Update on the ASHA PROGRAMME

July 2011

National Rural Health Mission
Ministry of Health and Family Welfare
Government of India, New Delhi

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ASHA Programme, July 2011

Introduction

The National Rural Health Mission (NRHM), includes several processes which aim to actively engage communities in improving health status. The key elements of the community processes under NRHM are in Box 1. While the ASHA is intended to facilitate access to health services, mobilize communities to realize health rights and access entitlements and provide community level care for a number of health priorities to save lives and improve health, the other elements focus on promoting action by village level organizations and enhance people's participation in marginalized communities. The VHSC was expected to develop village health plans, specific to the local needs, support the ASHA and generally serve as a mechanism to promote community action for health, particularly for social determinants of health. The provision of untied funds to the VHSC was expected to meet needs related to local action.

Currently the number of ASHA in all states[1] is 835,808 which is approximately 94% of the target, which is one ASHA for every 1000 rural population. A total of about Rs. 1771 crores has been released for the ASHA programme.

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

service delivery. A key support system for the ASHA is the Village Health and Sanitation Committee (VHSC). The VHSC was intended to function as a village level organization comprising of key stakeholders including members of PRI, ASHA, AWW and ANM, and include representations from women (including from Self Help Groups) and

A total of 483, 496 VHSCs have been formed in the country, covering about 76% of the villages. Of these, 9% (42,640) are in the North East states, 56% (269, 213) are in the non NE High Focus states, and

1 Except Himachal, Goa, non tribal regions of Tamil Nadu, Puducherry and Daman and Diu.

the remainder in the non high focus states and UTs. States such as Bihar, Uttar Pradesh, Haryana, Himachal Pradesh, Kerala and Tamil Nadu have formed the VHSC within the Gram Panchayat while in the remaining it is at the level of the revenue village. There is a provision of Rs. 10,000 untied funds for each VHSC. Under this scheme a total of Rs. 1464 crores have been disbursed over four years for expenditure by the VHSC at the village level. Of this 11% went to the north east VHSCs and 50% has gone to the VHSCs of other high focus states.

Rogi Kalyan Samitis- or hospital development societies: 678 district hospitals, 4,875 CHCs, and 27,596 other facilities have a registered RKS in place. A total of Rs. 4,373 crores have been released to these facilities, of which Rs. 898 crores was in the form of RKS corpus funds and the rest in the form of untied grants, grants for annual maintenance, and grants for up-gradation of CHCs. Though there are exceptions, in most states, meetings of RKS are held regularly. However their functionality and effectiveness need to be assessed more carefully.

This report is the fourth in a series of ASHA updates,[2] produced by the National Health Systems Resource Center (NHSRC) for the National Rural Health Mission, Ministry of Health and Family Welfare (MOHFW). The objective of these biannual updates is to report on the progress of the ASHA and community processes programme in the states.

2 Three updates have been issued so far: October 2009, June 2010, January 2011. Available on http://nhsrcindia.org/thematicdata.php?thematicresourceid=1.

Since the last update, in January 2011, a few developments merit mention. The first is that the report of the ASHA evaluation served to enhance understanding of the multiple roles of the ASHA, and the fact that such a substantial investment risked showing little return unless her capacity to provide community level care for the newborn and sick children was built. Based on a recent decision by the Mission Steering Group (the decision making body of the National Rural Health Mission); the ASHA will now be trained and supported through training in Module 6 and 7, and will get an incentive of Rs. 250 to provide home based care of the newborn.

Continuing the tradition of reporting on recent evaluations, this update also summarizes the findings of an evaluation of the Mitanin programme, a community health worker intervention launched in 2003 which covered the entire state of Chhattisgarh, and which was the inspiration for the ASHA programme. The findings of the evaluation of the VHSC component from the ASHA evaluation are also discussed. This update also provides information on VHSC and state level facilitatory mechanisms in the ASHA programme.

The update is divided into five sections. Section 1 discusses the evaluations. Using data as of June 30, 2011, Sections 2 provides data on selection, population coverage and training of ASHAs, and information on support structures. Section 3 discusses state level efforts to motivate the ASHA and Section 4 discusses the status of the VHSC in the states. Section 5 reports on expenditure incurred on the ASHA programme in the States and Union Territories, updated as of March, 2011.

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Section 1

Findings of the Recent Evaluations

The previous updates on the ASHA programme reported on the - Eight State evaluation of the ASHA Programme – ASHA: Which way forward?; Concurrent evaluation by Ministry of Health and Family Welfare and a study on Improving the performance of ASHAs in India, prepared for International Advisory Panel by the EARTH Institute, Columbia university and IIM, Ahmedabad. Continuing this tradition, this update reports on evaluation of the Mitanin programme, which served as the inspiration for the ASHA.

1.1 Findings from the Mitanin Evaluation

Background

The Mitanin Programme which predates the ASHA programme, was scaled up in a space of three years from 2002 to 2005 to cover 60,000 villages and hamlets, every hamlet in the state, with 54,000 Mitanin in place. The Mitanin programme was not just the inspiration for the ASHA programme, it also influenced and shaped programme design. The Mitanin provide information and first level care on a range of primary health care issues and promote activism and advocacy with government on behalf of poor and marginalized communities. The state had institutionalized support and programme management structures from the launch of the programme. Thus there is one Mitanin Trainer (for every 10-20 Mitanin, depending on population density), one facilitator for a block (covering about 10-15 Mitanin Trainers), and one District Facilitator (for about 6-8 Block facilitators). This is supported by the State Health Resource Center, which provided the technical content (in terms of curriculum development, training design and implementation), management support and continuous advocacy with the political and bureaucratic apparatus.

The mixed method evaluation (similar to that used in the NHSRC led eight state evaluation) was conducted in eight districts, and interviewed 1280 Mitanin, 2560 each of currently pregnant women and women with a child less than six months, 5120 women with a child less than two years, and 640 each from the following categories: ANMs, AWW and PRI. Field work for the evaluation was undertaken between November 2010 to January 2011.

Highlights

While it is not possible to attribute declines in mortality to the activity of the Mitanins alone, given that the component was part of a larger sector reform programme, the rural IMR in Chhattisgarh declined by a remarkable 40 points from 88 in 2001 to 55 in 2009. These results have occurred despite slow progress in expanding health infrastructure and recruiting trained medical providers. One could therefore impute this to changes in home care practices such as early and exclusive breastfeeding and the use for ORT for diarrhea, likely effected through the activity of the Mitanin.

The qualitative evaluation findings note that the programme has had the positive impact that was envisaged in promoting good practices and utilization of public health services. The Mitanin have effectively played the role of an activist in raising community awareness about their rights. However, the assessment has raised the potential risk that the introduction of task based incentives may affect the ability of the Mitanins to play their activist role.

Access to and utilization of services: *feedback from women with children aged less than 6 months*

- Proportion of respondents who reported having received various antenatal services has ranged from 43% (blood pressure measurement) to a high of more than 90% for IFA tablets and TT injection; weight measurement and pregnancy testing rates are also found to be high for this group of respondents.
- Mitanin has been the main source of advice and/or service for the respondents, particularly for IFA tablets, institutional delivery, weight and blood pressure measurement and TT injection.
- About 42% of the respondents reported having one or more symptoms requiring help during pregnancy; more than half of the respondents sought help and assistance from their Mitanin.
- More than 80% respondents were advised/ encouraged for institutional delivery, the PHC or CHC being the most frequently recommended place. However, 50% deliveries actually took place at home; the main reported reasons for opting not to go for institutional delivery are time (night) of delivery, unavailability of transport and distance of facility.
- In more than 80% cases of institutional delivery, the Mitanin accompanied the woman for institutional delivery (mostly in addition to husband and/or mother/mother-in-law); majority of respondents reported that the Mitanin helped them in various ways particularly in dealing with health workers/staff and getting the JSY benefits.
- In more than 70% cases the post partum visit was reported to have taken place within 12 hours of birth and immediate initiation of breastfeeding and colostrums has been the most important post partum advice by the Mitanin, followed by advice for immunization of the new born.
- 90% respondents confirmed receiving supplementary nutrition on regular basis; nearly 3/4th were helped by the Mitanins for receiving the benefits.
- Most respondents were aware about the need to keep the baby warm, use of blanket being the main method for doing so.
- About 15% respondents reported newborn illness in first month after birth; Mitanin was reported as preferred source of help ahead of local doctor; however the main source of treatment is reported to be a private doctor.

Access to and utilization of services: *feedback from the Women with children aged 6–24 months*

- More than 60% of the children born to respondents were delivered at home while about 30% were born in government health facilities. In more than 90% cases breastfeeding was initiated within 4 hours and exclusive breastfeeding for 6 months was found to be very high at 87%.
- Over 90% respondents confirmed having utilized immunization services and the person who helped in accessing services the most is the Mitanin.
- Overall, 85% respondents confirmed receiving supplementary food/ration on a regular basis and 77% reported Mitanin help in enrolling the child with the AWC.

Feedback from the Mitanins themselves

- About 82% respondents have been working as a Mitanin for more than 5 years (at the time of survey in September/October, 2010).
- Close to 90% of the Mitanins spend, on an average, up to a maximum of 3 hours a day on their Mitanin related work.
- 4% of the respondents are holding a position in the PRI (in addition to being a Mitanin); close to one third are also involved with the self-help group work either as a member or as its President.
- Of the 58 respondents who are members of the Panchayat, 46 became so after they became Mitanin and 34 (feel that they were elected to the Panchayat because of their Mitanin work).

- For 85% of Mitanins, 'to serve the community' has been the main reason for becoming a Mitanin; raising awareness about health issues in the village and 'to look after family and children better' was reported as other leading reasons. Expectation of money or government job were reported as less important a reason than getting recognition in the community and/or opportunity to learn.
- The respondents were asked to recall the main subjects taught to them during their training. They were also asked to mention their most favorite topic as well as the subjects where they would like more training. The responses revealed a consistent result which placed child nutrition and newborn care as not only most popular subject, but also the subject where more training should be given.
- The average incentive amount received by the respondents is estimated to be less than Rs. 200/- per month.
- While about 95% of the Mitanin had the drug kit, only 54% reported regular replenishment.
- Most Mitanins have reported receiving significant support from Mitanin Trainers and are frequently contacted by them. The cluster meetings of Mitanins were also found to be regular in most places.
- The knowledge levels of Mitanins on critical aspects like care during pregnancy, post-natal care, immunization, complementary feeding, diarrhea and malaria management etc. were found to be adequate for a large proportion of Mitanins.

Impact of the Mitanin programme: *feedback from ANMs and AWW*

- Almost all ANMs and AWWs interviewed acknowledged the help extended by the Mitanins in mobilizing women and children for the VHND. Other areas where their help is acknowledged includes motivating women for family planning, identifying women from marginalized communities and providing beneficiary list for JSY, DOTS, family planning etc.
- About 90% respondents feel that Mitanins have helped increase institutional deliveries. Other impact areas identified include increasing immunization, increasing mother and child attendence in the VHNDs, increase in the utilization of public health services and better hygiene in the community.

Impact of the Mitanin programme: *feedback from the PRI members*

- Increase in the immunization coverage is the main impact of the Mitanin programme according to 89% respondents. Other impact areas identified include increasing institutional deliveries, increasing the attendence of mother and child in the VHNDs and better hygiene in the community.

Conclusion

A comparison of key parameters between Mitanin (Chhattisgarh) and ASHA (from the ASHA evaluation report) shows that the effectiveness of Mitanin in terms of reaching the pregnant women, newborn and infants in aspects like newborn care, child feeding practices, diarrhea management etc. is markedly higher than of ASHA in other states. This is attributable to the character of the Mitanin programme that was more focused on the social mobilization aspect, the spirit of voluntarism, the intensive focus on building competencies and the strong support and management. Programme managers in Chhattisgarh are conscious that over time the gains may become limited if the programme not only continues with these components but also finds new direction. Thus career progression paths for the ASHA are being charted out, a Foundation for Mitanin is being considered, and there is talk of increasing their action for nutrition through fellowships in all districts. Although the programme predates the ASHA, it is in the Mitanin programme that one can find all the elements of a successful CHW programme in place, and where there is equal emphasis on the roles of facilitation, service provision and activism for social mobilization and inclusion.

1.2 Findings on the VHSC evaluation

Background

Findings on the VHSC from the eight state ASHA evaluation[3], showed that functional VHSCs defined minimally as at least "holding some meetings in the

3 **ASHA:** Which Way Forward, AN evaluation of the ASHA programme in Eight States, National Health Systems Resource Center, December 2010.

year" was about 83% (mode- across the states- range 58% to 97% excluding Bihar and West Bangal).[4] This is based on information collected independently from the ASHA, ANMs and Anganwadi workers of the village. The VHSCs appear to be active in support to VHND and promotion of immunization in about 63%, in health awareness campaigns in 56%, in promotion of institutional delivery in 53% (excluding Kerala where this was not necessary), and in clearing stagnant pools of water in 45%. On Village Health Planning, there appear to be wide variations, but overall, about 60% of VHSCs had made such an effort. About 20 to 40% of ASHAs felt supported by the VHSC, but it was precisely in these villages that the mobilization role of ASHA played out best. VHSC members helped ANMs in hosting village level meetings and in disseminating key health related information. Although, in terms of percentages the achievements are modest, the absolute numbers of people mobilized by the VHSC and sensitized to health issues are likely to be high.

4 Bihar is excluded since the VHSC formation had just begun at the time of survey and West Bengal is not included because the panchayat elections were going on during period of data collection.

However, it appears that in the absence of a well planned strategy to build the VHSC into an effective planning and implementing body to address village health planning and social mobilization, they have remained auxiliaries of the JSY, immunization and in some areas agencies to conduct source reduction activities of vector control- and that too in a scattered manner. However where there is support and training provided, there is considerable potential in these committees.

The Village Health and Sanitation Committees remain the key mechanism to address action on social determinants including age at marriage, literacy, water and sanitation, nutrition and substance abuse. This aspect was always part of the design, but there was no management capacity to handle this. There is a need to bring in NGO participation in a major way so as to expand the systemic capacity to train and support VHSCs to play a role in addressing social determinants of health in a meaningful way. This VHSC programme with an adequate support structure is also needed to support the ASHA to play the mobilisational and health education roles.

Table 1A: Findings on VHSC from ASHA Evaluation in eight states

	% of ASHAs who reported functional VHSC	% of ASHAs who reported a functional VHSC and VHSCs providing support in promotion of institutional deliveries	% of ASHAs who reported a functional VHSC and VHSCs providing support in promotion of immunization	% of ASHAs who reported a functional VHSC and VHSCs providing support in Health awareness campaigns	% of ASHAs who reported a functional VHSC and VHSCs providing support in eliminating water clogging to prevent vector borne
Andhra Pradesh	58.5	65	79.5	65	45.3
Assam	93.5	55.6	67.9	50.8	16.6
Jharkhand	84.3	45.8	51.8	38	42.2
Kerala	97	27.8	53.6	71.6	82.5
Orissa	82.5	52.7	58.2	67.9	59.4
Rajasthan	77	48.1	64.3	39	44.8

Section 2

Progress of the ASHA Program

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

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

The matrix also provides information on modes of payment to the ASHA, innovations in the ASHA programmes for improving motivation and supervision, and strengthening the linkages with the health system. The data in this update are substantially taken from the monthly matrix for the period ending June 30, 2011.

2.1 Selection and Recruitment

In most high focus states except Rajasthan and to a certain extent in Bihar, the required number of ASHA are already in place. In the NE states, 99% of the ASHA are in place. In the non high focus states, Delhi, Karnataka, West Bengal and Tamil Nadu have yet to select the ASHAs as planned for.

In terms of population density majority of states have one ASHA for 1000 population or less, with Chhatissgarh having one ASHA per 277 population, Jharkhand one per 511. For the NE states, Meghalaya has one ASHA per 298, Arunachal one per 225, and Tripura one per 360. In the non high focus states, only Delhi has one ASHA per 261 population, with all the rest being nearly 1000 or more.

Table 2A: Status of ASHA selection in High Focus States (June, 2011)

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
Bihar	87,135	79,952	91.8%
Chhattisgarh	60,092	60,092	100%
Jharkhand	40,964	40,964	100%
Madhya Pradesh	52,117	50,113	96.2%
Orissa	41,102	40,942 (596 ASHAs in slums)	99.6%
Rajasthan	54,915	48,736 (600 ASHAs in slums)	88.7%
Uttar Pradesh	136,268	136,182	99.9%
Uttarakhand	11,086	11,086	100%
Total	**483,679**	**468,067**	**96.8%**

Table 2B: Status of ASHA selection in North East States (June, 2011)			
State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
Assam	29,693	29,172	98.2
Arunachal Pradesh	3,862	3,683	95
Manipur	3,878	3,878	100
Meghalaya	6,258	6,258	100
Mizoram	987	987	100
Nagaland	1,700	1,700	100
Sikkim	666	666	100
Tripura	7,367	7,367	100
Total	**54,411**	**53,711**	**99**

Table 2C: Status of ASHA selection in Non High Focus States (June, 2011)			
State Name	Proposed No. of ASHA	Number of ASHA selected	% of ASHA selected
Andhra Pradesh	70,700	70,700	100
Delhi*	5,400	3,622	67.1
Gujarat	32,806	29,731	90.6
Haryana	14,075	12,857	91.3
Jammu and Kashmir	10,000	9,500	95
Karnataka	39,195	33,105	84.5
Kerala	32,854	31,868	97
Maharashtra	59,384	59,151	99.6
Punjab	17,360	16,597	95.6
Tamil Nadu*	6,850	2,650	38.7
West Bengal	61,008	43,229	70.9
Total	**349,632**	**313,010**	**89.5**

* Tamil Nadu and Delhi do not propose complete coverage of the population.

Table 2D: Status of ASHA selection in Union Territories (June, 2011)			
State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHAs selected
Andaman and Nicobar Island	407	407	100
Dadra and Nagar Haveli	250	107	42.8
Lakshadweep	85	83	97.6
Chandigarh	423	423	100
Total	1,165	1,020	87.6
Grand total for All States and Union Territories			
	888,887	835,808	94

Table 2E: Density of ASHA in High Focus States					
State Name	Proposed No. of ASHAs	Selected	Rural Population (2011)	Density of ASHA (ASHA : Population)	Density of ASHA (ASHA : Population)
				Selected	Proposed
Bihar	87,135	79,952	74,316,709	1: 930	1:853
Chhattisgarh	60,092	60,092	16,648,056	1: 277	1:277
Jharkhand	40,964	40,964	20,952,088	1: 511	1:511
Madhya	52,117	50,113	44,380,878	1: 886	1:852
Orissa	41,102	40,942	31,287,422	1: 764	1:761
Rajasthan	54,915	48,736	43,292,813	1: 888	1:788
Uttar Pradesh	136,268	136,182	131,658,339	1:967	1:966
Uttarakhand	11,086	11,086	6,310,275	1:569	1:569

Table 2F: Density of ASHA in North East States					
State Name	Proposed No. of ASHAs	Selected	Rural Population (2011)	Density of ASHA (ASHA : Population)	Density of ASHA (ASHA : Population)
				Selected	Proposed
Assam	29,693	29,172	23,216,288	1:796	1:782
Arunachal Pradesh	3,862	3,683	870,087	1:236	1:225
Manipur	3,878	3,878	1,590,820	1:410	1:410
Meghalaya	6,258	6,258	1,864,711	1:298	1:298
Mizoram	987	987	447,567	1:453	1:453
Nagaland	1,700	1,700	1,647,249	1:969	1:969
Sikkim	666	666	480,981	1:722	1:722
Tripura	7,367	7,367	2,653,453	1:360	1:360

Table 2G: Density of ASHA in Non High Focus States					
State Name	Proposed No. of ASHA	Number of ASHA selected	Rural Population (2011)	Density of ASHA (ASHA : Population)	Density of ASHA (ASHA : Population)
				Selected	Proposed
Andhra Pradesh	70,700	70,700	55,401,067	1:784	1:784
Delhi	5,400	3,622	944,727	1:261	1:175
Gujarat	32,806	29,731	31,740,767	1:1068	1:968
Haryana	14,075	12,857	15,029,260	1:1169	1:1068
Jammu and Kashmir	10,000	9500	7,627,062	1:803	1:763
Karnataka	39,195	33,105	34,889,033	1:1054	1:890
Kerala	32,854	31,868	23,574,449	1:740	1:718
Maharashtra	59,384	59,151	55,777,647	1:943	1:939
Punjab	17,360	16,597	16,096,488	1:970	1:927
Tamil Nadu*	6,850	2,650			
West Bengal	61,008	43,229	57,748,946	1:1336	1:947

* Selected only in Tribal areas.

Table 2H: Density of ASHA in Union Territories					
State Name	Proposed No. of ASHA	Number of ASHA selected	Rural Population (2011)	Density of ASHA (ASHA : Population)	Density of ASHA (ASHA : Population)
				Selected	Proposed
Andaman and Nicobar Island	407	407	239,954	1:590	1:590
Dadra and Nager Haveli	250	107	170,027	1:1589	1:680
Lakshadweep	85	83	33,683	1:406	1:396
Chandigarh	423	423	92,120	1:218	1:218

2.2 Training of ASHA

ASHA training in Module 5 has been initiated in all high focus status except Bihar. Madhya Pradesh has accelerated its training programmes, and despite having initiated training in Module 5 much later than the rest has trained nearly 65% ASHA in Module 5. Rajasthan has trained only about 35%, although there was an early start. In the North East all states have completed training upto Module 5. In the non high focus states, Module 5 training is underway in most states, except for Punjab and Kashmir where it has been completed. In the non high focus states, only Karnataka has started two rounds of ASHA training. Jammu and Kashmir and Maharashtra have begun Round 1 training. The training of ASHA trainers has yet to begin in other states.

Training in Modules 6 and 7 which cover a range of competencies in maternal, newborn, and sick child care, is being scaled up. The training visualizes a two tier cascade of state and district trainers, who would be trained in national and state training sites and accredited as trainers. The ASHA is expected to be trained in all of the competencies of Modules 6 and 7 conducted in four rounds over a one year period. Training modules for the ASHA and Trainer manuals have been translated into Urdu, Assamese, Garo, Khasi, Bengali, Manipuri, Telugu, Kannada, Marathi, Gujarati, and Oriya. An accompanying communication kit for the use of the ASHA to facilitate interpersonal communication has been developed and disseminated to the states.

Most states have initiated the roll out of training in Modules 6 and 7, although the rate of progress varies substantially across the states. Challenges to scaling up the training include the lack of full time training structures and the limited availability of demonstration cum practice sites where trainers and ASHA can be trained.

Of the high focus states, only the state of Uttarakhand has completed the first round of ASHA training. Uttar Pradesh is in the middle of rolling out the Comprehensive Child Survival Programme (CCSP) training which partially covers some of the skills of Module 6 and 7, but not all, and is planning a different strategy. Chhattisgarh which followed a different pattern of training has covered the competencies in these Modules much earlier. While training of ASHA trainers has been initiated in Madhya Pradesh, it has yet to start elsewhere. For the North East region, most states are in the process of completing the second of the four rounds of ASHA training. The state of Assam is yet to train district trainers in Modules 6 and 7.

Table 2I: Training Status for High Focus states					
State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Bihar	79,952	52,859 (66.11%)	52,859 (66.11%)	#[5]	♦ State trainers trained for ASHA Module 5, 6 and 7. ♦ Training of district trainers and ASHAs is not yet done.

5 Bihar - A combined training for Modules 5, 6 & 7 will be done in the state.

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
Chhattisgarh	60,092	♦ 60092 (100%) Mitanins trained in Module 1 to 12[6]. ♦ 50000 Mitanins (83.2%) trained on 13th module. ♦ 44219 Mitanins (73.58%) trained on 14th module. ♦ 43200 Mitanins (71.89%) trained in 15th module.			
Jharkhand	40,964	39214 (95.73%)	35675 (87.08%)	40964 (100%)	State trainers trained
Madhya Pradesh	50,113	47022 (93.83%)	45777 (91.35%)	32474 (64.80%)	State and ASHA trainers trained
Orissa	40,942	40814 (99.7%)	40814 (99.7%)	40683 (99.37)	♦ State trainers trained ♦ District trainers training is underway.
Rajasthan	48,736	34776 (71.35%)	34776 (71.35%)	17428 (35.76%)	State trainers trained
Uttar Pradesh	136,182	128434 (94.31%)	128434 (94.31%)	118199 (86.79%)	#[7]
Uttarakhand	11,086	11086 (100%)	11086 (100%)	8978 (81%)	♦ State and ASHA trainers trained ♦ 544 out of total 550 (99%) ASHA facilitators trained (7 days) ♦ 10313 ASHAs trained (93%) in 1st Round 1of 5 days ♦ Training of ASHAs for Round 2 is underway

= yet to begin

6 Chhattisgarh – Chhattisgarh follows a different pattern of modules and trainings as the Mitanin Programme predates NRHM. Module 13 is on BCC, Module 14: National Disease Control Programme, Module 15: Management of the sick newborn.

7 UP - UP has rolled out CCSP (Comprehensive Child Survival Programme) in 35 districts and have trained the ASHAs for the same in selected districts.

Table 2J: Training Status for North East States

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Assam	29,172	27141 (93.04%)	27122 (92.9%)	26736 (91.6%)	State trainers trained
Arunachal Pradesh	3,862	3539 (91.65%)	3521 (91.2%)	3519 (91.1%)	♦ State trainers trained ♦ 3566 ASHAs (92%) trained in round 1 (5 days)
Manipur	3,878	3878 (100%)	3878 (100%)	3878 (100%)	♦ State trainers trained ♦ 3878 (100%) ASHAs trained in round 1 (5 days)
Meghalaya	6,258	6250 (99.8%)	6250 (99.8%)	6250 (99.8%)	♦ State trainers trained ♦ 4287 (68.5%) ASHAs trained in round 1 (5 days)

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
Mizoram	987	987 (100%)	987 (100%)	976 (98.9%)	♦ State trainers trained ♦ 551 (55.8%) ASHAs trained in round 1(5 days)
Nagaland	1,700	1538 (90.5%)	1588 (93.4%)	1690 (99.4%)	♦ State trainer trained ♦ 1576 (92.7%) ASHAs trained in round 1(5 days)
Sikkim	666	666 (100%)	666 (100%)	666 (100%)	♦ State trainers trained ♦ 546 (81.9%) ASHAs trained in a combined round 1 and 2
Tripura	7,367	7367 (100%)	7367 (100%)	7367 (100%)	♦ 6963 (94.5%) ASHAs trained in round 1 (5 days)

= yet to begin

Table 2K: Training Status for Non High Focus states

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andhra Pradesh	70,700	30 days training as the programme preceded NRHM, but covered women's and children's health.			♦ State trainers trained ♦ Training of District Trainers is under way.
Delhi	3,622	Module 1–4 clubbed as Module 1, 2, 3 – 2075 (57.3%) ASHAs trained.		Module 5 as Module 4 – 1713 (47.3%) ASHAs trained	#
Gujarat	29,731	26191 (88%)	24898 (84%)	20404 (69%)	State trainers trained
Haryana	12,857	12857 (100%)	12086 (94%)	10985 (85%)	♦ State trainers trained for Module 6 and 7 ♦ 7714 (60.40%) ASHAs trained in a Home Based Post natal care (HBPNC) module supported by NIPI.
Jammu and Kashmir	9,500	9000 (94.73%)	9000 (94.73%)	5711 (60.11%)	♦ State and ASHA Trainers trained.
Karnataka	33,105	Up to Module 5 - 32939 (99.5%)			♦ State Trainers and 1 Master trainer for every district trained. ♦ 4000 ASHAs trained in round 1 and 2.
Kerala	31,868	28205 (88.5%)	25673 (80.56%)	14372 (45.09%)	NA
Maharashtra	59,151	20758 (35%)	8354 (14%) Module 4 completed only in tribal districts	7646 (13%) Module 5 – completed only in tribal districts	♦ State trainers trained ♦ 400 ASHAs from one district trained in Round 1 (of 5 days)
Punjab	16,597	16191 (97.55%)	16191 (97.55%)	13476 (81.19%)	State trainers trained

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
Tamil Nadu	2,650	1639 (62%)- completed only in tribal districts	1639 (62%)- completed only in tribal districts	1639 (62%) completed only in tribal districts	#
West Bengal	43,229	28969 (67.01%)	26918 (62.27%)	20379 (47.14%)	State and ASHA trainers trained

= yet to begin.

Table 2L: Training Status for UTs

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andaman and Nicobar Island	407	184 (45%)	188 (46.2%)	188 (46.2%)	#
Dadra and Nager Haveli	107	85 (79.43%)	85 (79.43%)	85 (79.43%)	#
Lakshadweep	83	83	#	#	#
Chandigarh	423	Module 1 to 4 Combined – 30 (7%)		#	#

= yet to begin.

2.3 Support Structures

The National ASHA Mentoring Group provides input to the NHSRC and the MOHFW on key policy matters related to the ASHA programme. Currently the group meets on a biannual basis to review the ASHA programme and provide policy inputs. Several members are also members of state level ASHA mentoring groups and thus bring valuable field insights from various states to the forum. NHSRC functions as the secretariat for the National ASHA Mentoring Group.

The supportive institutional network at state level and below (Tables 2M to 2P) has expanded rapidly in the past year, as states have increasingly become cognizant of the necessity of a strong support structure to enhance the community processes component.

Most states have established support and supervisory mechanisms at state, district, block and sub block levels. While some states such as UP and MP have no State ASHA Resource Centers, there is a dedicated team, which undertakes the functions related to the ARC. Madhya Pradesh is in the process of appointing district and block community mobilizers. The North East has fairly good support systems upto the block level.

The ASHA facilitator was considered an integral part of the ASHA programme and were expected to be deployed even before the selection of the ASHA. They were intended to facilitate the community led selection of the ASHA. While some states did appoint them for the selection, they tended to drop them after the ASHA were in place. States such as Uttarakhand, Chhattisgarh, Jharkhand, and most of the North East states, have now engaged ASHA facilitators. Madhya Pradesh, Bihar, and Orissa are expected to appoint them shortly. The non high focus states have no support systems below the state and not even at the state in several cases. However, they are using the existing programme structures to manage and support the ASHA programme. A challenge across the states is training of the support structures to effectively carry out their functions of ensuring outcomes of the ASHA and community processes programme.

Table 2M: Status of ASHA support structure and drug kit distribution in High Focus States					
	Status of Support Structure for ASHA				
	State Level	District Level	Block Level	Sector Level	Drug Kits
Bihar	♦ State ASHA Mentoring group in place. ♦ State ASHA Resource Centre established	♦ 29 out of 38 District Community Mobilizers are in place ♦ 31 out of 38 District Data Assistants are in place	♦ 421 out of 504 Block community mobilizers are in place	None	Distributed to 79,952 (100%) ASHAs
Chhattisgarh	♦ State ASHA Resource centre is part of State Health Resource Centre (SHRC) ♦ State AMG yet to be constituted ♦ 30 State field coordinators are in place to support the programme	427 District Resource Persons placed in 18 districts	♦ Block Coordinator placed in each block ♦ 2920 Block Resource Person placed in 146 blocks	3000 Mitanin (ASHA) trainers are in place. (1 per 20 Mitanin)	Distributed to all 60,092 Mitanins (100%)
Jharkhand	♦ State ASHA Mentoring group constituted ♦ Village Health Committee and Sahiya (ASHA) Resource Centre established.	District programme Coordinator placed in 20 out of 24 districts	None but managed by existing systems	2149 Sahiya Sathi selected and trained. (1 per 20 Sahiyas)	Distributed to 35,000 (85.44%) Sahiyas
Madhya Pradesh	♦ State Mentoring Group for Community Action constituted (includes ASHAs and other community processes) ♦ No State ARC but State Nodal officer for ASHA appointed and State Community Mobilizer placed in SPMU	District Community Mobilizers placed in 7 out of 50 districts	None but managed by existing systems	None	Distributed to 45,971 ASHAs (91.73%)
Orissa	♦ State ASHA Mentoring group constituted ♦ Community Processes Resource Centre functioning as ASHA Resource Centre.	♦ District ASHA Coordiantors in place in all districts ♦ District ASHA Mentoring groups constituted	None but managed by existing systems	1152 sector in charge placed to facilitate monthly meeting of ASHAs.	♦ Drug kits available with 40,932 (99.97%) ASHAs ♦ First Aid Kit given to all trained ASHAs
Rajasthan	♦ State ASHA Mentoring group constituted. ♦ ARC is moved to SHSRC, with ED (SHSRC) being the incharge of ARC	District ASHA coordinators are functional in 30 out of 33 districts	119 Block ASHA Coordinators are in place	1321 PHC ASHA Supervisors are in place (1 per PHC)	Drug Kits distributed to 34,029 (79.07%) ASHAs
Uttar Pradesh	♦ State AMG constituted ♦ No ARC, managed by one nodal officer and one facilitator supported by NHSRC	District Community mobilizers are placed in all districts	None but managed by existing systems	None	Drug Kits distributed to 128,434 (94.31%) ASHAs
Uttarakhand	♦ State ASHA Mentoring Groups constituted ♦ State ASHA Resource centre is outsourced to NGO	District ARC in all districts outsourced to NGOs	47 Block coordinators placed (1 per 2 blocks)	550 ASHA facilitators are in place (1 per 15–20 ASHAs)	Drug Kits distributed to 9,983 (90%) ASHAs

Table 2N: Status of ASHA support structure and drug kit distribution in North East states					
	Status of Support Structure for ASHA				
	State Level	District Level	Block Level	Sector Level	Drug Kits
Arunachal Pradesh	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre in place	District community mobilizers and District Data Assistants placed in all districts	None but managed by existing systems	216 ASHA Facilitators in place (1 per 30–40 ASHAs)	Distributed to 3,646 (94%) ASHAs
Assam	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre outsourced to NGO.	District Community Mobilizers and District Data Assistants are placed in all districts, managed by ARC.	Block Facilitators placed in each block	ASHA Facilitators placed (1 per 20 ASHAs)	Distributed to 27,855 (94%) ASHAs
Manipur	♦ State ASHA Mentoring group constituted ♦ Formation of State ASHA Resource centre is underway	None but managed by existing systems	None but managed by existing systems	None	Distributed to 3,878 (100%) ASHAs
Meghalaya	♦ State ASHA Mentoring group formed. ♦ State ASHA Resource Centre established.	District Community Mobilizers are in place in all districts	None but managed by existing systems	143 ASHA Facilitator in place (1 per 15–20 ASHAs)	Distributed to 6,175 (99%) ASHAs
Mizoram	♦ State ASHA Mentoring group constituted ♦ ARC does not exist	None but managed by existing systems	None	None	Distributed to 987 (100%) ASHAs
Nagaland	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre constituted and functional under Directorate of Health services	None	40 ASHA Facilitators at Block level are in place	None, managed by existing systems.	Distributed to 1,700 (100%) ASHAs
Sikkim	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre does not exist	None but managed by existing systems	None	68 ASHA Facilitators placed (1 per 10 ASHAs)	Distributed to 637 (95%) ASHAs
Tripura	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre constituted	4 ASHA Programme Managers and 11 Subdivisional Programme Managers support the programme.	None	None	Distributed to 7,362 (99.90%) ASHAs

Table 2O: Status of ASHA support structure and drug kit distribution in Non High Focus states					
	Status of Support Structure for ASHA				
	State Level	District Level	Block Level	Sector Level	Drug Kits
Andhra Pradesh	♦ State ASHA Mentoring group constituted ♦ Indian Institute of Health and Family welfare designated as State ASHA Resource centre	♦ None but Project Officer, District Training Team (PODTT) are the monitoring officers supported by District Public Health Nursing Officer (DPHNO)	None	Every PHC has one ASHA coordinator	Distributed to all 70,700 (100%) ASHAs

	Status of Support Structure for ASHA				
	State Level	District Level	Block Level	Sector Level	Drug Kits
Delhi	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre established	District Nodal Officers in place all districts	50 ASHA Unit are in place one unit per 100,000 population. Support to each unit is through one MOIC and 10 facilitators		Distributed to 2680 (74%) ASHAs
Gujarat	♦ State ASHA Mentoring group constituted ♦ No ARC in place	♦ District Pro-gramme Mobilizer and Data entry operator for ASHA programme are palced in 12 tribal districts ♦ In other non tribal districts, no support structures exist and the programme is managed by existing systems	None but managed by existing systems	ASHA facilitator per 10 ASHAs is in place	Distributed to 30,000 (91.44%) ASHAs
Haryana	♦ State ASHA Mentoring group does not exist ♦ No ARC, two M.Os and one state NGO coordinator support the programme	None but managed by existing systems	None but managed by existing systems	None but managed by existing systems	Distributed Drug kits to 5000 (38.89%) ASHAs
Jammu and Kashmir	♦ State ASHA Resource Centre does not exist ♦ State ASHA Mentoring Group does not exist	None	None	None	Distributed to all 9,500 (100%) ASHAs
Karnataka	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre established under SHSRC	None but managed by existing systems	None but managed by existing systems	None	Distributed to 33,105 (100%) ASHAs
Kerala	♦ State ASHA Mentoring group constituted ♦ State ASHA Rresource Centre established under SHSRC	None but managed by existing systems	None but managed by existing systems	None but managed by existing systems	Distributed to 23,350 (73.27%) ASHAs
Maharashtra	♦ State AMG constituted ♦ SHSRC function as a State ASHA Resource Centre	♦ District ASHA Mentoring group formed in 15 tribal and 18 Non–tribal districts ♦ District Community mobilizers placed in all districts	Block ASHA Mentoring group formed in 70 tribal blocks and 18 Non-tribal blocks	♦ 1 block facilitator placed in each PHC ♦ 893/952 facilitators placed in tribal district ♦ 1303/1496 facilitators placed in non Tribal districts	Distributed to 23000 (38.73%) ASHAs in tribal districts
Punjab	♦ State ASHA Mentoring group does not exist ♦ State ASHA Resource Centre does not exist but a team of two Persons are working with SHSRC for ASHA Programme	15 out of 20 District Community mobilizers are placed	None	None	Distributed to 16,463 (95%) ASHAs

	Status of Support Structure for ASHA				
	State Level	District Level	Block Level	Sector Level	Drug Kits
Tamil Nadu	♦ The formation of State ASHA Mentoring group is in process ♦ Institute of Public Health, Poonamallee is working as State ASHA Resource Centre	None but managed by existing systems	None but managed by existing systems	None	Distributed to 1639 (61.84%) tribal ASHAs
West Bengal	♦ State ASHA Mentoring group constituted ♦ State ASHA Resource Centre outsourced to CINI	None but managed by existing systems	None but managed by existing systems	None	Distributed to 13,034 (30.15%) ASHAs

Table 2P: Status of ASHA support structure and drug kit distribution in UTs

UTs	Status of Support Structure for ASHA				
	State Level	District Level	Block Level	Sector Level	Drug Kits
Andaman and Nicobar Island	♦ ASHA Mentoring group does not exist ♦ ASHA Resource Centre does not exist and SPMU manage the programme	None but managed by existing systems	None	None but managed by existing systems	Distributed to 49 (12%) ASHAs
Dadra and Nagar Haveli	♦ UT ASHA Mentoring group does not exist ♦ UT ASHA Resource Centre does not exist ♦ SPMU supports the ASHA Programme	Not Applicable	Not Applicable	None but managed by existing systems	Distributed to 85 (79.43%) ASHAs
Lakshadweep	♦ ASHA Mentoring group does not exist ♦ ASHA Resource Centre does not exist ♦ Medical officer in charge of Island is the nodal officer for the Programme	Not Applicable	Not Applicable	None but managed by existing systems	Distributed to 85 (100%) ASHAs
Chandigarh	♦ ASHA Mentoring group does not exist ♦ PGI Chandigarh is mentoring the Programme ♦ The formation of SHSRC is under process and the ASHA support staff will work under it	None	None but managed by existing systems	None but managed by existing systems	No drug kit procured ASHAs are existing AWWS

Section 3

Mechanisms for Motivation and Social Recognition of ASHA

States have introduced various mechanisms to serve as instruments for motivation of the ASHA, to facilitate her tasks and to provide social recognition. The table provides a state wise listing of such mechanisms. In the high focus states such as Orissa, Chhattisgarh, Uttarakhand, Jharkhand and Uttar Pradesh these initiatives have been underway for some time, and in the remaining states they are just being introduced. Chhattisgarh has moved ahead in terms of career progression for ASHA. Rest houses for ASHA in facilities are being introduced in some states, newsletters and awards for performance are seen across most states.

Table 3A: Mechanisms for motivation and social recognition of ASHA in High Focus States

State	Mechanisms
Bihar	♦ Four districts organized ASHA Samellans with cash awards for best performing ASHAs. ♦ A pilot for fund transfer to the ASHA through mobiles, is underway in Sheikpura. ♦ Programme incentives communicated to every individual ASAH through a personal letter from the Executive Director, State Health Society. ♦ A newsletter highlighting success stories/gaps is proposed in this financial year.
Chhattisgarh	♦ A well structured Monitoring Information System (MIS) is in place and is updated monthly from cluster level up to district level. ♦ News letter 'Mitanin Paati' and Radio Programme (Kahat hai Mitanin) in place; a three series broadcast was launched recently. ♦ Planned career development where Mitanins from tribal areas can be sponsored for ANM trainings and 31 Mitanins are already in the 2nd year of BSc. (Nursing). ♦ Mitanin Welfare Fund: for social security and economic empowerment of Mitanins. ♦ Joint campaigns with PRIs – Mobilisation campaign done on Leprosy and malaria prevention.
Jharkhand	♦ A monthly news letter "Sahiyya Sandesh" serves as a platform for sharing success stories, new information on health and messages from Mission Director. ♦ District level Sahiyya Sammelans organized. ♦ Sahiyya Sandesh Yatra carried out for positioning the Sahiyya as the community's voice. ♦ "Jan Samwad" (Public meeting) for Community Based Monitoring, completed in one block in each district. ♦ Sahiyya Help Desks were introduced, and 88 of 98 are functional for grievance redressal, incentive payments and for support in health institutions.
Madhya Pradesh	♦ Does not yet have such mechanisms in place, but has proposed: Cycle to all ASHAs, Rest room for ASHA in hospitals, Monthly ASHA's conference at Block level, and an ASHA Radio.
Orissa	♦ ASHA Gruha operational at 106 health facilities managed by ASHAs. ♦ Bicycles for ASHA provided through Gaon Kalyan Samiti. ♦ Payments made on fixed day – 10th of every month. ♦ ASHA data base in place. ♦ ASHA convention – 515 ASHAs awarded for best performance.
Rajasthan	♦ Development of an ASHA Sahyogini pass book for regularizing payments. ♦ Exposure visits of ASHA Sahyogini to different field sites.
Uttar Pradesh	♦ ASHA Sammelan organized on August 23rd each year in all districts, with awards for the best performing ASHA. ♦ Saas Bahu Sammelans organised at the district level to enable effective communication of key health messages among gatekeepers.
Uttarakhand	♦ Developed prototype of ASHA name plate for one block. ♦ Developed movie on ASHA activity. ♦ Developed ASHA Directory – data base.

Table 3B: Mechanisms for motivation and social recognition of ASHA in North East states	
Assam	♦ ASHA Radio Programme (Twice in a week). ♦ ASHA Postcards for sharing success stories/grievance. ♦ Bicycle, Umbrella, and Radio distributed to all ASHA. ♦ Regular payment to ASHA on the 10th of every month.
Arunachal Pradesh	♦ Monthly Newsletter for ASHA. ♦ Radio programs: Kalyani is available on Doordarshan, Itanagar where ASHAs are also called to share their experiences. ♦ ASHA Help Desk/Help line is being established at selected facilities. ♦ ASHA Rest room operational in few facilities. ♦ Single window payments piloted in a few districts.
Manipur	♦ Radio Umbrella, and Bicycle distributed to ASHAs. ♦ ASHA Gi Mangal- Radio programme – once a week. ♦ ASHA stay facility cum help desk introduced in four districts at few facilities.
Meghalaya	♦ Help desk- on market days. ♦ Transit homes for ASHAs to be established in all 26 24x7 PHCs.
Nagaland	♦ Radio sets provided to all ASHA. ♦ Regular Radio programmes on Health Issues. ♦ Best performing ASHAs featured in NRHM quarterly newsletter.
Sikkim	♦ Fixed payment of Rs. 3000 for all ASHA through state funds in addition to performance based incentives from April 2011.
Tripura	♦ Provision of radio, Sharee/Pachra, Umbrella, Torch, Rain coat to each ASHA. ♦ Regular Radio programme: "ASHAR Katha". ♦ ASHA Ghar to be established in 20 health facilities.

Table 3C: Mechanisms for motivation and social recognition of ASHA in Non High Focus States	
Andhra Pradesh	♦ A flat sum of Rs. 700-Rs. 850 will be paid to each ASHA based on the performance review done by Medical Officer of PHC, MPHA (F). ♦ Regular programme on TV. ♦ Awards for best performing ASHA are presented during World Population day, World health day, World AIDS day and World TB day.
Delhi	♦ GIS Mapping of the ASHA population pockets. ♦ Single window disbursal of incentives. ♦ ASHA database established.
Gujarat	♦ ASHA Sammelans – Awards for best performance given.
Haryana	♦ Booklets containing Self–Appraisal Forms and Field Diaries provided to all the ASHAs for planning and monitoring of the tasks and incentives. ♦ Nameplates provided to all ASHAs. ♦ Trained Dais being selected as ASHAs in Mewat.(underserved, tribal district). ♦ Proposed – career progression scheme for ASHAs, fixed day payments and trophies for good performance.
Jammu & Kashmir	♦ Radio programmes in Urdu and Hindi. ♦ News letters. ♦ Re imbursement of mobile charges made to ASHAs.
Karnataka	♦ Rest rooms for ASHAs. ♦ Grievance redressal mechanism in place. ♦ Bus pass provided to ASHAs.
Kerala	♦ ASHA involved in Non Communicable Disease interventions in two districts – Wayanad and Thiruvanathapuram ♦ Pilot project to involve ASHA in ensuring safe delivery among patients with epilepsy. ♦ Software developed for incentive payments.
Maharashtra	♦ Awards for best performing ASHAs at Block and District level. ♦ Provision of geriatric care services through ASHAs. ♦ ASHAs to follow up the ANC of women having 1 or 2 daughters, to increase their role in declining sex ratio. ♦ ASHA's involved in the 12 x12 initiative for anaemia reduction.
West Bengal	♦ ASHA radio programme. ♦ News letter.

As part of ongoing technical support to the states, NHSRC organized a meeting of State ASHA Nodal Officers between June 3–4, 2011 in New Delhi. Mr. P. K. Pradhan, Special Secretary and Mission Director, NRHM, delivered the keynote address. 55 participants from all high focus and non high focus states attended the meeting. Key agenda items were: sharing of the progress on the ASHA programme from the various states, a performance monitoring system for ASHAs, a grievance redressal mechanism and the ASHA evaluation report. The minutes of the meeting are available on NHSRC's Website at http://nhsrcindia.org/thematicdata.php?thematicresourcesid=1. A similar meeting for the North East states was held on June 21–22, 2011 in Guwahati.

Section 4

Status of VHSC Across the States

This set of tables captures key information on the status of VHSC in the states. The table provides information on the number of VHSCs constituted, status of training, key activities undertaken, fund flow mechanisms and use of untied funds. The maturity of the VHSCs and the activities undertaken depend upon the level of support provided by the States. Overall it appears that while the VHSCs are by and large in place, and even spending funds, much more needs to be done to enhance their role in village health planning, as support to the ASHAs and in addressing social determinants.

Table 4A: VHSC Status Across the States: High Focus States

State	Key Findings
Bihar	♦ Formed at Gram Panchayat level, Co-opted with the Panchayat Committee and called as Lok Swathya Pariwar Kalayanevam Gramin Swaschhata Samiti. ♦ 7962 VHSCs formed against 8462 Gram Panchayats. ♦ Consists of five members including Chairman and Secretary (ANM). ♦ Chairman (any elected member of the panchayat) and secretary (ANM) operate the bank account. ♦ There is a Nigrani Samiti at each revenue village and all the ASHAs, AWWs, elected members and leader of SHGs are members to monitor the fund utilization. ♦ Major expenditure of the funds is on Sanitation activities, (approx 84%), also Rs. 500 being paid to doctors to attend VHND every month.
Chattissgarh	♦ Formed at the revenue village level. ♦ Sub-committee of the statutory committee of Gram Panchayat on Health, Education and Social Welfare. The panch who chairs the PRI committee also chairs the VHSC. ♦ 18706 VHSCs formed against 19642 revenue villages. ♦ Mitanin is the convener & operates VHSC bank account jointly with woman Panch. ♦ Expenditure is mainly on two categories: 1. Self-directed (as decided by VHSCs on their own) – Spent on-Water and Sanitation and referral support to poor patient. 2. Govt. directed (as per state level orders) includes vector control sprays, information boards in villages, ANC tables in AWCs ♦ Village Health plans prepared for 10609 villages.
Jharkhand	♦ VHSCs formed at the level of revenue village. ♦ 32,643 VHSCs formed against total 30,012 revenue villages. ♦ Bank accounts opened for 26,636. ♦ VHSC President and Sahiyya are signatories of VHSC account. ♦ Three members of each VHSCs trained on Village Health Planning and roles & responsibilities of VHSC members & Chairperson, Sahiya and ward member oriented on account keeping.

State	Key Findings
Madhya Pradesh	♦ Formed at the level of revenue village. ♦ Called as - Gram Sabha Swastha Gram Tadarth Samiti, integrated with existing Village Water Sanitation Committee under total sanitation campaign, Matri Sahyogini Samiti (Department of Women & Child Welfare), but VHSCs fund is a separate account called Swasthya Nidhi. ♦ 52,117 VHSCs formed in 40,000 revenue villages. ♦ Members (50% must be women): women panch, ASHA, AWW, Panchayat Secretary, chairperson of Matri Sahyogini Samiti, Representative of mid-day meal group & hand pump mechanic. ♦ Bank accounts opened for all 40000 VHSCs, ASHA is the treasurer. ♦ Major Expenditure on : Sanitation, cleaning of drainage, putting dust bin, IEC material.
Orissa	♦ Formed at revenue village level, known as Gaon Kalyan Samitis, 45471VHSCs formed. ♦ Bank accounts opened for all VHSCs, Ward member & AWW jointly operate the account. ♦ Ward member is the chairperson, and Convener is AWW. ♦ Basic orientation of GKS members conducted. ♦ Major Expenditure on Jalachhatra (provision of drinking water during summer), facilitate referral of needy patients, disinfection of water sources, cleanliness drive, preparation of health information display boards.
Rajasthan	♦ Constituted at revenue village level. ♦ 2 VHSCs are formed in Villages with more than 3500 population. ♦ Total VHSCs in the state- 43437. ♦ Ward Panch/(Sarpanch in some places) is the president & ASHA is Convener. ♦ Funds kept in Sub Centre's untied funds account, Sarpanch and ANM are joint signatories. ♦ 7 members of each VHSC trained last year. ♦ Two years back Village Health Planning done on a standard template of mainly targets. ♦ For last two years a process of CNA (Community Needs Analysis) is being done.
Uttar Pradesh	♦ Formed at Gram Panchayat level in all of existing 51414 Gram panchayats. ♦ Bank accounts opened for all 51494 VHSCs, Account jointly operated by ANM & Pradhan. ♦ Pradhan is President, ANM - Vice-president, ASHA is Member Secretary. ♦ Orientations for members done at block level. ♦ In some project areas NGO-supported VHSCs are performing better on expenditure.
Uttarakhand	♦ Constituted at revenue village level, Total 15431 VHSCs formed in state. ♦ Pradhan of Panchayat is President & Panchayat Secretary is secretary of VHSC. ♦ Pradhan of Panchayat and Panchayat Secretary jointly operate the account. ♦ Main expenditure is on- Cleaning of water tank, cleaning of Toilets, purchasing bleaching powder, purchasing dustbins, medicine kit, support for transport cost for BPL family to Hospital for delivery and weighing Machine for AWC. ♦ 5 key members from each VHSC trained in two days training, during FYs 9–10 & 10–11. ♦ State plans to do Village Health Planning in two VHSCs in each block this year.

Table 4B: VHSC Status Across North East States

State	Key findings
Assam	♦ Formed at revenue village level, total 26312 VHSCs formed, Bank Account opened for all. ♦ 8 to 10 members in each VHSC, VHSC president (Ward member) and Secretary (ASHA) are joint signatories of account. ♦ Training of VHSC member conducted in 2010-11 ,total no. of VHSCs trained - 25,482. ♦ Village Health Planning process planned this year to be done in 5 sample VHSCs in each block.
Arunachal Pradesh	♦ Total 3012 VHSCs constituted for 3862 Revenue villages, accounts opened for 2449. ♦ 5 to 10 members in each VHSC, account operated jointly by Village Headman and ASHA. ♦ Of the total Rs. 539.45 Lakh released about 30% (Rs.161.55 Lakhs) was utilized.
Manipur	♦ Total VHSCs in the state are 4081. ♦ Accounts opened for 3758. ♦ 10 to 11members in each VHSC. ♦ The Chairman of VHSC (Village Headman) and ASHA jointly operate VHSC account. ♦ VHSC committee members trained twice - 1st Batch in - 2007 - 08, 2nd batch – 2010 – 11 ♦ Total funds released – Rs. 320 Lakhs, funds spent Rs. 159 Lakhs (50% utilized).

State	Key findings
Meghalaya	♦ Formed in all the revenue villages ♦ Total 6306 VHSCs formed ♦ 10 to 15 members in each VHSC – selected by village council ♦ Village Headman and ASHA are the joint signatories of VHSC account ♦ 5 Members of each VHSC trained, ♦ Untied fund used in cleaning drive, cleaning and renovation of water source, putting up waste bins in the roadside, construction of signboards , referral for patients in times of emergency, buying utensils for AWW Centres, etc.
Mizoram	♦ VHSCs formed at revenue village, total 815 formed (100% against target) ♦ 8 to 10 Members include ASHA, the AWW, the ANM, and the Village Council members. ♦ Village Council President (VCP) is the Chairperson of VHSC, and member secretary is ANM in sub-centre villages, and ASHA in other villages. ♦ VCP president & Member Secretary (ASHA or ANM) joint signatories of VHSC account ♦ Of the total fund released Rs. 81.50 Lakhs, 100% was spent ♦ All VHSC members trained at the PHC level
Nagaland	♦ Total 1278 VHCs formed against 1324 proposed. ♦ 9 to 10 members in each VHSC ♦ VHSC account operated jointly by Village headman and ASHA (who is secretary). But in some villages ANM is the signatory in place of ASHA. ♦ Unspent balance – a cumulative of Rs. 321.67 lakhs till 2011. ♦ Under communitisation/NRHM PRI initiative – 10865 members trained during 2010-11. ♦ Major expenditures – on development activities to revamp the rudimentary infrastructure and to procure basic equipment. It also supports health preventive and promotive activities.
Sikkim	♦ Total revenue villages – 452, but VHSCs formed depending on the no. of ASHAs selected (641). ♦ 637 VHSCs are constituted against a target of 641VHSCs. ♦ Total 12 to 15 members in each VHSC,VHSC account operated jointly by Village headman and ASHA ♦ A cumulative unspent balance of Rs. 33.39 lakhs. ♦ In 2010–11 four members of each VHSC were trained and training of rest of the member is proposed in 2011–12. ♦ Major expenditures are on – conducting the VHND, procuring basic instruments for VHNDs etc.
Tripura	♦ VHSCs formed at gram panchayat level, 1040 VHSCs formed (100%). ♦ Bank accounts opened for 1039 VHSCs ♦ Total 9 to 10 members in each VHSC ♦ VHSC account is operated jointly by Village headman and ASHA ♦ Major expenditures on are – Sanitation, Drinking water, Mosquito net, Incentive to ASHA for mosquito net impregnation, Poll repairing, Facilitate referral of needy patients, Disinfection of water sources, Cleanliness drive and Household survey.

Table 4C: VHSC Status Across Non High Focus States

State	Key Findings
Andhra Pradesh	♦ VHSCs formed at revenue village level ♦ 21, 916 VHSCs formed out of the required 26, 613 ♦ Members include Village Sarpanch as President, Village Secretary (Employed person) employed staff to work for VHSC as per decision of Advisory committee) and members are ASHA, AWW, SHG Member and NGO representative - if available ♦ Account operated by Village Secretary and ANM ♦ Major expenditure is on - bleaching powder and lime, lifting and dumping of materials, preparation of IEC materials on Malaria, other vector borne diseases, HINI etc. and sanitation.
Delhi	♦ One VHSC per 2000 population. ♦ 325 Health and Sanitation Committees have been set up in Slums Members are Government. Employees (retired)/honorarium paid staff eg. School teacher, AWW, preferably not more than one third, Representative of local women's self help group, representative of the local NGO. President is representative Self Help Group/Senior Citizens Group/Resident Welfare Association/Gender Resource Centre. And Area ASHA is the Convener. ♦ Funds were not sanctioned as no mechanism could be developed so far in the absence of panchayats or RKS. Fund was planned to go through Jan Swasthya Samiti, which could not be formed. VHSCs are working without funds. ♦ ASHA is the Convener of the VHSC.

State	Key Findings
Gujarat	♦ Formed at the revenue village level ♦ 17,954 VHSCs formed out of the required 17,330. ♦ 10 members, ASHA, ANM, AWW, 1 PRI member of village (panch) nominated by District Development Officer,1 member of SHG of village, 5 community members selected by village's Gram Sabha ♦ ASHA and VHSC president operate the account. Wherever Sarpanch is President he/she is signatory but in few cases (less than 10%) AWW is the joint signatory. ♦ Major expenditure is on-Improving the facility and quality on MAMTA DIVAS, water and sanitation, transportation of ANC, PNC mother, newborn and child; and for preventive activities on Malaria & TB as well as refundable but no interest loans to families in need for any illness. ♦ Members of 3800 VHSCs have been trained so far by NGOs with funds support from NRHM, one day orientation and 2 days training at PHC level given to 5 members from each VHSC. ♦ Since two years Village Health Planning is done on a standard template of main tar-gets to be achieved which is filled by 16000 VHSC and forwarded upwards.
Haryana	♦ Village Health Sanitation Committee (NRHM) and Village Level Committee (WCD) merged at the level of Gram Panchayat levels. ♦ 6280 VHSC/VLCs formed for 6955 revenue villages. ♦ Aanganwadi Worker and Mahila Panch (i.e. Head of VHSC/VLC) are the designated joint Account Holders. To ensure better utilization of NRHM funds, ANM will also be made the joint Account Holder in 2011–12.
Jammu & Kashmir	♦ Formed at the level of revenue villages. ♦ 6788 VHSC are in place. ♦ Accounts are operated by two signatories duly nominated by VHSC members i.e. one ASHA and one PRI member, or AWW and PRI pardhan of the village , or ANM and PRI member. ♦ 5500 accounts were opened but could not be operationalized because of ongoing Panchayat elections. Post elections PRI members were given orientation on VHSC & operationalization of accounts is under process. ♦ 45 batches with 35 members in each batch i.e. 1575 VHSCs members have been trained.
Karnataka	♦ VHSCs formed at revenue Village level. ♦ 24,208 VHSCs formed out of the required 27,481 ♦ Members include : Village Panchayat Member as President and ASHA as Member Secretary. Other Members : ASHA, ANM, MPW, School Teacher, Member-SHG, One member from Village Religious Group, One member from Local NGO. ♦ Bank Account is operated by President of VHSC committee and ASHA. ASHA also maintains the account books. ♦ Major Expenses on Referral Transport, Epidemic control, Conduct House Hold survey and Sanitation. ♦ Over 80% VHSCs trained by NGOs for 3 days. ♦ Community Health Day (CHD) held once in 6 months at every PHC, where VHSC and ARS – Arogya Raksha Samiti (RKS) discuss about the health issues of the villages, PHC Health Plan Preparation and solutions to address Health Issues. A total of 2087 CHDs were organized during last year. ♦ Village Health Planning is also done.
Kerala	♦ Ward Health and Sanitation Committees formed at ward level. ♦ 18,369 WHSCs formed out of the required 19,560. ♦ VHSC account operated jointly by Panchayath member and Junior Public Health Nurse. ♦ Major expenditure on - Disease control, awareness programmes, screening programmes and other public health activities ♦ All the members were trained
Maharashtra	♦ Formed at revenue village level. ♦ Total 39820 Village Health Nutrition and Water supply & Sanitation Committee established in all revenue villages. ♦ It comprises of Panchayat Representatives, ANM, Anganwadi Workers, Teachers, Community Health Volunteers and ASHA ♦ Chairperson (Sarpanch) & Member secretary (Anganwadi Worker) holds the Joint Account of VHNSC ♦ In the Year 2010-11, training was imparted to 2972 newly elected members of VHNSC.
Punjab	♦ Formed at revenue village level ♦ 13104 VHSCs have been formed at every revenue village ♦ 11 members - Sarpanch or Panch, SHG, SC/ST PRI ,Weaker sections, Ex servicemen ,Retired teacher or PTA, NGO, ANM, PPH W Male, AWW, ASHA. ANM is convener of VHSC in the Sub Centre village while in other villages ASHA or AWW is convener. ♦ ANM and Sarpanch of the village operate the account. ♦ Main expenditure of VHSCs has been on village level cleanliness drive, sanitation drive, betterment of anganwadi centers, incentive to ASHA, referral transport, school health activities etc. ♦ One to two members from each PRI were trained on general NRHM in one day training last year.

State	Key Findings
Tamil Nadu	♦ Known as Village Health Water and Sanitation Committee. ♦ 12618 VHWSC formed in Village Panchayats and 2540 in Town Panchayats ♦ At village level members are Village Panchayat President as Chairperson, Village Health Nurse as Member Cum Secretary, the other three members include AWW (to be nominated by the Chairperson in rotation for one year), Health Inspector, SHC Women Representatives (to be nominated by the chairperson in rotation for one year). For Town Panchayats also the composition is almost the same. ♦ All VHWSCS have opened bank accounts ♦ At village level, Village President and Village Health Nurse and at level of town, Town Panchayat President and Village Health Nurse jointly operate the account. ♦ Main expenditure is on any public Health activity like, sanitation drive, school health activities, ICDS activities, house hold survey etc. ♦ VHWSC training was organized by involving the SHG/NGO and the community by orienting them on the right and responsibilities of citizens as well as Maternal and Child health. The 2 day training programme was held at one of the panchayat village in 3 - 4 afternoon sessions.
West Bengal	♦ Formed at revenue village level, known as Gram Unnayan Samiti ♦ 22,707 VHSCs have been formed against the requirement of 37,855 ♦ Members are persons who received second highest vote in last gram Panchayat election, 3 Women member from community (selected by member of Village Unayan Samiti), 3 members elected from Secretary and Treasurer of Women Self Help Group of Gram Sansad area, ANM, ASHA and AWW; elected representative from Gram Sansad is the chairman. ♦ Account is operated by Chairman of GUC (VHSC) and ANM ♦ Expenses are mainly on Sanitation, Referral, cleaning of area, during epidemic outbreak, planting tubewell etc. ♦ Member of Gram Unayan Samiti (VHSC) has been trained by a programme called Community Health care Management Initiative. ♦ Village Health Planning is done at the Sub-centre level with involvement of the committee

Section 5

Expenditures Incurred on the ASHA Programme

Accredited Social Health Activist guidelines,[8] issued by the Ministry of Health and Family Welfare in July 2006, laid out the operational guidelines for the ASHA programme, including financial flows and budgets.

At that time, the financial norms provided for a budget of up to Rs. 7415 per ASHA (which included costs incurred on selection processes including social mobilization, training of ASHAs and ASHA trainers and drug kit). The guidelines also stipulated that the incentive payments would come from the various programmes and thus were not part of this amount.

In October 2006, a revised set of financial guidelines were issued by the MOHFW to make provision for a support structure from state to sub block levels, and for the supply of identity cards, bags, and badges for the ASHA. In this revised version of financial guidelines, different norms were specified for states with less than 20,000 ASHA and for states with more than 20,000 ASHA. With this set of revised guidelines, the amount allocated per ASHA was increased to Rs. 10,000. The original amount of Rs. 7415 was left unchanged and the additional amount was budgeted for support systems.

As against these norms, information on funds released and expenditures incurred over the period of FY 05-06 to FY 10-11 are provided in the table below. Until 2007, expenditures were low because the programme was just picking up. Although funds were released in the years 05–06 and 06–07, hardly any expenditure were reported by the states. Subsequently however the expenditures have increased although the pace is still low, and overall expenditures on the programme are much lower than planned for. This is almost entirely due to delays in establishing the support mechanism, and in conducting the training. This is in part contributed to by the reluctance of states in involving NGOs in conducting training and support functions

Of the eight high focus states, only Uttarakhand and Chhattisgarh have spent an amount of more than Rs. 20,000/- per ASHA, over this period (05-11), and Orissa stands next at Rs. 17,427/-. All three states have a strong program on the ground. Chhattisgarh has a well grounded support system and has done extensive training, and Uttarakhand has provided quality training using its strong support system of state and district level resource NGOs. Bihar and Jharkhand are two lowest expenditure states, which also reflects in their weak ASHA training and support systems. The pattern of expenditures is same for FY 10-11.

Four out of the eight NE states, report a total expenditure of over Rs. 20,000 over the period of 05-11. In the non high focus states, where the programme expanded statewide in FY 2008, Delhi reports highest expenditures for the period (05-11) at Rs. 30,450/-, followed by Gujarat and West Bengal spending more than Rs. 20,000/- . Poor absorption of funds correlates with lack of support structures and other support activities, little investment in training quality, limited internal capacity, and reluctance to engage with external technical resources, such as NGOs.

8. Accredited Social Health Activist Guidelines, (ASHA), Ministry of Health and Family Welfare, Government of India.

Table 5A: Funds released and Expenditure on ASHA Program - High Focus States - reported in Rs. Crores

Name of State	No. of ASHAs (as on April 10)	2005-08			2008-09				2009-10				2010-11				Total : 2005 - 2011				
		Fund released	Expenditure	% Expenditure over fund released	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Total Fund released	Expenditure	% Expenditure over total fund re-leased	**Total Fund Spent per ASHA, (in Rs.)**	**Fund Spent per ASHA, (in Rs.) FY 010-11**
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	**21**	**22**
Bihar	71395	31.89	4.73	14.83	17.15	44.31	5.78	13.04	56.03	94.56	13.57	14.35	57.04	138.03	19.35	14.02	162.11	43.43	26.79	**6083**	**2710**
Chhattisgarh	28000	18.11	20.12	111.10		0	5.99		17.7	11.71	12.21	104.27	25.83	25.33	19.95	78.76	61.64	58.27	94.53	**20811**	**7125**
Jharkhand	40964	28.78	6.72	23.35	9.51	31.57	17.96	56.89	8.56	22.17	5.42	24.45	22.02	38.77	4.73	12.20	68.87	34.83	50.57	**8503**	**1155**
Madhya Pradesh	49282	19.39	13.22	68.18	7.94	14.11	4.88	34.59	39.87	49.1	7.38	15.03	34.64	76.36	27.25	35.69	101.84	52.73	51.78	**10700**	**5529**
Orissa	34252	24.51	4.6	18.77	4.07	23.98	9.54	39.78	27.9	42.34	18.51	43.72	35.78	59.61	27.04	45.36	92.26	59.69	64.70	**17427**	**7894**
Rajasthan	43111	25.43	4.35	17.11	12.23	33.31	12.88	38.67	41.5	61.93	15.23	24.59	27.91	74.61	29.67	39.77	107.07	62.13	58.03	**14412**	**6882**
Uttar Pradesh	136182	45.24	12.13	26.81	116.11	149.22	65.06	43.60	135	219.16	7.96	3.63	137.30	348.50	84.96	24.38	433.65	170.11	39.23	**12491**	**6239**
Uttarakhand	11086	2.58	2.47	95.74	8.87	8.98	4.18	46.55	9.85	14.65	6.99	47.71	11.08	18.74	11.11	59.28	32.38	24.75	76.44	**22325**	**10022**
Total for All States	**414272**	**195.93**	**68.34**	**34.88**	**175.88**	**305.48**	**126.27**	**41.33**	**336.41**	**515.62**	**87.27**	**16.93**	**351.60**	**779.95**	**224.06**	**28.73**	**1059.82**	**505.94**	**47.74**	**12213**	**5409**

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.

Cl. No. 7 = 6+(3-4), Cl. No. 11 = 10 + (7-8), Cl. No. 15 = 14+(11-12), Cl. No. 21 is Cl. 19/2, Cl. No. 22 is Cl. 16/2

No. of ASHAs in CG is taken as equal to no. of Anganwadi centres, which is the the basis of allocation of funds to state for ASHA program. Actual no. of ASHAs in state, with one ASHA for every habitation, is 60092.

Table 5B: Funds released and Expenditure on ASHA Program : Non - High Focus States - reported in Rs. Crores

Name of State	No. of ASHAs (as on April 10)	2005-08			2008-09				2009-10				2010-11				Total : 2005 - 2011				
		Fund released	Expenditure	% Expenditure over fund released	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Total Fund released	Expenditure	% Expenditure over total fund released	**Total Fund Spent per ASHA, (in Rs.)**	**Fund Spent per ASHA, (in Rs.) FY 010-11**
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	**21**	**22**
Andhra Pradesh	70700	0	2.23				0.18		8.5	8.32	9.74	117.07	26.90	25.48	15.25	59.85	35.40	27.40	77.40	**3876**	**2157**
Delhi	2266	0	0		14.72	14.72	2.62	17.80	19.04	31.14	1.37	4.40	0.00	29.77	2.91	9.77	33.76	6.90	20.44	**30450**	**12842**
Gujarat	25861	4.85	0.87	17.94	11	14.98	14.4	96.13	25.38	25.96	4.95	19.07	32.08	53.09	37.41	70.47	73.31	57.63	78.61	**22285**	**14466**
Haryana	12753	0	1.36				0.22		8.89	7.31	4.82	65.94	7.32	9.81	8.78	89.50	16.21	15.18	93.65	**11903**	**6885**
Jammu & Kashmir	9500	1.02	1.4	137.25	2.92	2.54	2.17	85.43	4.21	4.58	1.14	24.89	6.60	10.04	1.59	15.84	14.75	6.30	42.71	**6632**	**1674**
Karnataka	31876	0	0.63		7.71	7.08	6.34	89.55	34.66	35.4	16.04	45.31	9.43	28.79	13.68	47.52	51.80	36.69	70.83	**11510**	**4292**
Kerala	30909	0.57	1.38	242.11			21.6		21.17	-1.24	10.06	-811.29	15.00	3.70	12.76	344.86	36.74	45.80	124.66	**14818**	**4128**
Maharashtra	57897	3.36	0.28	8.33	16.34	19.42	5.33	27.45	71.77	85.86	17.69	20.60	54.86	123.03	39.43	32.05	146.33	62.73	42.87	**10835**	**6810**
Punjab	16494	0	0.38				0.78		4.49	3.33	3.47	104.20	14.75	14.61	9.18	62.83	19.24	13.81	71.78	**8373**	**5566**
West Bengal	23518	0	4.96		5.17	0.21	1.7	809.52	5.72	4.23	12.86	304.02	97.49	88.86	36.19	40.73	108.38	55.71	51.40	**23688**	**15388**
Total for All States	**281774**	**9.8**	**13.49**	**137.65**	**57.86**	**56.4**	**55.34**	**98.12**	**203.83**	**204.89**	**82.14**	**40.09**	**264.43**	**387.18**	**177.18**	**45.76**	**535.92**	**328.15**	**61.23**	**11646**	**6288**

Tamilnadu data is not available for 05 to 09-10 period. In FY–10-11 fund released and expenditure was Rs. 3.01 crores and Rs. 0.46 crore respectively

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.

Cl. No. 7 = 6+(3-4), Cl. No. 11 = 10+(7-8), Cl. No. 15 = 14+(11-12), Cl. No. 21 is Cl. 19/2, Cl. No. 22 is Cl. 16/2

Table 5C: Funds released and Expenditure on ASHA Program - North East States - reported in Rs. Crores

Name of State	No. of ASHAs (as on April 10)	2005-08			2008-09				2009-10				2010-11				Total : 2005 - 2011				
		Fund released	Expenditure	% Expenditure over fund released	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Total Fund released	Expenditure	% Expenditure over total fund released	**Total Fund Spent per ASHA, (in Rs.)**	**Fund Spent per ASHA, (in Rs.) FY 2010-11**
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	**21**	**22**
Arunachal Pradesh	3599	1.2	1.1	91.67	3.86	3.96	1.49	37.63	3.86	6.33	2.48	39.18	3.86	7.71	2.31	29.96	12.78	7.38	57.75	**20506**	**6418**
Assam	28798	14.55	4.53	31.13	29.69	39.71	2.27	5.72	29.69	67.13	29.33	43.69	31.04	68.84	29.00	42.13	104.97	65.13	62.05	**22616**	**10070**
Manipur	3878	0	0.39		1.28	0.89	0.91	102.25	3.88	3.86	1.37	35.49	3.88	6.37	1.78	27.94	9.04	4.45	49.23	**11475**	**4590**
Meghalaya	6258	1.16	0.05	4.31	3.96	5.07	2.18	43.00	6.25	9.14	1	10.94	6.25	14.39	3.99	27.73	17.62	7.22	40.98	**11537**	**6376**
Mizoram	943	0.02	0.05	250.00	0.94	0.91	0.92	101.10	0.94	0.93	0.76	81.72	0.94	1.11	0.56	50.45	2.84	2.29	80.63	**24284**	**5938**
Nagaland	1700	0.83	0.44	53.01	0.75	1.14	0.88	77.19	1.7	1.96	1.04	53.06	1.70	2.62	1.39	53.05	4.98	3.75	75.30	**22059**	**8176**
Sikkim	637	0.18	0.19	105.56	0.19	0.18	0.12	66.67	0.64	0.7	0.34	48.57	0.65	1.01	0.48	47.52	1.66	1.13	68.07	**17739**	**7535**
Tripura	7362	3.78	0.95	25.13	4.17	7	4.49	64.14	5.26	7.77	2.44	31.40	7.37	12.70	1.29	10.16	20.58	9.17	44.56	**12456**	**1752**
Total for All States	**53175**	**21.72**	**7.7**	**43.53**	**44.84**	**58.86**	**13.26**	**22.53**	**52.22**	**97.82**	**38.76**	**39.62**	**55.69**	**114.75**	**40.80**	**35.56**	**174.47**	**100.52**	**57.61**	**18904**	**7673**

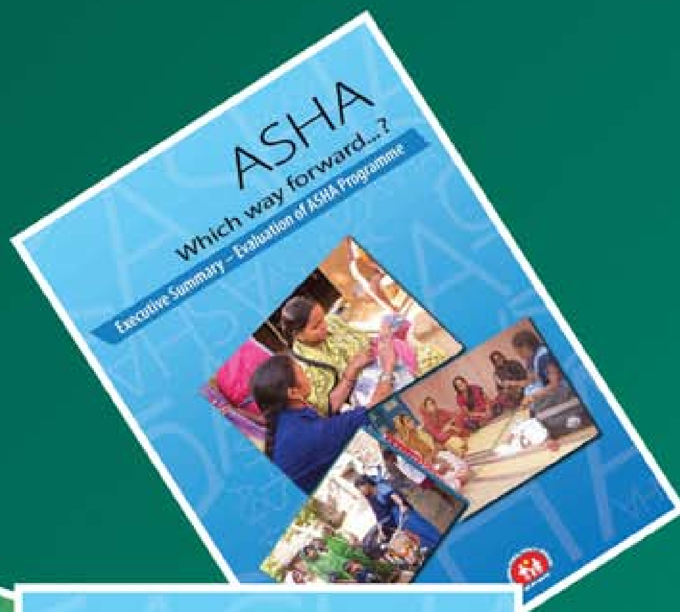
Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.

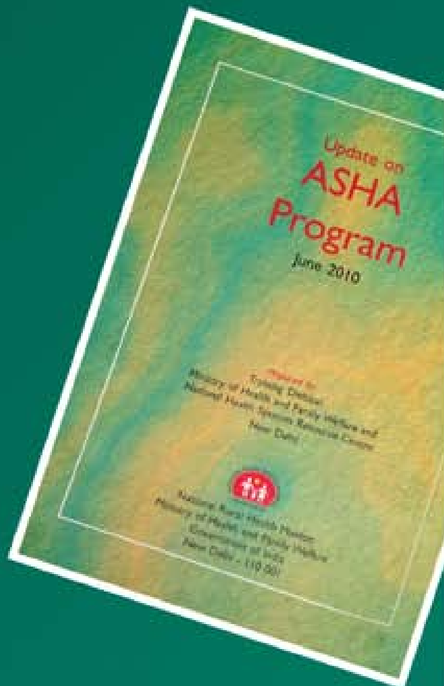
Cl. No. 7 = 6+(3-4), Cl. No. 11 = 10+(7-8), Cl. No. 15 = 14+(11-12), Cl. No. 21 is Cl. 19/2, Cl. No. 22 is Cl. 16/2

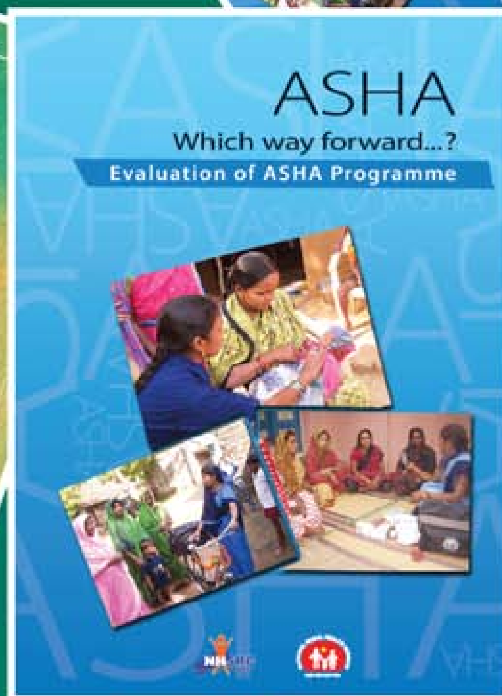
Table 5D: Funds released and Expenditure on ASHA Program - Union Territories - reported in Rs. Crores																					
		2007-08			2008-09				2009-10				2010-11				Total-2005-10				
Name of State	No of ASHAs (as on April 10)	Fund released	Expenditure	% Expenditure	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expenditure	% Expenditure over cumulative fund	Total Fund released	Expenditure	% Expenditure over total fund released	**Total Fund Spent per ASHA, (in Rs.)**	**Fund Spent per ASHA, (in Rs.) FY 010-11**
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	**21**	**22**
Andaman and Nikobar	369	0.02	0.003	15.00	0.04	0.057	0.033	57.89	0.01	0.034	0.04	400.00	0.10	0.09	0.07	74.47	0.17	0.146	85.88	**3957**	**1897**
Dadra & Nagar Haveli	107	0	0.016		0.07	0.054	0.1	185.19	0.04	-0.006	0.007	17.50	0.11	0.10	0.01	10.31	0.22	0.133	60.45	**12430**	**935**
Lakshdweep	85	0.07	0.051	72.86	0.02	0.039	0.13	333.33	0.06	-0.031	0	0.00	0.09	0.06	0.03	50.85	0.24	0.211	87.92	**24824**	**3529**
Chandigarh	200	0	0		0	0	0		0.11	0.11	0	0.00	0.01	0.12	0.01	8.33	0.12	0.01	8.33	**500**	**500**
Total for All UTs	**761**	**0.09**	**0.07**	**77.78**	**0.13**	**0.15**	**0.263**	**175.33**	**0.22**	**0.107**	**0.047**	**21.36**	**0.31**	**0.37**	**0.12**	**32.43**	**0.75**	**0.5**	**66.67**	**6570**	**1577**

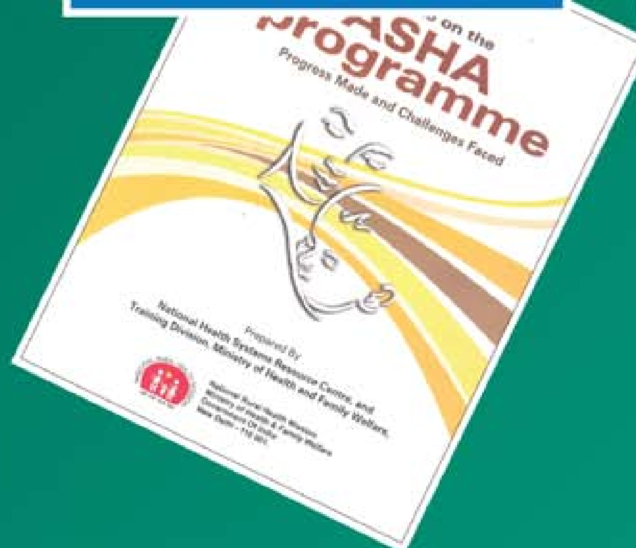
Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.

Cl. No. 7 = 6+(3-4), Cl. No. 11 = 10+(7-8), Cl. No. 15 = 14+(11-12), Cl. No. 21 is Cl. 19/2, Cl. No. 22 is Cl. 16/2









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