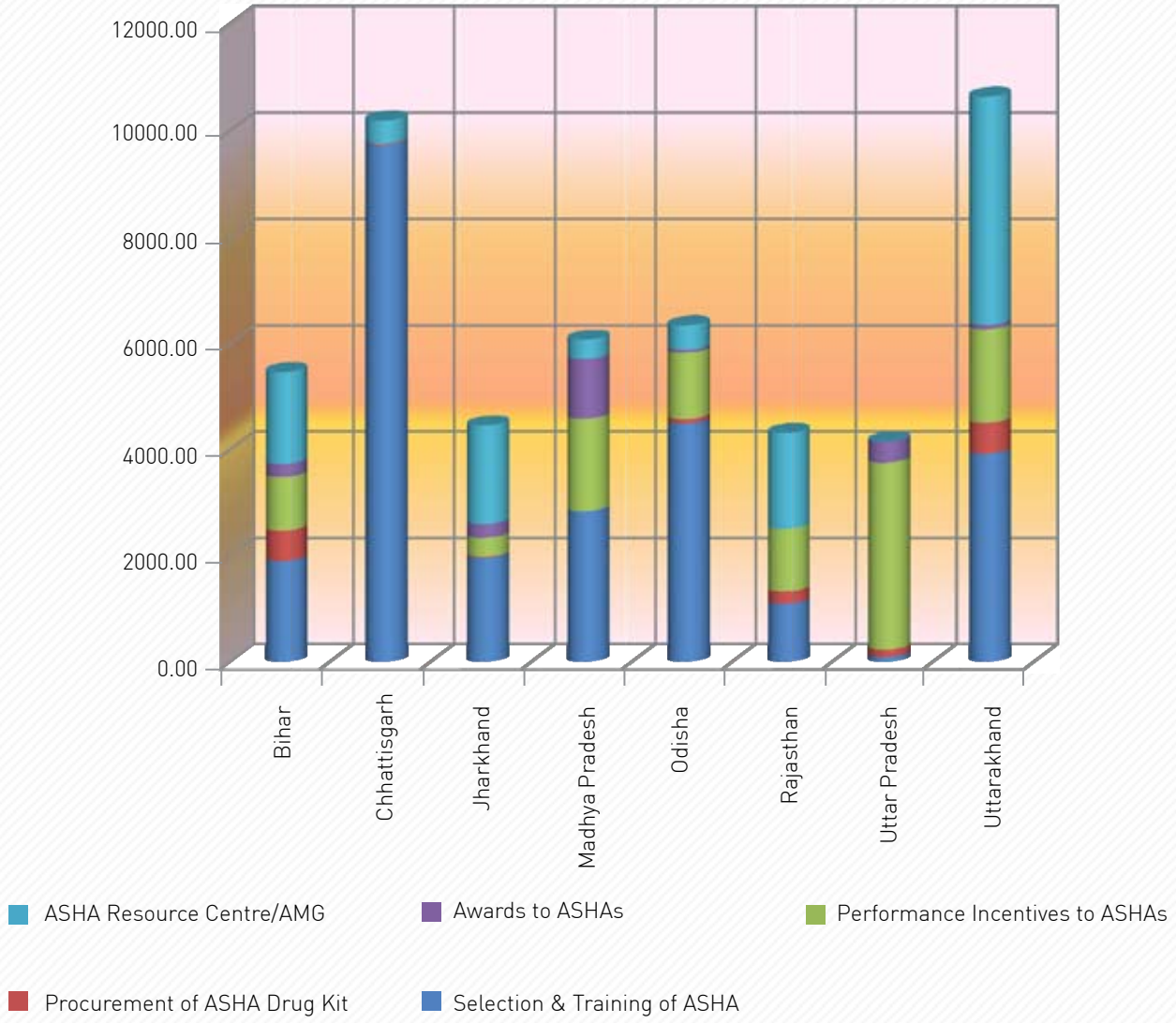
Within the High Focus states, during the period of 2005-08, five out of eight states had a percentage of expenditure in the range of 15% (in Bihar) to 27% (in UP). Chhattisgarh, Uttarakhand and MP were the high spenders at 111%, 96% & 69% respectively. In a clear contrast to this in FY 2011-12, three states (Bihar, Jh, & MP) spent between 53% to 66%, and all others were at above 83%, with CG & Odisha at 107 & 100%. Similarly in FY 2012-13, Except UP (at 44%), all states had spent above 50%, of which three had spent above 80%. Though the amounts spent per ASHA in FY 2012-13 reflect a picture that is less encouraging, with UP, Rajasthan & Jharkhand spending between 4154 to 4452, and only CG & Uttarakhand spending above Rs. 10000 per ASHA. Reflecting a robust expenditure pattern, the eight North East states, spent an overall 44% in the starting phase of 2005-08, which rose to 77% in 2009-10, rising further to 81% in 2011-12. Within the Non High Focus group a no. of states have shown consistently high expenditures since 2009-10, which are; AP, Gujarat, Haryana, Karnataka, Kerala, Punjab. Other states like West Bengal and Maharashtra have also caught up well. In FY 2012-13 the overall percentage expenditure of the 11 states is 93%, and the amount spent per ASHA is at 9298. The four Union Territories with ASHA programme had an overall expenditure of 54% and per ASHA expenditure of 2911 in FY 2012-13.

We are also presenting a graphical analysis of the patterns of ASHA programme expenditure in the FY 2012-13, detailing out the share of different components of ASHA programme in the total expenditure (Tables A-1 to A-5). The figures show Rs. 5419 as total amount spent per ASHA in the High Focus Group, while North East States, Non High Focus states, and UTs have spent Rs. 8283. Rs. 9298, and Rs. 2940 respectively.

VHSNC expenditure pattern has been presented in the last at table 1.5 for the period of 2008-09 to 2012-13. It shows wide variations in the percentage of expenditures over the years and across states, but overall expenditure at all India level has been consistently high being above 84% in four out of these five years.

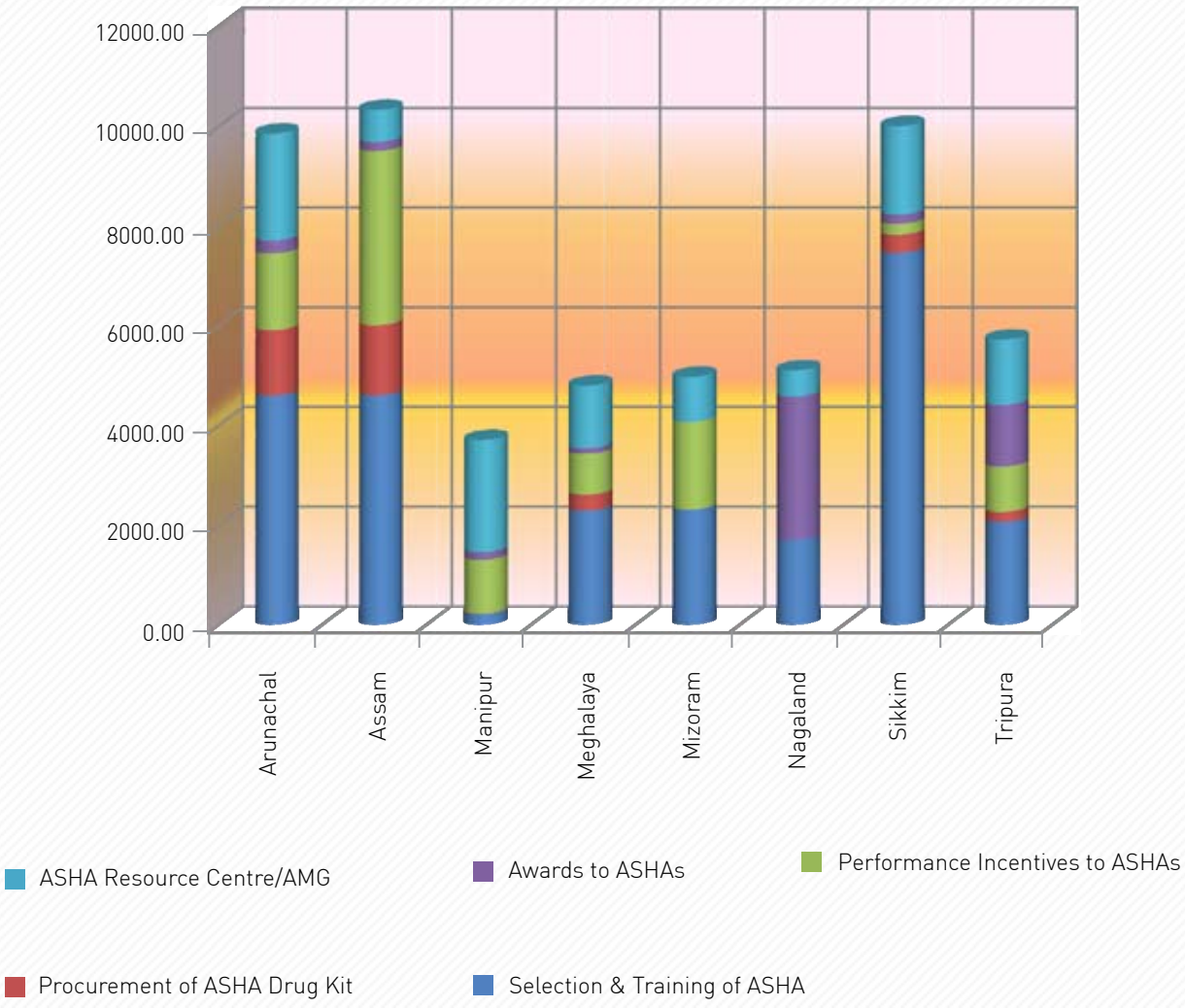
ASHA Programme – Patterns of Fund Approved and Expenditure in Financial Year 2012-13

Table A-1 : RELATIVE SHARE OF PER ASHA EXPENDITURES ON DIFFERENT PROGRAMME COMPONENTS - HIGH FOCUS STATES



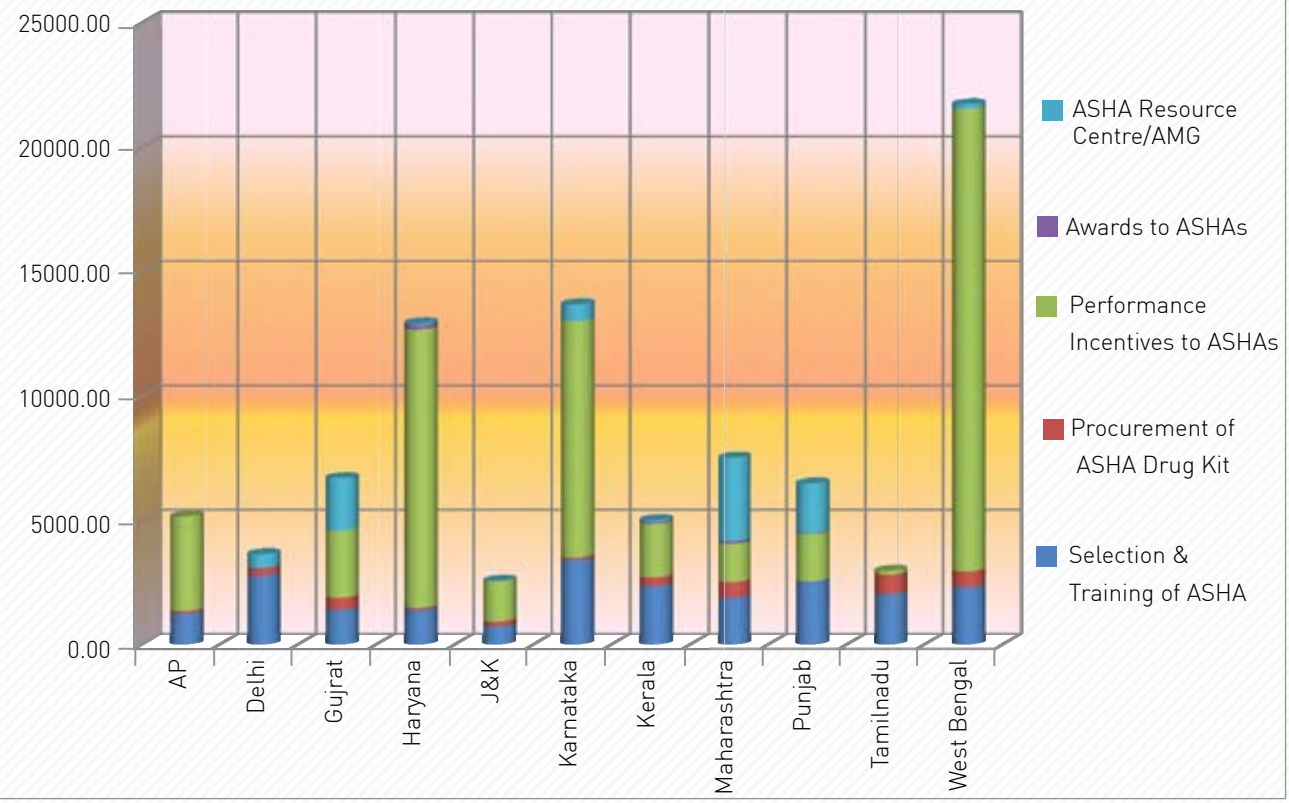
The graph shows the pattern of expenditure on different components of ASHA programme in FY 2012-13. We note that the expenditure on Performance Incentives presented above does not include JSY and Family Planning incentives, which in many states are the main incentives. Chhattisgarh with its comprehensive support structure and extensive trainings, is spending above 90% on training (which in the above graph includes the support structure costs), but shows negligible expenditures on incentives. At the other end, UP is spending close to 90% on ASHA incentives. This is largely due to under-spending on support structures below district level, and limited progress in trainings. Odisha has spent about 65% on trainings, about 20% on incentives and about 8% on support structures. Chhattisgarh and Uttarakhand, both have more than 100% expenditure and have spent overall above Rs. 10000 per ASHA. Uttarakhand also reflects a balanced pattern of expenditure with about 40% each spent on training and support structures, and about 17% on incentives. MP has also done well on programme support & training, as its programme has picked up momentum recently. Many states have low expenditures on drug kit as supplies are being given from facilities and are often not reflected in the expenditures.

Table A-2 : RELATIVE SHARE OF PER ASHA EXPENDITURES ON DIFFERENT PROGRAMME COMPONENTS – NORTH EAST STATES



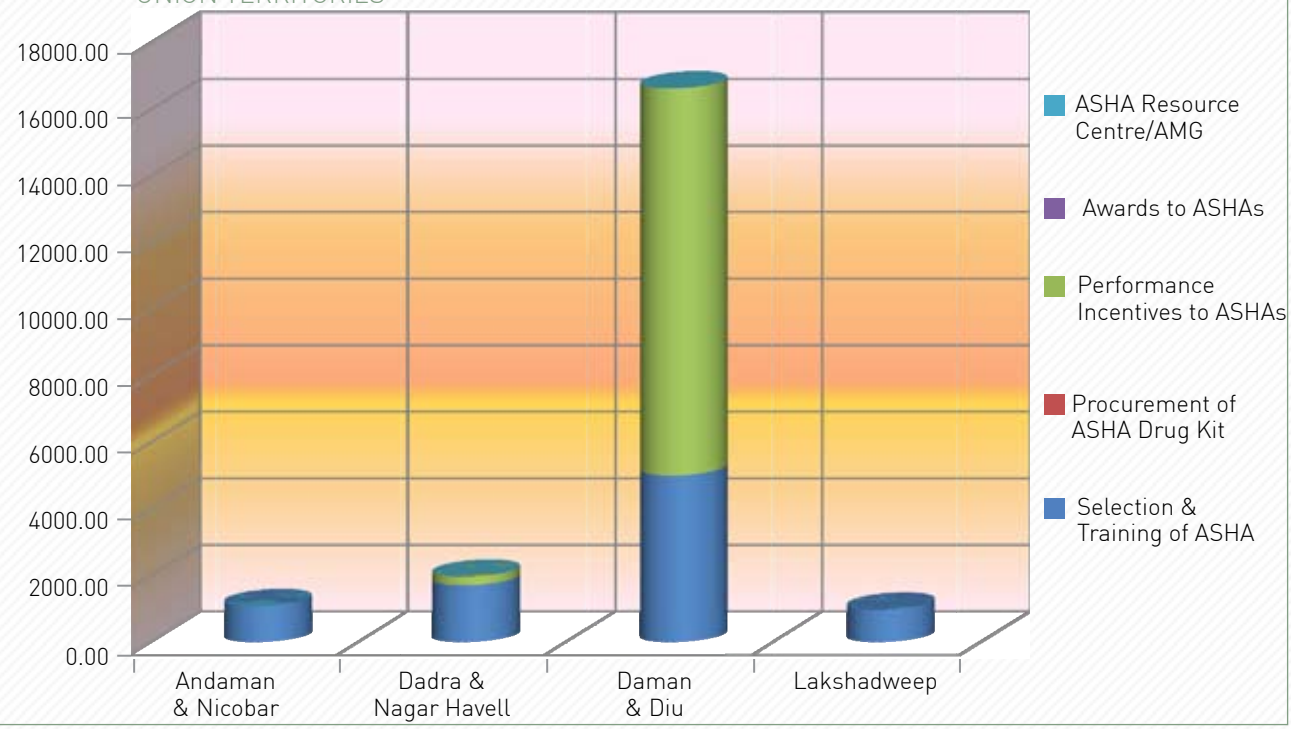
The states across North east reflect a wide variety of expenditure patterns, but almost all states have spent well on selection & training and ARC/support. Expenses on incentives are not very high across the eight states and are very low in Nagaland & Sikkim. Nagaland has expenses in only training and awards to ASHAs and ARC. Assam, Manipur and Mizoram have all spent about 30% on incentives. Expenditures on Drug Kits are also low in many states, as supplies are often being given from facilities.

Table A-3 : RELATIVE SHARE OF PER ASHA EXPENDITURES ON DIFFERENT PROGRAMME COMPONENTS – NON HIGH FOCUS STATES



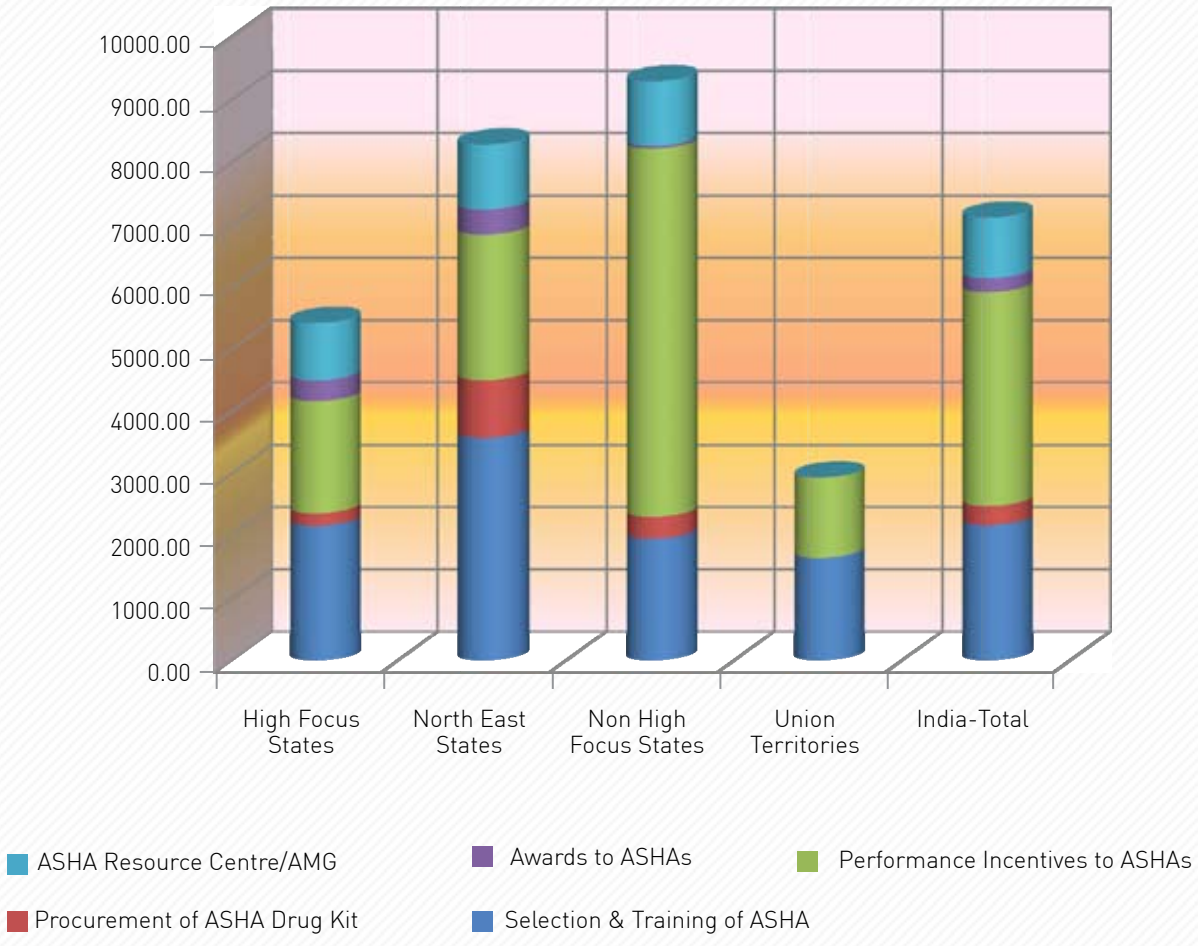
Among the Non High Focus group almost all states have shown high overall programme expenditures. Two of these states, namely Haryana, & WB spend about 90% of their expenditure on ASHA Incentives. AP & Karnataka are other two states with high incentive expenditure at 75%, and J&K is at about 65%. Expenditure on Drug Kit is high at about 25% in Tamilnadu, reflecting the state's focus on ensuring reaching drugs to community. States of AP, Haryana, Punjab & Karnataka have no or negligible expenses on Drug Kit. Delhi & Tamilnadu are states with high expenditure on selection & training at about 72% & 65% respectively. Across the 11 states, only Gujarat, Maharashtra & Punjab have significant expenses on support structures.

Table A-4 : RELATIVE SHARE OF PER ASHA EXPENDITURES ON DIFFERENT PROGRAMME COMPONENTS – UNION TERRITORIES



A&N and Lakshadweep have incurred all their expenditures in only selection and training. D & NH has spent about 16% on incentives, but Daman & Diu has spent about 65% on incentives.

Table A-5 : RELATIVE SHARE OF PER ASHA EXPENDITURES ON DIFFERENT PROGRAMME COMPONENTS – ACROSS STATES & INDIA TOTAL



The graph shows the expenditures patterns across different groups of state. Again we reiterate that the graph does not include JSY and Family Planning incentives. Thus non high focus states may be compensating for lower JSY incentives paid, by non-JSY incentives. The graph shows that overall, states spent about 50% on incentives, and less than 30% on training & support. In High Focus states and NE states, the expenditures on Selection and training, which comprises mainly training at present, stands at about 40%. The overall expenditure on Drug Kit is quite low at Rs. 305 per ASHA. The analysis of expenditure for previous years as presented in the table later in this chapter, shows an increasing investment in training and support activities over the period, but there is still a substantial ground to be covered especially in Non High Focus states.

Table 5.1 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM - HIGH FOCUS STATES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No. of ASHAs (as on 31 March 2012)	2005-08			2008-09			2009-10			2010-11			2011-12			2012-13				Total : 2005 - 2013			
			Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Total Fund Spent per ASHA, (in Rs.)	Total Fund released	Total Expenditure	% Expenditure over fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1	Bihar	83301	31.89	4.73	14.83	17.15	7.36	42.92	56.03	13.58	24.24	57.04	19.35	33.92	57.41	33.17	57.78	77.65	45.46	58.54	5457.32	297.17	123.65	41.61	14844
2	Chhattisgarh	28000	18.11	20.12	111.10		6.58		17.7	12.21	68.98	25.83	19.95	77.24	23.68	25.31	106.88	27.47	28.54	103.90	10192.86	112.79	112.71	99.93	40254
3	Jharkhand	40964	28.78	6.72	23.35	9.51	18.96	199.37	8.56	5.77	67.41	22.02	4.73	21.48	19.88	13.12	66.00	28.34	18.24	64.36	4452.69	117.09	67.54	57.68	16488
4	Madhya Pradesh	52393	19.39	13.22	68.18	7.94	8.2	103.27	39.87	12.85	32.23	34.64	27.25	78.67	42.08	22.48	53.42	49.48	31.79	64.25	6067.60	193.40	115.79	59.87	22100
5	Odisha	42597	24.51	4.6	18.77	4.07	9.58	235.38	27.9	18.95	67.92	35.78	27.04	75.57	28.76	28.76	100.00	37.24	26.99	72.48	6336.13	158.26	115.92	73.25	27213
6	Rajasthan	50287	25.43	4.35	17.11	12.23	12.88	105.31	41.5	15.23	36.70	27.91	29.67	106.31	27.78	24.92	89.70	27.01	21.68	80.27	4311.25	161.86	108.73	67.18	21622
7	Uttar Pradesh	136094	45.24	12.13	26.81	116.11	65.06	56.03	135	71.92	53.27	137.30	84.96	61.88	38.6	33.94	87.93	128.87	56.53	43.87	4153.75	601.12	324.54	53.99	23847
8	Uttarakhand	11086	2.58	2.47	95.74	8.87	4.18	47.13	9.85	6.99	70.96	11.08	11.11	100.27	12.25	10.2	83.27	10.45	11.80	112.92	10644.06	55.08	46.75	84.88	42170
	Total for All States	444722	195.93	68.34	34.88	175.88	132.8	75.51	336.41	157.5	46.82	351.60	224.06	63.73	250.44	191.9	76.63	386.51	241.03	62.36	5419.79	1696.77	1015.63	59.86	22837

Table 5.2 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM - NORTH EAST STATES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No. of ASHAs (as on 31 March 2012)	2005-08			2008-09			2009-10			2010-11			2011-12			2012-13				Total : 2005 - 2013			
			Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Total Fund Spent per ASHA, (in Rs.)	Total Fund released	Total Expenditure	% Expenditure over fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1	Arunachal Pradesh	3740	1.2	1.1	91.67	3.86	1.49	38.60	3.86	2.48	64.25	3.86	2.31	59.84	3.28	2.81	85.66	3.58	3.69	103.07	9866.31	19.64	13.88	70.67	37112
2	Assam	29172	14.55	4.53	31.13	29.69	6.45	21.72	29.69	29.33	98.79	31.04	29.00	93.43	28.00	25.46	90.93	37.74	30.15	79.89	10335.25	170.71	124.92	73.18	42822
3	Manipur	3878	0	0.39		1.28	0.91	71.09	3.88	2.05	52.84	3.88	1.78	45.88	3.50	2.37	67.66	3.73	1.44	38.61	3713.25	16.27	8.94	54.94	23053
4	Meghalaya	6258	1.16	0.05	4.31	3.96	2.24	56.57	6.25	1	16.00	6.25	3.99	63.84	6.26	2.89	46.18	6.00	3.01	50.17	4809.84	29.88	13.18	44.11	21061
5	Mizoram	987	0.02	0.05	250.00	0.94	0.92	97.87	0.94	0.76	80.85	0.94	0.56	59.57	0.54	0.43	80.79	0.86	0.49	56.98	4964.54	4.24	3.21	75.85	32564
6	Nagaland	1700	0.83	0.44	53.01	0.75	0.98	130.67	1.7	1.04	61.18	1.70	1.39	81.76	1.70	1.42	83.52	0.82	0.87	106.10	5117.65	7.50	6.14	81.86	36116
7	Sikkim	666	0.18	0.19	105.56	0.19	0.12	63.16	0.64	0.38	59.38	0.65	0.48	73.85	0.67	0.68	101.72	0.73	0.67	91.78	10060.06	3.06	2.52	82.39	37838
8	Tripura	7367	3.78	0.95	25.13	4.17	4.49	107.67	5.26	2.97	56.46	7.37	1.29	17.50	5.71	4.16	72.88	7.91	4.22	53.35	5728.25	34.20	18.08	52.87	24542
	Total for All States	53768	21.72	7.7	43.53	44.84	17.6	39.25	52.22	40.02	76.64	55.69	40.80	73.26	49.65	40.22	81.01	61.37	44.54	72.58	8283.74	285.49	190.88	66.86	35501

Table 5.3 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM : NON - HIGH FOCUS STATES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No. of ASHAs (as on 31 March 2012)	2005-08			2008-09			2009-10			2010-11			2011-12			2012-13				Total : 2005 - 2013			
			Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Total Fund Spent per ASHA, (in Rs.)	Total Fund released	Total Expenditure	% Expenditure over fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1	Andhra Pradesh	70700	0	2.23			27.56		8.5	9.74	114.59	26.90	15.25	56.69	26.44	40.73	154.02	46.80	36.44	77.86	5154.17	108.64	131.95	121.45	18663
2	Delhi	4121	0	0		14.72	2.62	17.80	19.04	1.74	9.14	0.00	2.91		5.73	1.08	18.82	6.27	1.50	23.92	3639.89	45.76	9.85	21.52	23899
3	Gujarat	29508	4.85	0.87	17.94	11	14.4	130.91	25.38	28.63	112.81	32.08	37.41	116.61	32.33	43.05	133.15	37.94	19.78	52.13	6703.27	143.58	144.14	100.39	48848
4	Haryana	13683	0	1.36			0.22		8.89	4.82	54.22	7.32	8.78	119.95	5.96	5.62	94.28	12.74	17.69	138.85	12928.45	34.91	38.49	110.25	28130
5	Jammu Kashmir	9700	1.02	1.4	137.25	2.92	2.17	74.32	4.21	1.14	27.08	6.60	1.59	24.09	3.48	3.72	106.92	8.03	2.49	31.01	2567.01	26.26	12.51	47.64	12897
6	Karnataka	33750	0	0.63		7.71	6.34	82.23	34.66	32.86	94.81	9.43	13.68	145.07	55.63	41.67	74.91	48.65	46.21	94.98	13691.85	156.08	141.39	90.59	41893
7	Kerala	31868	0.57	1.38	242.11		22.12		21.17	14.26	67.36	15.00	12.76	85.07	10.86	7.30	67.24	14.27	15.96	111.84	5008.16	61.87	73.78	119.26	23152
8	Maharashtra	59316	3.36	0.28	8.33	16.34	6.19	37.88	71.77	22.08	30.76	54.86	39.43	71.87	38.03	44.16	116.13	38.12	44.58	116.95	7515.68	222.48	156.72	70.44	26421
9	Punjab	16800	0	0.38			0.78		4.49	4.08	90.87	14.75	9.18	62.24	7.40	7.31	98.79	19.75	10.89	55.14	6482.14	46.39	32.62	70.32	19417
10	Tamilnadu	2650					20.28						0.46		1.78	0.06	3.21	5.52	0.79	14.31	2981.13	7.30	21.59	295.54	81462
11	West Bengal	45564	0	4.96		5.17	1.7	32.88	5.72	12.86	224.83	97.49	36.19	37.12	74.24	49.10	66.14	79.89	99.03	123.96	21734.26	262.51	203.84	77.65	44737
	Total for All States	317660	9.8	13.49	137.65	57.86	104.38	180.40	203.83	132.21	64.86	264.43	177.64	67.18	261.88	243.80	93.10	317.98	295.36	92.89	9297.99	1115.78	966.88	86.65	30437

Table 5.4 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM - UNION TERRITORIES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No. of ASHAs (as on 31 March 2012)	2007-08			2008-09			2009-10			2010-11			2011-12			2012-13				Total-2005-13			
			Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Total Fund Spent per ASHA, (in Rs.)	Total Fund released	Total Expenditure	% Expenditure	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1	Andaman and Nikobar	407	0.02	0.003	15.00	0.04	0.033	82.50	0.01	0.04	400.00	0.10	0.07	70.00	0.10	0.09	90.54	0.08	0.04	50.00	982.80	0.35	0.28	78.99	6781
2	Dadra & Nagar Haveli	208	0	0.016		0.07	0.1	142.86	0.04	0.007	17.50	0.11	0.01	9.09	0.10	0.02	18.46	0.11	0.04	36.36	1923.08	0.43	0.19	44.25	9246
3	Lakshadweep	83	0.07	0.051	72.86	0.02	0.13	650.00	0.06	0	0.00	0.09	0.03	33.33	0.10	0.01	10.04	0.07	0.01		1204.82	0.41	0.23	56.40	27831
4	Daman & Diu	92							0.015	0	0.00	0.24	0.05		0.14	0.13	92.86	0.17	0.14	82.35	15217.39	0.57	0.32	92.86	0.57
	Total for All UTs	790	0.09	0.07	77.78	0.13	0.263	202.31	0.125	0.047	37.60	0.54	0.16	29.63	0.44	0.25	56.20	0.43	0.23	53.49	2911.39	1.76	1.02	57.96	12903

Table 5.5 - PERCENTAGE EXPENDITURE OF VHSNC FUNDS ACROSS STATES

A. High Focus States		2008-09	2009-10	2010-11	2011-12	2012-13
1	Bihar	0.00	50.34		94.35	81.23
2	Chhattisgarh	36.03	23.27	50.01	140.16	114.12
3	Himachal	0.05	105.55	100.09	0.13	0.00
4	J & K	14.21		43.31	125.34	41.83
5	Jharkhand	99.03		106.34	66.46	114.96
6	MP	18.10	33.18	51.19	73.16	114.00
7	Odisha			96.23	70.21	121.97
8	Rajasthan	119.24	89.86	98.78	34.99	47.63
9	UP			78.09	8.12	35.68
10	Uttarakhand	0.00	11.12	177.66	104.52	98.00
	Total	**84.94**	**148.85**	**86.83**	**63.57**	**85.34**
B. NE States		**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**
11	Arunachal Pradesh	31.87	54.98	74.45	53.75	83.58
12	Assam	91.64	97.36	100.25	117.31	32.13
13	Manipur	51.72	117.81	112.75	104.79	89.59
14	Meghalya	43.01	30.78	83.82	62.24	39.93
15	Mizoram	100.00	99.51	73.66	99.52	100.00
16	Nagaland	23.47	77.16	176.29	93.64	128.59
17	Sikkim	122.77	115.93	93.21	101.08	87.30
18	Tripura	76.14	115.18	120.95	75.15	83.83
	Total	**76.16**	**86.95**	**99.22**	**102.13**	**44.88**
C. Non-High Focus States		**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**
19	Andhra	100.22	67.08	59.30	57.54	93.87
20	Goa	82.11	23.74	30.52	44.23	39.15
21	Gujarat	71.99	77.55	76.39	75.51	105.35
22	Haryana	93.32	144.25	84.67	11.49	23.78
23	Karnataka	137.36	31.26	57.89	67.58	78.84
24	Kerala	92.21	91.17	100.00	107.01	113.26
25	Maharashtra	149.40	69.45	82.07	88.37	94.86
26	Punjab	148.33	108.98	100.27	102.44	73.10
27	Tamilnadu	101.22	98.22	92.18	84.18	102.11
28	West Bengal		63.82	79.92	1.13	2106.26
	Total	**124.08**	**71.58**	**78.75**	**64.32**	**99.44**
D. Small States/UTs		**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**
29	Andaman & Nicobar		76.05	81.98	76.84	77.71
30	Chandigarh		101.32	104.55	100.00	0.00
31	Dadra & Nagar Haveli		0.00	0.00	0.00	
32	Daman		100.00	0.00	169.03	14.29
33	Delhi		0.79	0.00	0.00	
34	Lakshadweep		0.00		11.11	87.50
35	Puducherry	6.74	88.51	128.10	100.70	66.83
	Sub Total	**36.04**	**51.95**	**13.44**	**46.17**	**65.20**
Grand Total		**100.56**	**104.57**	**84.36**	**66.86**	**86.46**

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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