Update on the
ASHA PROGRAMME

JANUARY 2012

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NATIONAL RURAL HEALTH MISSION

Ministry of Health and Family Welfare
Government of India, New Delhi

Update on the

ASHA PROGRAMME

January 2012

CONTENTS

Update on the ASHA Programme

ASHA Programme So Far…..

Background: Launched in 2005, the NRHM promised an "architectural correction" of the health system, and placed for the first time, Community Processes (Box 1) as one of its key components. The year 2012 marks the end of the first phase of the National Rural Health Mission (NRHM). This section briefly describes the evolution of the ASHA Programme.

Box 1: Key Components of the ASHA programme

- The ASHA and her support network at block, district and state levels.
- The Village Health, Sanitation and Nutrition Committee (VHSNC) 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.

Evolution of ASHA Programme under NRHM:

Phase of Initiation:

India's experience with community health workers goes back a long way. While Community Health Workers (CHW) are a mainstay of NGO managed health programmes, both state and national programmes have also at various times included CHWs. However the past programmes were not sustained at the scale and scope with which they were envisioned. Chhattisgarh, which initiated its Mitanin programme in 2003, four years before NRHM, has been a pioneer in effectively implementing community processes for improving health outcomes. The Mitanin programme provided valuable lessons for scaling up the training, support and institutional mechanisms in the ASHA programme.

What distinguishes the ASHA programme from these past efforts has been a sustained policy and programmatic commitment to provide support systems for the ASHA in the form of supervision and on the job mentoring through full time personnel, drug kits, performance based incentives and a range of non monetary benefits. Added to this has been a high level of political commitment and interest in the programme. The number of ASHA related questions in every parliament session, since 2008, shows an increasing trend. The ASHA programme has also been subject to intense scrutiny through studies, evaluations and reviews, ever since the time of its inception.

This phase saw formulation of ASHA guidelines by the Ministry of Health and Family Welfare in year 2006 lay out three roles for ASHA: that of a facilitator of health services, of a service provider and that of an activist. This role definition of ASHA evolved through advocacy by civil society activists, resulting in a significant revision of the first concept note of NRHM. A multi stakeholder task force was created to design the ASHA programme, which led to the development of ASHA Guidelines (Box 2).

BOX - 2 ROLES AND RESPONSIBILITIES[1]

- ASHA will be a health activist in the community who will create awareness o health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices.
- She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows.
- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health and family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding, immunisation, contraception and prevention of common infections including Reproductive Tract Infection/ Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will mobilise the community and facilitate them in accessing health and health related services available at the village/sub-centre/primary health centres, such as Immunisation, Ante Natal Checkup (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She will work with the Village Health and Sanitation Committee of the GramPanchayat to develop a comprehensive village health plan.
- She will arrange escort/accompany pregnant women and children requiring treatment/admission to the nearest pre-identified health facility i.e. Primary Health Centre/Community Health Centre/ First Referral Unit (PHC/CHC/FRU).
- ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.
- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills and Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.
- Her role as a provider can be enhanced subsequently.
- States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-centres/Primary Health Centre.
- She will promote construction of household toilets under Total Sanitation Campaign.

[1] *Excerpted from Accredited Social Health Activist (ASHA) Guidelines, (pages 8-9) National Rural Health Mission, Ministry of Health and Family Welfare, Government of India, 2006.*

When the NRHM was launched in April 2005, the ASHA was intended primarily for the high focus states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttarakhand, the eight states of the North East, and Jammu and Kashmir. Flexibility was provided to the remaining states to select and train ASHA in tribal and difficult areas. While the states of the high focus groups began the process of selection and training within a few months of the launch of the NRHM, the non high focus states approached this at a slower pace.

Phase of Scaling up:

In 2008, all non high focus states barring Himachal Pradesh, Tamil Nadu, Goa and Pudducherry, opted to scale up the programme across the states. In October 2011, the state of Himachal Pradesh where the ASHA selection was under litigation opted to train its Anganwadi Workers for a set of skills related to community mobilization and provision of community level care for mothers, newborns and children. Tamil Nadu has an ASHA programme functional in a few of its tribal areas. Today the country has 846,309 ASHAs in place, except in the states of Goa, Pudducherry and the non tribal areas of Tamil Nadu. All Union Territories except Daman and Diu have implemented the ASHA programme.

Other Components of Community Processes:

Another major community processes component which was expected to provide a mooring for the ASHA and undertake village level planning including social determinants for health is the Village Health, Sanitation, and Nutrition Committee (VHSNC). The VHSNCs receive about Rs. 10,000 annually as an untied fund. About 483, 496 VHSNCs are in place across the country. Given an ambitious architectural correction of health systems agenda and the steep learning curve that this entailed for most states, progress on the VHSNC is not as visible as in the ASHA. Nonetheless several states have been persistent in strengthening VHSNC, notably Chhattisgarh with its Swasthya Panchayat Yojana, and Orissa's efforts with its Gaon Kalyan Samitis.

NRHM also envisaged public participation in management of health facilities. Such Hospital Development Societies or Rogi Kalyan Samitis are in place at District hospitals, Community Health Centres and Primary Health Care Centres. Community Monitoring which was implemented in selected districts in nine states between 2008 to 2010 is now being scaled up in selected states to cover all districts. The process is primarily facilitated through NGOs.

Dialogues on Future Directions for the ASHA Programme:

The ASHA programme completes seven years in April 2012, and it is now appropriate to begin planning for the future. The stage for such planning was set in the last six months. Major policy reports that have substantial implications for the future of the Community Processes interventions were also launched in the period between the issue of the last update and this one. Following on the XII plan approach paper, the report of the Working Group on NRHM and the Steering Committee report were drafted. The third report of significance is the report of the High Level Expert Group. Pertinent sections on the ASHA and community processes from these reports are also excerpted in this update. All reports strongly emphasize the continuing relevance of the ASHA and Community Processes components. The HLEG, inter-alia, makes a recommendation for introducing a second community health worker and transformation of the existing Village Health Sanitation and Nutrition Committees to take on additional responsibilities. The Working Group report on NRHM looks at the evolving nature of the ASHA programme over the next five years. Key among its recommendations are the need to plan for turnover of ASHA, provide career opportunities both as a means of empowerment for the ASHA and to expand the human resources available at the local level and creating mechanisms to address social determinants of health. Issues such as establishing grievance redressal mechanisms,

community monitoring, involvement of civil society organizations, are common to both reports.

A consultative meeting on "Five Years of ASHAs and Primary Healthcare in India: Past, Present and Future" was organized by UNICEF, MOHFW and the NHSRC. The meeting was planned on the premise that with the launch of the XII plan, a better resourced NRHM would continue its objective of improving access to quality assured services with adequate human resources for health within an adequate infrastructure. The role of the ASHA is likely to evolve in consonance with varying contexts and needs. The meeting included presentations on selected state experiences with different aspects of the ASHA programme. Insights on the programme were provided by senior officials of the MOHFW, and presentations on evaluations undertaken by NHSRC, the Earth Institute, and the Technical and Management Support Team in Odisha were also made. The meeting was attended by senior representatives from the Ministry of Health and Family Welfare, Civil Society representatives, Programme Managers from selected states, and Public Health experts.

About This Update:

This is the fifth in the series of bi-annual ASHA updates produced by the National Health Systems Resource Centre (NHSRC) for the Training Division, 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

The update is organized as follows: Section 1 of the report pertains to the findings from the CRM and JRM. Section 2 covers the details on the policy initiative related to the ASHA Programme. Section 3 provides data on selection, population coverage and training of ASHAs, and information on support structures and Drug Kits, using data provided by the states as of December 31, 2011. One of the key contributions by the state of Chhattisgarh is the focus on village planning, as envisaged in the NRHM implementation framework. The state has also recently established a comprehensive social security fund for its Mitanin. Section 4 reports on both initiatives in the hope that other states are inspired to include these in their programs.

Key Findings from Recent Reviews:

In the interim between the last update issued in July 2011 and this, reports of two programme reviews led by the Ministry of Health and Family Welfare, have become available. The first is the report of the Fifth Common Review Mission, undertaken in fifteen states, and which studied all aspects of NRHM implementation and outcomes so far. The second review, is the report of the Eighth Joint Review Mission (JRM) which focuses on the Reproductive and Child Health 2 programme. The ASHA programme has also been reviewed in the JRM report, which covered five states. This update thus reports on key findings from both reviews related to the ASHA programme in twenty states. The common thread through both reviews, although each views the ASHA from different perspectives, is that she is now rooted in the community and considered an important stakeholder by the system. Based on the field level observations of the CRM, the authors make important recommendations for strengthening the existing programme and sustaining the ASHA programme in the future.

I Findings from Fifth Common Review Mission:

1 The findings of the Fifth Common Review Mission (CRM) affirm and reinforce those of the previous CRMs. The ASHA continues to be a key part of the community participation component of the NRHM, and is also seen by providers and community as having enabled increased access to the health system and providing community level care for mothers and children.

2. Collaboration between the ASHA, ANM and AWW has improved, and there is increasing responsiveness to the ASHA and her contributions from the health facilities. Social and public recognition of the ASHA and her role is also growing. In Chhattisgarh where the programme is nearly a decade old, the state government has announced a special annual "Mitanin Day". Many states call their monthly block level meeting with ASHAs as the ASHA Divas.

3. Though selection is near complete there is a reason for concern about where the last mile is located Thus Haryana reports a 90% of ASHAs selected, but in Mewat, the very district where demand side problems are most acute in all of Haryana, only 60% of the requisite ASHA are in place. The state had lowered the educational bar to the 5th class, but still did not find suitable candidates. Other states have overcome this by relaxation of criteria based on local context, with good results. In this respect Orissa's selection of ASHA in remote and inaccessible areas is commendable. With appropriate relaxation of literacy norms, the state has been able not only to secure ASHAs for the most challenged habitations, but also ensure proportionate representation of ASHA in the tribal communities.

4. All states for which drop out figures were available, report low attrition rates, and even these are primarily on account of the ASHA moving forward on a career path, the commonest being entering the Anganwadi system or becoming elected as a representative of the Panchayati Raj Institutions (PRI). Another reason is that there was a mismatch of expectations, and drop out on this account is a to be seen as self-correcting measure. However systems to select, train and replace a new batch of ASHAs in their place is needed in most states. Most states have no systems of detecting ASHAs who are losing interest, or turned inactive since monitoring of functionality is not in place, and this needs to be kept in mind.

Of the 7 high focus states visited, except Uttar Pradesh, all had a support structure in place, although more capacity building of the staff is

urgently needed. Assam, Uttarakhand, Rajasthan, Chhattisgarh and Bihar, all have the specified structures at sub block, block, district, and state levels. In Bihar, Assam and Chhattisgarh facilitators have been selected from amongst the ASHA, indicating yet another avenue for promotion. Orissa has support structures up to block level. Dedicated training structures are also in place in Bihar, Assam, Chhattisgarh and Orissa . In the non high focus states, the support structure is not in place in most states. Given that the numbers are high and that the form and content of the programme is similar, this aspect needs to be addressed soon.

NAME OF STATE	NUMBER OF ASHA DROPPED OUT SINCE 2006	ATTRITION RATE (OVER 5 YEARS)
Andhra Pradesh	4800	6.8%
Assam	583	2%
Chhattisgarh	1803	3%
Haryana	NA	NA
Jharkhand	1229	3%
Karnataka	1306	3.9%
Gujarat	402	1.4%
Orissa	388	1%
Rajasthan*		3% to 4%
Sikkim	0	0
Uttar Pradesh	5898	4.3%

*In visited districts

Module 5 training is now complete for the majority of the ASHAs in all the 13 states, except in Bihar. Even in Bihar the state and district training agencies are in place and training of district trainers is scheduled to start in January 2012. In 8 out of 13 states modules 6 and 7 training has been initiated for ASHAs. Important states which have lagged behind are Jharkhand, Assam and Bihar. Assam which was one of the best performing states in ASHA shows signs of fatigue and slowing down on many parameters. Uttar Pradesh has initiated home based care in 17 districts, but now are synergising with the module 6 and 7 strategy and taking it to scale. Himachal Pradesh, where Anganwadi workers exist at the one in 300 population level, and therefore perform many of the ASHA functions, has initiated e training in a special module based on 5, 6 and 7.

AP, Assam, Chhattisgarh, Odisha and Sikkim have established grievance redressal systems for the ASHA. In all states monthly meetings are more regular, incentive payments are becoming more regular, and in some states bank transfers are the norm. Only Orissa and Uttarakhand have streamlined mechanisms to ensure regular payments with minimal or no disruption. Delays in payments are reported from all other states with longer delays from states such as Andhra Pradesh, Chhattisgarh, Jharkhand, and Uttar Pradesh.

Incentive payments range from Rs. 200 in Chhattisgarh to nearly Rs. 4000 in Sikkim. Sikkim and Rajasthan provide fixed payment to the ASHA of about Rs. 3000 and Rs. 1000 respectively. In Chhattisgarh, incentive payments are low, but while active Mitanins who were met, said that they were not motivated by the money, district officials tended to dismiss those who had not claimed incentives as non functional. The idea that community level workers could provide services on a voluntary basis is not clearly understood by programme implementers. Assam, Gujarat, Odisha, Haryana, UP, Karnataka, Rajasthan have bank accounts for

payment to ASHA. Bihar and Jharkhand are in part and Andhra Pradesh is just starting up. In Assam many ASHAs and mothers are unable to open accounts and cash their cheques for reasons of rigid banking formalities. Uttarakhand uses bearer checks. Chhattisgarh and Sikkim find cash payment as the only possible and efficient way of making the payment.

While the promotion of institutional delivery and immunization are the two key tasks that continue to be seen as her most important responsibilities the ASHA is active on a range of tasks including malaria surveillance, nutrition, DOTS, home based newborn care, motivation for family planning and contraceptive counselling. In Chhattisgarh, Sikkim, Uttarakhand, they are also serving as RSBY motivators. In Sikkim, ASHAs are also involved in supporting health workers on screening for diabetes, hypertension, and care of chronically ill patients. Routine home visits for post partum and new born care are established in Uttarakhand, Orissa, Sikkim, Rajasthan, Uttar Pradesh and Chhattisgarh where the ASHA training in Module 6 or equivalent has been initiated.

Replenishment of the drug kit is an issue across the board, even in a mature programme such as Chhattisgarh. States will need to step up to this challenge and enable timely and regular replenishment of the drug kits.

Staying arrangements for ASHA in facilities and help desks are in place in Orissa, Assam, Sikkim and Chhattisgarh. In other states there is strong case for establishing these, given that almost everywhere ASHAs report accompanying pregnant women to the hospitals, and staying overnight with them.

The linkage of the ASHA with the Village Health, Sanitation and Nutrition Committees (VHSNC) is peripheral and needs to be strengthened.

ASHA as agents of social marketing is being introduced for contraceptives and oral pills and sanitary napkins. But these programmes are in too early a phase for comment. On the ground the programme was seen only in Uttar Pradesh and Uttarakhand and the interesting observation from this state was that she was not accepting the payment for contraceptives as she did not want to alter the social image that she had built up. It would be interesting to see how the ASHA herself would respond to efforts to shape her role in this direction.

RECOMMENDATIONS:

- There is a need for sustained advocacy to explain the characterization of the ASHA. It is the particular combination of roles- as facilitator of services, as a person working for health rights and as a community level care provider- that makes for effectiveness and sustainability. Over-emphasis on any one of these dimensions and failure to recognize the others makes for a sub-critical programme that leads to lesser coverage, functionality or effectiveness.
- There is need for building capacities in the support structures that have been built up already. Other states that have not built up the support structures need to start this up immediately. Similarly community based training sites and training teams which have been initiated in most states as part of training for module 6 and 7 need to be institutionalized.
- Regular monitoring and support to ASHA functioning is important at the local level to replace non functional ASHAs and at the block level to provide additional support and resources where the challenges are more. The use of functionality indicators and the process of gathering this are key to this change and needs to be rapidly introduced. Another aspect of this is creation of an ASHA database at all levels to track and replace drop-outs as also to facilitate certification and career options for those who require it.
- Ensure achievement of the minimum skill sets required for an ASHA as defined by modules 5 , 6 and 7 within the coming year, with some

process of certification of ASHAs who have achieved the prescribed skills.

- Improve mechanisms of performance based timely payments and urgently put in place the payments for newborn visits.
- Reiterate once more the need for regular replenishment of drug kits- especially life saving first line drugs of ORS and Zinc, Cotrimoxazole, Choloroquine and equivalent, as well as drugs for management of anemia.
- Functioning of the Village Health and Sanitation Committees are to be revitalized with the ASHA playing a central role
- Creating facilities for the ASHA to stay-in during facility visits is likely to improve access of the community to health facilities.
- The administrative willingness for long term planning for the ASHA programme is essential for most of the above reforms. Too much of the ASHA planning has a mindset that views her as an ad hoc passing phase. The other problem in administrative will is the failure to understand the diversity of expectations of stakeholders and the ASHAs themselves from the programme. As we complete the seventh year of the ASHA programme, and the programme gets a five year mandate which would take it to its 12th year by 2017, such a long term 'operational' plan would be an urgent necessity.
- Long term planning requires planners to provide space for those ASHAs who are happy to remain local volunteers indefinitely with the performance based incentives acting as social recognition. At the same time, those ASHAs who aspire for regular employment and incomes, must be enabled to enter into training programmes for becoming ANMs, nurses, ASHA facilitators, anganwadi workers etc. Options for voluntary ASHAs to opt out voluntarily and be replaced by next generation volunteers after ten years may also be encouraged. Certification of ASHAs for having acquired minimum skills and opportunities for them to upgrade skills would be an important component of this plan. Over a much longer time framework an ASHA who provides a much wider level of community care and health care facilitation, which includes all of non communicable diseases, geriatric care, and palliative care etc is likely to emerge- and this would not be excessive from whatever international experience teaches of human resource requirements for the health sector.

II Findings of the Eighth Joint Review Mission

The eighth JRM was conducted between July and September 2011 and was led by the Ministry of Health and Family Welfare and included state representatives and all Development Partners supporting the Reproductive and Child Health II programme. Field visits were made to five states, i.e. Jammu and Kashmir, Maharashtra, Madhya Pradesh, Meghalaya and West Bengal. This note summarizes the findings from the review on ASHA programme.

ASHA's Roles:

In general ASHA programme received a positive report across all the states. ASHAs showed high level of motivation in performing major RCH related activities. Her main effectiveness was observed in motivating women for institutional delivery, immunization and adoption of Family Planning methods. ASHAs were seen as first port of call and are sought for advice on these activities. The review findings highlight that ASHAs need training in management of common childhood ailments and provision of HBNC at the community level. Three of the five states- Madhya Pradesh, Meghalaya and West Bengal have started implementing home visit programme by ASHA. In MP and West Bengal quality of counselling and skills need to be strengthened. In Meghalaya, the coverage of home visit when compared against the expected births was found to be very low. ASHAs are undertaking home visits soon after delivery, but follow up for

PNC and newborn care is irregular or not done.

The states are now in the stage of introducing Scheme for Promotion of Menstrual Hygiene and social marketing of contraceptives by utilizing the services of ASHAs.

The report recommends that states plan for demand generation/outreach activities with appropriate engagement of ASHAs in the Adolescent Health Programmes.

Training: Concern about quality of training for management of childhood illnesses at community level was raised in Madhya Pradesh. This could be due to lack of proper monitoring of training quality. The report highlighted the need for states to strengthen skills of ASHAs and develop a training strategy to roll out ASHA Module 6 and 7

Support: The report highlights effective coordination among ASHAs, ANMs and AWWs in most states. Role clarity among IMNCI trained ASHAs and ANMs was an issue. The report reinforced the need to strengthen supportive supervision for ASHAs in all five states. The need for facility based lodging arrangements for ASHAs to facilitate her work came out clearly from the survey. Amounts and mechanisms for incentive payment for ASHA varied across states. Regular payments through bank transfers and cheque are made in Madhya Pradesh, Maharashtra and West Bengal. Reports of delayed payments for JSY and immunization emerged from Jammu and Kashmir and Meghalaya respectively. This delay in payments has also affected the immunization coverage in Meghalaya. West Bengal has recently withdrawn the fixed payment scheme for ASHAs, under which every ASHA was paid an incentive of Rs. 800 per month, causing some unrest. Incentives were perceived to be low and request for some fixed remuneration were conveyed by ASHAs across all the states. The report also recommended that incentives be linked with objective outcomes.

Recent Policy Initiatives

Strategic Options for the Community Processes , including the ASHA programme

Part A1 of this section summarizes the discussions and recommendations on Community Processes of the Approach Paper to the XII Plan. In drafting the approach paper, the Planning Commission consulted a range of experts including state government representatives as well as local representative institutions and unions[1] across the country. This was strengthened by the constitution of Working Groups to examine issues in detail pertaining to different programmes. The Community processes programme, including the ASHA is discussed in depth in the report of Working Group 1 on NRHM and Working Group 3 on Non Communicable Diseases. These were then summarized in the report of the Steering Committee on Health. Part A.II discusses the recommendations of the Working Group on NRHM. In addition to this, the High Level Group on Universal Health Coverage was constituted by the Planning Commission in October 2010 with the mandate of developing a framework for providing easily accessible and affordable health care to all Indians. The group provided recommendations on a range of topics including financing, access to medicines and technology, human resource and health service norms and on community participation and citizen engagement and social determinants and health. These are discussed on Part A III of this section. Part A IV provides information on two key guidelines for the ASHA programme which have bearing on the role of the ASHA and clarity to states on training for newborn and child health.

A I Recommendations from the Approach Paper to the Twelfth Five Year Plan in relation to Community Processes:[2]

While preventive health care is much cheaper than curative care it has not received the attention it deserved. Existing frontline health educators and counsellors should play a lead role in compiling and disseminating preventive health practices to every nook and corner of the country. The state should play a lead role in building a culture of familiarity and knowledge around public health by involving Panchayayti Raj /institutions, Rogi Kalyan Samitis, Village Health Sanitation and Nutrition Commitees, Urban Local Bodies and the available cadre of frontline health workers, through innovative use of folk and electronic media, mobile telephony, multimedia tools and Community Service Centers. But most importantly families and communities must be empowered to create an environment for healthy living.

The effectiveness of the health care system is also affected by the ability of the community itself to participate in designing and implementing delivery of services. The opportunity to design and manage such delivery provides empowerment to the community as well as better access, accountability and transparency. In essence, the healthcare delivery must be made most consultative and inclusive. This can be achieved through a three dimensional approach of (1) strengthening PRIs/ULBs through improved devolution and capacity building for better designing and management (2) increasing users' participation through institutionalized audits of health care service delivery for better accountability and (3) bi - annual evaluation of this process by empowered agencies of civil society organizations for greater transparency. Methodologies based on community based monitoring which have proved successful in some parts of the country, will need to be introduced in other parts.

---

[1] *Overview Faster Sustainable and more Inclusive Growth An Approach to The Twelfth Plan- Planning Commission*

[2] *Excerpted from Section-9.4 Towards Comprehensive Health Care from Faster Sustainable and more Inclusive Growth An Approach to The Twelfth Plan- Planning Commission*

The Twelfth Plan should aim at locating a Health Sub Centre in every Panchayat and an AWC in every habitation, their formal inter-linkage being a must for integrating the delivery of health, nutrition and pre-school education services. Through this approach, at least one ASHA would get positioned in each AWC; and one ANM/ Health Worker (Female) would be available for a cluster of AWCs within every Panchayat. Both could be brought under the oversight of the Panchayat level health, nutrition and sanitation committee recently notified by the Ministry of Health and Family Welfare.

AII Proposals for the Twelfth Five Year Plan from Working Group on NRHM-[3]

Community Processes and action on social determinants of health

1. For the ASHA programme to impact on maternal and child survival the ASHA must be taught the skills for counselling pregnant women and families with children on nutrition and improved health care practices as well as community level care for the newborn and sick child. Just ensuring increased attendance at immunization and promotion of institutional delivery exclusive of other strategies, cannot make a dent on child survival, nor be able to reach out to the most marginalized. Modules 6 and 7 for the ASHA programme for home based new born care must be scaled up rapidly and effectively. The current emphasis on community mobilisation must be strengthened. All this in turn would mean strengthening the support structures and creating high quality training teams at state and district levels.

2. Sustaining the ASHA programme in the next phase of NRHM requires planning for an annual turnover and fresh recruitment of the ASHA from between 5% to 10%. Increasing the avenues for career progression of those ASHA who have such an aspiration, will enable expanding the human resource pool at the local level by giving them preference in education in local training institutions.

3. The voluntary nature of the ASHA programme needs to be preserved. Her work should be such that it is done without impinging on her main livelihood and adequate monetary compensation for the time she spends on these tasks- through performance based payments.

4. Managing the turn over, retraining ASHAs and facilitators and enabling the implementation of newer interventions by ASHAs requires established training and development centers at the state level.

5. The Village Health, Sanitation and Nutrition Committee (VHSNC) remains the key mechanism to address the action on social determinants including age at marriage, literacy, water and sanitation, nutrition, substance abuse etc. This aspect was always part of the design, but there was no management capacity to handle this. There is a need to train and support VHSNCs to play a role in addressing social determinants of health in a meaningful way. This VHSNC programme with an adequate support structure is also needed to support the ASHA to play her mobilisational and health education roles. The VHSNC would need recurrent rounds of training- and just one round would not suffice. It would also require linkages with block level and district level committees. Incentives in the form of awards can be introduced to VHSNCs for specific achievements.

6. The approach paper for the 12th Plan suggests that the Anganwadi Centre and the Sub Centre both could be brought under the oversight of Panchayat level Health Nutrition & Sanitation Committee. However, the Health Sanitation & Nutrition Committees under NRHM are set up at the level of village and not the Gram Panchayat. While the number of Gram Panchayats is approximately 2.45 lakhs in the country, the number of Village Health Sanitation & Nutrition Committees (VHSNC) is approximately 5

[3] *Report of Working Group on "Progress and Performance of National Rural Health Mission (NRHM) and suggestions for the Twelfth Five Year Plan (2012-2017)"*

lakhs at the moment. Hence, the appropriate course would be to put the health Sub Centre, Anganwadi Centre and also the Village Health, Sanitation & Nutrition Committees under the oversight of the Gram Panchayat.

7. The NRHM flagged the issue of action on social determinants – but could not launch a programme on this. In the Twelfth Plan, the VHSNCs supported by civil society organisations could take the lead in action on social determinants of health, especially on equity of access. Block level health committees would provide coordination to this VHSNC action and these committees would report to the district health societies. An important aspect of this approach is that the VHSNC's action gets focussed on identifying and acting on inequities within panchayats and between panchayats. The village health plan should express health priorities as perceived by people, it should identify and address inequities in access, and it should address social determinants. On determinants like roads and township planning, it should ensure convergence with rural development and urban development plans so that health concerns are adequately addressed in their plans.

8. NGO participation would be enhanced and upto 5% of the resources of NRHM can be spent through NGO assisted interventions. The support from these NGOs should be broad based in the twelfth five year plan. A substantial proportion would be for capacity building and support for community processes (the VHSC, the ASHA programme, public participation in RKS, public participation in district planning and in community monitoring). The element of community monitoring could be further expanded in areas such as improving data quality in HMIS and MCTS, measuring availability of drugs, monitoring support to JSSK, support to users in RSBY and other cashless PPP arrangements. NGOs must be supported to mobilise additional technical capacity from a national canvas, where intra-district management capacity and training capacity is overwhelmed by requirements in high focus districts. A National Resource Centre and Regional Resource Centres would be set up to coordinate and support country wide NGO assisted interventions, provide support, develop capacity and monitor performance of NGOs. While the engagement with NGOs will be operationalised in a decentralised way, the Centre may offer direct grants to a few NGOs for very innovative projects.

9. NGOs must also be used for supplementing capacities in some key areas where they have interest and a high priority, but where medical professionals are unable to give continued attention to it. Examples include the monitoring of PCPNDT implementation, assessing environmental health impact, monitoring of food and drug adulteration (consumer education and assistance to inspection roles), promotion of rational drug use- amongst the population and amongst professionals.

10. The Rogi Kalyan Samitis should be strengthened by having better rules in place for public participation and transparency and by orientation to ensure quality of care and improved access to care. It should act as effective grievance redressal mechanism at the facility level. The engagement of PRIs should be very active in RKS. The exact position that the PRI leadership has in the RKS will vary from state to state depending on the context, but there should be an institutionalised process of capacity building so as to ensure their increasing role – in the RKS. Regularity in their functioning would be ensured by improved supervision and support. In fact, RKS should take leadership role in the management of the facility to give it a patient friendly orientation.

11. Community monitoring which emerged as a viable strategy in the Eleventh plan needs to

be built upon in Twelfth plan and scaled up. VHSNCs and service user groups should have the capacity to undertake monitoring. This is one area where NGOs can play an important role in capacity building and support as for the line department staff, building capacity at the local level to monitor itself would understandably a low priority activity. However this must be closely linked to village health planning and facilitation of service delivery- and efforts must be made to bring community and service provider closer together and develop mutual trust and support.

12. Effective district level grievance redressal systems for the public to address their grievances and have it redressed with timely feedback on action taken- would be an important step forward. The grievances not addressed by RKS and VHSNC may be escalated to district level grievance redressal system. These systems and mechanisms would need adequate publicity and public participation to be effective across a wide form of contexts.

2: AII Recommendation of High Level Expert Group on Community Participation and Citizen Engagement:[2]

Recommendation 1: Strengthening institutional mechanisms for community participation in health governance and oversight at multiple levels (rural and urban).

(a) Transformation of existing Health Committees (or Health and Sanitation Committees) into participatory Health Councils at five levels: 1) village / mohalla; 2) block / taluka / town / MLA constituency; 3) district / city; 4) state; and 5) the national level.

We propose the transformation of the existing system of Health Committees into Health Councils at all levels - from the village and urban settlement level to block, district, state and the national level. The membership of these Councils needs to include representatives of non-governmental actors (such as Community Based Organisations (CBO), membership organisations, women's groups, trade unions and health providers), who should constitute at least 50% of the Council's strength. The composition of the reconstructed Councils will ensure representation of all members of the previously constituted Health Committees, including members of the Gram Panchayat or other elected representative for the concerned geographical unit, and of frontline health workers (such as ANM, AWW and CHW). In instances where Health Committees do not previously exist, new Health Councils should be instituted with roles and functions identical to those of the transformed Health Councils.

The process of reconstitution and trans formation will expand the role and functions of the erstwhile Committees (now Councils), while ensuring that their existing functions are not adversely affected. The enhanced role of the transformed Councils will include drawing upon the perspectives of the different groups represented within and evolving recommendations by consensus, on health plans and budgets for further implementation by designated executive agencies. The Councils will also exercise oversight on performance of the health plan, with monitoring of selected health indicators every six months, and will also track the extent and areas of budget expenditure. The Councils will thereby bring the strengths of broader representation as well as more frequent monitoring to the existing mechanisms of planning and review. Over a period of time, Councils should be encouraged and empowered to take on greater and more direct roles in the operational and financial planning of health services for the mandated geographical units.

Specific additional functions of the transformed Health Councils (in addition to those already

[5]*Excerpted From Report of High Level Expert Group on Universal Health Coverage for India*

mandated to existing Health Committees) should be:

(i). To organize periodic health assemblies.

(ii) To ensure that relevant documentation (i.e., annual report, finance report, action plan, and disaggregated data from community monitoring) is tabled at the time of the assembly, to record the minutes and synthesize the pro ceedings of the assemblies; to convey the summarized proceedings of the assembly to health authorities; to take cognisance of 'action taken' by authorities in response to the assembly proceedings.

(b) Organizing of periodic Health Assemblies from village to national levels. The Health Councils will organize annual Health Assemblies at different levels (district, state and national) to enable community review of health plans and their performance as well as record ground level experiences, which call for corrective responses at the systemic level. The needs and priorities identified by the community as well as articulated grievances of sub-optimal or inequitable performance of health services would enable the Councils to provide constructive feedback to policymakers and health system managers. It will also provide an opportunity to health system managers to explain, to the community, the constraints which prevented a prompt response to all the stated needs. Data from the annual report, finance report, action plan and community monitoring will be presented to the assemblies, for review and feedback. By organizing such Health Assemblies, the Health Councils will serve as a bridge between the executive agencies responsible for design and delivery of health services and the wider community which is the intended beneficiary of such services.

(c) The participatory governance and review and oversight process envisioned through the assembly activities and council or committee functions will be supported by requisite legal sanction, financial investment and continuous capacity building. Academic institutions will be engaged to provide capacity building for the members of the Councils, and research institutions will be engaged to synthesize the proceedings of assemblies and prepare policy briefs. The impact of health assemblies will be evaluated. CSOs with the appropriate capacity and commitment should be engaged for the training of council or committee members.

Recommendation 2: Increasing the number of community health workers to two workers per village and equivalent urban administrative unit.

(a) Deployment of two community health worker in each village and equivalent urban setting (mohalla). The CHWs may be either two women, or one woman and one man.

(b) CHW functions: providing preventive, promotive and basic curative care in a role complementary to health staff; educating and mobilizing communities for promotion of a healthy lifestyle; enhancing appropriate utilization of services; participation in health campaigns; and claiming of health entitlements. The two CHWs will operate as a team, sharing tasks and functions related to six core health components, as follows:

i. maternal and newborn health;

ii. sexual and reproductive health;

iii. child health and nutrition for children, adolescent girls and women;

iv. communicable disease control and sanitation;

v. chronic disease control;

vi. gender-based violence, mental health and health promotion.

(c) CHW affiliation: CHWs should be de facto members of, and answerable to the village or

mohalla Health Council.

(d) CHW compensation: CHWs will be guaranteed fixed compensation or payment (estimated at Rs 1500 per month), in addition to performance based incentives (estimated at a maximum of Rs 1500 per month). Emoluments should be routed through and approved by the village or urban Health Council or panchayat. Performance-based incentives should be calculated transparently and provided by the health dpartment.

(e) CHW career and mentoring: CHWs should be provied opportunity to pursue training as auxiliary nurse midwife or male health worker, if performance is excellent. CSOs with the appropriate capacity and commitment should be engaged for training CHWs, using existing health service personnel as resource persons. A mentoring scheme should be introduced to provide an internal support system and career guidance for CHWs.

Recommendation 3: Enhancing the role of Panchayati Raj Institutions (PRIs) and elected representatives in health governance and community oversight, and in facilitating convergence with other services.

(a) Devolve local health functions and finances to the vilage Health Council, block Health Council and district Health Council. Define responsibilities of health department officials with relation to PRIs and vice versa, supported by sufficient and clear directives, guidelines or orders, as applicable. PRI representative needs to approve disbursing of CHW emoluments.

(b) Define PRI / other elected representative's responsibil ties in facilitating convergence of health with other services, at each level-1) Village / Mohalla; 2) Block / taluka / town / MLA constituency; 3) District/city; 4) State; and 5) National.

(c) Elected peoples' representatives to chair Village, Taluka and District Health Councils and Assemblies. Similarly, elected representatives to chair Councils and Assemblies at different levels, and in urban areas, including 1) Mohalla, 2) Town or legislative assembly constituency; 3) Municipality; 4) State; and 5) National.

(d) CSOs with the appropriate capacity and commitment should be engaged for the training of PRI /elected representatives in health administration and in convergence of health with other services, at all levels

Recommendation 4: Enhancing the role of Civil Society Organisations (CSOs) in delivering information about health-related entitlements, enabling community participation in health governance, community mobilisation for health, and capacitybuilding of community-based platforms and community health workers.

(a) Greater involvement of CSOs in facilitating community-based monitoring, buildingon prior experiences of the National Rural Health Mission.

(b) Minimum 50% representation of non-governmental sectors in Health Councils at all levels, including community based organisations and membership-based organisations of the poor, women's groups, trade unions or cooperatives, and health providers.

(c) CSOs need to be engaged to undertake campaigns for Universal Health Coverage, incoordination with Village Health and Sanitation Councils, Block Health Councils and District Health Councils, and at State and National levels.

(d) CSOs with the appropriate capacity and commitment should be engaged for capacity strengthening of Members of Health Councils, CHWS, and PRI / elected representatives at all levels, in relevant skills and subjects (see previous recommendations)

(e) CSOs should be engaged in provision of healthservices, including preventive and promotive services, as part of a coordinated network of Universal Health Coverage services (see chapter on Management and Institutional Reforms for further details).

(f) Mapping and selective identification of CSOs for all aforementioned activities, on the basis of excellence, tran parency of functioning and accountability, and established record of working for the poor or vulnerable groups.

Preference should be given to Indian organisations as opposed to international NGOs and agencies, and to membership based organisations of the poor, women's groups and self-help groups. A CSO that discriminates against any community caste, ethnicity, sexual orientation or other social group, vulnerable or otherwise, should be disqualified from participation in the aforementioned activities.

Recommendation 5: Instituting a formal grievance redressal mechanism.

(a) Create an empowered office (Jan Sahayata Kendra) for confidential grievance redressal, and for information services to be located at the block headquarters. The office would have two distinct functions:

(i) Grievance redressal: entertaining confidential complaints and grievances about public and private health services in that block. Procedure for corrective measures should be clearly enunciated at each level, with defined parameters for grievance investigation, feedback loop, corrective process, no- fault compensation and grievance escalation. Re sponsibilities of health department officials should be defined with relation to grievance redressal officer and vice versa, supported by sufficient and clear directives, guidelines or orders,as applicable.

(ii) Information and suggestion services: conduct periodic public hearings, receive suggestions, and operate a telephone helpline. Wherever possible, these would be managed by membership-based organisations of the poor (women's or farmers' groups,trade unions or cooperatives).

(b) Vertical linkages: The block-level office for grievance redressal should be linked, at the district level, with the office of the ombudsperson under the auspices of the Health Regulatory and Development Authority. Serious grievances and unresolved cases should be referred up to the ombudsperson. The department for information services should be linked with the Health Promotion and Protection Trust.

	RECOMMENDATIONS	EXPECTED OUTCOMES
1	Strengthening institutional mechanisms for community participation in oversight and governance of health at multiple levels (rural and urban).	• Transparent and participatory health governance/ administration at all levels; • A health system that is responsive to people's needs.
2	Increasing the number of community health workers to two workers for a village and equivalent urban administrative unit	• Improved outreach of health care support Improved access to primary drugs and first level care and prompt referrals at the neighbourhood. • Collective efforts by people, especially by women, to overcome health problems of the locality. • Improved health awareness, health seeking behaviours and health promotion initiatives at community level. • Optimum utilization of health care services. • Improved coverage of national health programs and optimum reduction in problems addressed by those programs. • Improved maternal health status and reduction in maternal mortality. • Improved neonatal, infant and child health status and reduction in mortality including in stillbirths.
3	Enhancing the role of Panchayati Raj Institutions and elected representatives in health governance and community oversight, and in facilitating convergence with other services	• Preparation and implementation of local health plans. • Better convergence and coordination between health and other initiatives that determine better health outcomes Improved accountability of healthcare providers to local bodies
4	Enhancing the role of Civil Society Organisations in delivering information about health and entitlements, enabling community participation in health governance, community mobilisation for health, and capacity building of community-based platforms and community health workers.	• Optimum level of community participation in all health related decision making processes and health events. • Improved and transparent management of unity level health initiatives. • Optimum knowledge and skill levels of community health workers and members of community. • structures Improved coverage and provision of health care services at otherwise underserved areas.
5	Instituting a formal grievance redressal mechanism	• Improvement in quality and outreach of health services. • Improved coverage of marginalized populations under health services. • Improved user satisfaction levels for all health and related services.

2B- Recent Guidelines and Orders

(i) Introduction of Home Based New Born Care Scheme Through ASHAs:

Home Based New Born Care Operational Guidelines were released in August 2011 with the main purpose to enable the states to develop and operationalize a strategy to ensure that all new borns are provided with care through a series of six home visits by ASHAs. In order to actualize, it is essential that ASHAs be trained in Modules Six and Seven. Under this scheme an incentive for Rs. 250 will be provided to ASHAs for conducting home visits for the care of new born and the post- partum mother. This amount would be provided at the completion of these visits 45 days after birth on due validation from the Facilitator.

(ii) Guideline regarding implementation of IMNCI strategy and Module 6 and 7 training of ASHAs:

Issued in December 2011 this guidelines from the MOHFW to all states, is based on the decision of the Expert Group set up by MOHFW to review and harmonize the elements of IMNCI modules and ASHA Modules 6 and 7. The Group after perusal of the contents of both training packages, came to the conclusion that Module 6 and 7 covers all essential elements of IMNCI besides skill building in respect of Maternal Health, Family Planning and Disease Control. The decisions highlighted in this guideline were:

1. ASHAs would be henceforth be trained in Modules 6 and 7 in place of IMNCI
2. ANMs would continue to receive training in IMNCI
3. Medical Officers would be trained in F-IMNCI
4. Anganwadi Workers would be trained in IMNCI only if funds are provided by Department of Women and Child Development.
5. This strategy henceforth will be called as IMNCI PLUS

Progress of the ASHA program

Section

III

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 December 31st, 2011.

Section 3.1 Selection and Recruitment

In most high focus states except Rajasthan and to a certain extent in Madhya Pradesh, the required number of ASHA as per the 2001 population estimate 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 Tamil Nadu and Gujarat have yet to select the ASHAs as planned for.

However, when the population Census 2011 is considered, it appears that states need to recruit more number of ASHAs to retain their primary target in terms of population density (Tables1E-1H). This holds true for majority of the states except Gujarat, Kerala, Nagaland and Sikkim where the Rural Population has actually decreased in comparison to 2001 population. The deficit varies considerably amongst the states, being largest for states like Bihar, Uttar Pradesh, Rajasthan and Chhattisgarh.

TABLE 1A : Status of ASHA selection in High Focus States (December, 2011)

STATE	PROPOSED NO. OF ASHAS	NUMBER OF ASHA SELECTED	% OF ASHA SELECTED
Bihar	87135	82522	94.70
Chhattisgarh	60092	60092	100
Jharkhand	40964	40964	100
Madhya Pradesh	56941	52393	92.01
Orissa	41102	42597	99.60
Rajasthan	54915	50287	91.57
Uttar Pradesh	136174	136094	99.94
Uttarakhand	11086	11086	100
Total	**4,88,409**	**476035**	**97.60**

TABLE 1B : Status of ASHA selection in North East States (Dec, 2011)

STATE	PROPOSED NO. OF ASHAS	NUMBER OF ASHA SELECTED	% OF ASHA SELECTED
Assam	29693	29172	98.20%
Arunachal Pradesh	3862	3712	96
Manipur	3878	3878	100
Meghalaya	6258	6258	100
Mizoram	987	987	100
Nagaland	1700	1700	100
Sikkim	666	666	100
Tripura	7367	7367	100
Total	**54411**	**53740**	**98.76**

TABLE 1C : Status of ASHA selection in Non High Focus States (Dec, 2011)

STATE	PROPOSED NO. OF ASHA	NUMBER OF ASHA SELECTED	% OF ASHA SELECTED
Andhra Pradesh	70700	70700	100
Delhi	5400	3716	68.81
Gujarat	33139	28827	87
Haryana	14000	13319	95.14
Jammu and Kashmir	10000	9700	97
Karnataka	39195	33750	86
Kerala	32854	31868	97
Maharashtra	59384	59289	99.84
Punjab	17360	16753	96.50
Tamil Nadu	6850	2650	38.69
West Bengal	61008	44841	73.50
Total	**349890**	**315413**	**90.14**

TABLE 1D : Status of ASHA selection in Union Territories (Dec, 2011)

STATE	PROPOSED NO. OF ASHAS	NUMBER OF ASHA SELECTED	% OF ASHAS SELECTED
Andaman and Nicobar Island	407	407	100
Dadra and Nagar Haveli	250	208	83.20
Lakshadweep	85	83	97.60
Chandigarh	423	423	100
Total	**1165**	**1121**	**96.20**

Grand total for All States and Union Territories

Total	**893875**	**846309**	**94.7**

TABLE 1E : Density of ASHA in HIGH Focus States

NAME OF THE STATE	PROPOSED NUMBER AS PER 2001 POPULATION	ASHAS SELECTED SO FAR	RURAL POPULATION AS PER 2011 CENSUS	PROPOSED DENSITY AS PER 2001 POPULATION	PROPOSED DENSITY AS PER 2011 POPULATION
Bihar	87135	82522	9,20,75,028	1/853	1/1057
Chhattisgarh	60092	60092	19603658	1/277	1/326
Jharkhand	40964	40964	2,50,36,946	1/511	1/611
Madhya Pradesh	56941	52393	5,25,37,899	1/852	1/923
Orissa	41102	42597	3,49,51,234	1/761	1/850
Rajasthan	54915	50287	5,15,40,236	1/788	1/939
Uttar Pradesh	136174	136094	15,51,11,022	1/966	1/1139
Uttarakhand	11086	11086	70,25,583	1/569	1/634

TABLE 1F : Density of ASHA in North East States:

NAME OF THE STATE	PROPOSED NUMBER AS PER 2001 POPULATION	ASHAS SELECTED SO FAR	RURAL POPULATION AS PER 2011 CENSUS	PROPOSED DENSITY AS PER 2001 POPULATION	PROPOSED DENSITY AS PER 2011 POPULATION
Assam	29693	29172	2,67,80,516	1/782	1/902
Arunachal Pradesh	3862	3862	10,69,165	1/225	1/277
Manipur	3878	3878	18,99,624	1/410	1/490
Meghalaya	6258	6258	23,68,971	1/298	1/379
Mizoram	987	987	5,29,037	1/453	1/536
Nagaland	1700	1700	14,06,861	1/969	1/828
Sikkim	666	666	4,55,962	1/722	1/685
Tripura	7367	7367	27,10,051	1/360	1/368

TABLE 1G : Density of ASHA in Non High Focus States:

NAME OF THE STATE	PROPOSED NUMBER AS PER 2001 POPULATION	ASHAS SELECTED SO FAR	RURAL POPULATION AS PER 2011 CENSUS	PROPOSED DENSITY AS PER 2001 POPULATION	PROPOSED DENSITY AS PER 2011 POPULATION
Andhra Pradesh	70700	70700	5,63,11,788	1/784	1/796
Delhi *	5400	3716			
Gujarat	33139	28827	2,18,96,928	1/968	1/661
Haryana	14000	13319	1,61,31,493	1/1068	1/1181
Jammu and Kashmir	10000	9700	91,34,820	1/763	1/913
Karnataka	39195	33750	3,75,52,529	1/890	1/958
Kerala	32854	31868	1,74,55,506	1/718	1/531
Maharashtra	59384	59289	6,15,45,441	1/939	1/1036
Punjab	17360	16753	1,73,16,800	1/927	1/998
Tamil Nadu**	6850	2650			
West Bengal	61008	44841	6,22,13,676	1/947	1/1020

* Delhi has selected 1 ASHA per 2000 population in certain identified clusters

** ASHAs have been selected only in the tribal areas

TABLE 1H : Density of ASHA in UTS:

NAME OF THE STATE	PROPOSED NUMBER AS PER 2001 POPULATION	ASHAS SELECTED SO FAR	RURAL POPULATION AS PER 2011 CENSUS	PROPOSED DENSITY AS PER 2001 POPULATION	PROPOSED DENSITY AS PER 2011 POPULATION
Andaman and Nicobar Island	407	407	244411	1/590	1/601
Dadra and Nager Haveli	250	208	183024	1/680	1/732
Lakshadweep	85	83	14121	1/396	1/166
Chandigarh	423	423	29004	1/218	1/69

Section 3.2 :Training of ASHA

ASHA training in Module 5 has been completed in all eight North Eastern states, Jharkhand, Orissa, Chhattisgarh, Jammu & Kashmir and Punjab and either underway or integrated with 6 & 7 in other states. For example-Bihar has planned to conduct consolidated training in Module five, six and seven.

Training in Modules 6 and 7 which cover a range of competencies in maternal, new born, 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.

In terms of training of Trainers State trainers from 23 states & District Trainers from 20 states have been trained in Round 1 OT and State trainers from 18 states and District Trainers from Two states have been trained in Round 2.

Round 1 of ASHA training is over in Uttrakhand and all North East states except Assam.

It is underway in six states - Madhya Pradesh, Orissa, Maharashtra, Karnataka, West Bengal and Dadra & Nagar Haveli.

Round 2 ASHA training has also been completed in Uttarakhand and all North East States excluding Assam and it is underway in Maharashtra and Karnataka.

TABLE 2A : Training Status for High Focus states

STATE	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	82522	52859 (64 %)	52859 (64 %)	• 19 state trainers trained for ASHA Module 5, 6 and 7 • Three State Training sites selected MOU has been signed • Training of District Trainers initiated	
Chhattisgarh	60092	60092 (100%) Mitanins trained in Module 1 to 12.		• 52018 Mitanins (86.56 %) trained on 13th module. • 51316 Mitanins (85.4 %) trained on module 14thand 15th module • Training of trainers completed for the 16th Module	
Jharkhand	40964	39214 (95.73%)	35675 (87.08%)	40964 (100%)	• 14 State trainers trained in module 6 and 7 in Round 1 and Round 2 • Six days state TOT for 115 District Resource Persons completed
Madhya Pradesh	52393	47022 (89.75 %)	45777 (87.37 %)	42405 (80.35 %)	• 24 state trainers trained in Round 1 and 19 in Round2 • 505 district trainers trained in Round1 • ASHA Trainings started in eight districts- 2280(4.35%) ASHAs have been trained
Orissa	40948	40948 (100%)	40948 (100%)	40883 (99.4 %)	• 16 state trainers trained in round 1 and 13 in Round 2 • District Trainers selected in 13 districts and 172 have been trained • 7323(18%) ASHAs have been trained in Round 1.
Rajasthan	50287	34776 (69.15%)	45110 (89.7 %)	27470(54.63 %)	• 16 state trainers trained in Round 1 & 9 in Round 2 • 224 District Trainers trained in Round 1
Uttar Pradesh	136094	129150 (95%)	129150 (95%)	121580 (89.33 %)	#

Uttarakhand	11086	11086 (100%)	11086 (100%)	8978 (80.98%)	• Six and five state trainers trained in Round 1 and Round 2 respectively • 231 and ten District trainers trained in Round1 and 2 of 6 & 7 training respectively • 544 out of total 550 (99%) ASHA facilitators trained in Round 1 and 2(7 Days) • 10313 ASHAs trained (93 %) in 1st Round 1of 5 days • 10064 ASHAs(91%) have been trained in Round 2 of five days

= yet to begin :ASHA Module 6 & 7 have been adapted to state specific requirements and training strategy is being finalized. State has already trained ASHAs in CCSP(Comprehensive Child Survival Programme) in 35 districts

TABLE 2B : Training Status for North Eastern states

STATE	NO. OF ASHAS SELECTED	TRAINING STATUS			
		NUMBER OF ASHAS TRAINED IN			
		LESS THAN MODULE 4	UP TO MODULE 4	MODULE 5	MODULE 6 AND 7
Assam	29172	27499 (9%)	27485 (94.2%)	27186 (93%)	• 13 State trainers trained. • 153 District trainers trained in Round 1
Arunachal Pradesh	3712	3559 (95%)	3606 (97%)	3635 (98%)	• State & District trainers trained in Round 1 and Round 2 • 3566 ASHAs (92%) trained in round 1 (5 days) • Round 2 ASHA training started. • 2 Refresher training for round 1 is over
Manipur	3878	3878 (100%)	3878 (100%)	3878 (100%)	• State & District trainers trained in Round 1 and 2 • 3878 (100%) ASHAs trained in round 1 (5 days • 2886(74.4%) ASHAs have been trained in Round 2 • Four days refresher training of ASHAs in Round 1 completed

Meghalaya	6258	6250 (99.8%)	6250 (99.8%)	6250 (99.8%)	• State & District trainers trained in Round 1 and 2 • 5136 (82%) ASHAs trained in round 1 (5 days) • Round 2 training of ASHAs in module 6 and 7 is underway • Refresher training of two days for ASHAs in Round 1 completed
Mizoram	987	987 (100%)	987 (100%)	987 (100%)	• State& District trainers trained in Round 1 and2 • 987 (100%) ASHAs trained in round 1 and round 2 of 5 days each
Nagaland	1700	1538 (90.5%)	1588 (93.4%)	1690 (99.4%)	• State & District trainers trained in Round 1 and 2 • 1576 (92.7%) ASHAs trained in round 1(5 days) • 1571((92%) ASHAs have been trained in Round 2 • Three days refresher training for ASHAs completed in Module 6 and 7
Sikkim	666	666 (100%)	666 (100%)	666 (100%)	• State & District trainers trained in Round 1 and 2 • 666 (100%) ASHAs trained in a combined round 1 &2 (8 days)
Tripura	7367	7367 (100%)	7367 (100%)	7367 (100%)	• State& District trainers trained in Round 1 and 2 • 7257 (98%) ASHAs trained in round 1 (5 days) • 3500 (47.5%) ASHAs have been trained in Round 2

TABLE 2C : Training Status for Non High Focus states

STATE	NO. OF ASHAS SELECTED	TRAINING STATUS			
		NUMBER OF ASHAS TRAINED IN			
		LESS THAN MODULE 4	UP TO MODULE 4	MODULE 5	MODULE 6 AND 7
Andhra Pradesh	70700	30 days training as the programme preceded NRHM, but covered women's and children's health.			• 12 State trainers trained in Round 1 and 2 • 386 District Trainers trained in Round 1
Delhi	3716	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	28827	25597 (89 %)	24845 (82 %)	23320 (81%)	• 4 state trainers trained in round 1 and 2 • 160 district trainers trained in Round 1 • 14475 ASHAs trained in Round 1 of Module 6 and 7
Haryana	13319	*13730 (103%)	13289 (97%)	11090 (83.45%)	• 11971 (90%) ASHAs trained in a HBPNC module supported by NIPI. This module covered many of the topics of Module-6. A second phase of training will be done to cover the remaining topics. • 12 state trainers trained for Module 6& 7
Jammu and Kashmir	9700	9000 (92.78%)	9000 (92.78%)	8300 (85.56%)	• 7 State Trainers trained in Round1 and 2 • 225 District Trainers trained in round 1 • 180 ASHA Facilitators trained in module 6 and 7
Karnataka	33750	Up to Module 5 - 33750 (100 %)			• 15 State Trainers trained in round 1 and 2 • 240 District Trainers trained in round 1 and 2 • 9500 ASHAs have been trained in a combined ten days training of Round 1 and 2
Kerala	31868	28205 (88.5%)	25673 (80.56 %)	18431 (57.83 %)	• NA
Maharashtra	59289	52638 (88.78%)	22022 (37.14%)	8761 (14.77%) Module 4 & 5 – Not done in Non- tribal districts	• 17& 15 state trainers trained in round 1 and 2 • 322 District trainers trained • Additionally-47 BCMs and 893 Block Facilitators trained • 6318 ASHAs trained in Round 1 (of 5 days) • 460 ASHAs trained in Round 2
Punjab	16753	16214 (96.78%)	16214 (96.78%)	16214 (96.78%)	• State trainers and 70 District Trainers trained in Round 1

Tamil Nadu	2650	1639 (62%)	1639 (62%	1639 (62%) Module 1-5 trainings done only in tribal districts	
West Bengal	44841	40692 (90.75%)	33539 (74.8%)	32277 (71.98%)	• 17 and 13 State Trainers trained in Round 1 and round 2 respectively • 122 District trainers trained in Round 1 • 727 ASHAs trained in Round 1

*Some of the ASHAs have been dropped out and replaced so the figure is more than the total ASHAs selected.

TABLE 2D : Training Status for UTs

STATE	NO. OF ASHAS SELECTED	TRAINING STATUS		
		NUMBER OF ASHAS TRAINED IN		
		UP TO MODULE 4	MODULE 5	MODULE 6 AND 7
Andaman and Nicobar Island	407	100%	100%	#
Dadra and Nager Haveli	208	85 (40%)	85 (40%)	45 ASHAs have been trained in Round 1 Module 6 and7
Lakshadweep	83	#	#	#
Chandigarh	423		#	#

SECTION 3.3: SUPPORT STRUCTURES

BOX-3 SUPPORT STRUCTURES AS PER GUIDELINES ON SUPPORT MECHANISMS FOR ASHAS[1]

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

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

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

1 http://mohfw.nic.in/NRHM/asha.htm#support

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. Some members of the mentoring group have also been represented on the High Level Expert Group and the Working Group on NRHM for the XII Plan. 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 (Tables3A to 3D) has expanded rapidly in the past year, as states have increasingly become cognizant of the necessity of a strong support structure to enhance the community processes component.

Most 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 Centres, 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 up to the block level.

ASHA facilitators were 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. Most of the High Focus and North East States have now engaged ASHA facilitators. 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.

Status of Drug Kit Distribution in the States:

Drug Kit was to be given to all ASHAs on completion of Training in Module 1. All the states have distributed Drug Kits to most of the ASHAs except Haryana which has not done it as yet. Rajasthan and Kerala are in the process of completing this distribution.

Regular annual replenishments is being done for all North East and in Chattisgarh, Orissa and Uttarakhand.

Among the Non High Focus states annual replenishments is done in Jammu and Kashmir, Punjab, Maharashtra and West Bengal.

TABLE 3A : Status of ASHA support structure in High Focus States

STATUS OF SUPPORT STRUCTURE FOR ASHA

HIGH FOCUS STATES	STATE LEVEL	DISTRICT LEVEL	BLOCK LEVEL	SECTOR LEVEL
Bihar	AMG constituted and meeting held quarterly ARC established Four Divisional ASHA Coordinators are placed	23 out of 38 DCMs and 31 out of 38 DDAs are in place.	421 out of 504 BCM are in place.	3463 out of 4150 ASHA Facilitators (one per 20 ASHA)
Chhattisgarh	ARC is working under SHRC AMG yet to be formalized. 30 State field coordinators are in place	438 DRPs placed in 18 districts	BCMs in all blocks 3000 BRPs in 146 blocks	Mitanin trainers in place. (1 per 20)
Jharkhand	AMG constituted and meeting held regularly VHSRC established under SHRC	24 DCMs in place	850 Block Trainers trained	2157 Sahiyaa Saathi selected and trained. (1 per 20 Sahiyas)
Madhya Pradesh	AMG merged with MGCA to from MGCA MGCA members allocated districts for monitoring and handholding State Nodal officer and team of six consultants for ASHA appointed. ARC is under the process of notification	DCM placed in 7 districts Training of District MGCA members is underway.	Existing staff	Existing staff
Orissa	AMG constituted CPRC in place	AMG constituted and meeting held regularly DAC in place	Existing staff	1152 sector in-charge to facilitate monthly meeting of ASHAs
Rajasthan	AMG constituted ARC moved to SHSRC, with ED (SHSRC) being the in-charge of ARC	DAC posted in all 34 districts	119/ 237 selected BAC are in place	1321 PHC ASHA Supervisors (1 per PHC)
Uttar Pradesh	AMG constituted and meeting held regularly No ARC, programme management done by one Nodal officer, two regional coordinators and one facilitator supported by NHSRC.	DCMs are in place. District AMG constituted	Existing staff	Existing staff
Uttrakhand	AMG constituted ARC is outsourced to NGO –HIHT	District ARC outsourced to NGOs	47 BCs placed (one coordinator per 2 blocks)	550 ASHAs facilitators 1 for 15-20 ASHAs)

TABLE 3B : Status of ASHA support structure in North East states
Status of Support Structure for ASHA

NE STATES	STATE LEVEL	DISTRICT LEVEL	BLOCK LEVEL	SECTOR LEVEL
Arunachal Pradesh	AMG constituted ARC formed	DCM and DDA placed in all districts.	Existing staff	216 ASHA Facilitators
Assam	AMG constituted and meeting held regularly ARC outsourced to Don Bosco Institute	DCM and DDA placed in all districts and managed by ARC	BFs placed in each block	ASHA Facilitators placed (One for 20 ASHAs)
Manipur	AMG constituted and meeting held regularly Formation of ARC is under way.	Formation of District ARC is underway in one district but managed by existing staff in other districts	Existing staff	None
Meghalaya	AMG formed and meetings held regularly ARC established	DCM placed in all seven districts and managed by ARC.	Existing staff	143 ASHA Facilitators (one for 15-20 ASHAs)
Mizoram	AMG formed and meetings held regularly ARC not established	Existing staff	None	None
Nagaland	AMG formed ARC functional under Directorate of Health services.	None	40 ASHA Facilitators at Block level	Existing staff
Sikkim	AMG formed ARC does not exist	Existing staff	None	68 ASHA Facilitators
Tripura	AMG formed and meeting held regularly ARC constituted	Four APMs and 11 Sub divisional Programme Managers support the programme	None	None

TABLE 3C : Status of ASHA support structure in Non High Focus states

NON HIGH FOCUS STATES	STATUS OF SUPPORT STRUCTURE FOR ASHA			
	STATE LEVEL	DISTRICT LEVEL	BLOCK LEVEL	SECTOR LEVEL
Andhra Pradesh	AMG constituted Indian Institute of Health and Family welfare designated as ARC	None but managed by Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer(DPHNO)	None	ASHA coordinators are placed at PHC level
Delhi	AMG formed ARC established	District Nodal Officer and District Mentoring Group in place.	50 ASHA Unit are in place, one unit per 100,000 population. Support to each unit through a Nodal Committee-one MOIC and 10 facilitators.	
Gujarat	AMG Constituted ARC exists	DPM for ASHA programme are placed in 12 Tribal Districts In other non-tribal districts managed through existing staff	Existing staff	650 out of 1147 ASHA facilitators one per PHC.

Haryana	AMG does not exist ARC does not exist- A team of two Medical officers and one state NGO coordinator, working under SPMU support the programme	Existing staff	Existing staff	Existing staff
J & K	ARC and AMG does not exist	None	None	None
Karnataka	AMG constituted ARC established under SHRC.	ASHA Mentors (Staff nurses with experience of Training ASHAs) have been placed	ASHA Mentors have been placed (Staff Nurses with experience of Training ASHAs)	Existing staff
Kerala	AMG formed but meetings are not held regularly ARC established under SHSRC	Existing staff	Existing staff	Existing staff
Maharashtra	AMG constituted and meetings held regularly. SHSRC functions as ARC	DCMs appointed in all districts District AMG formed in 15 tribal and 18 Non –tribal districts	Block AMG formed in 70 tribal blocks and 18 in Non-tribal blocks	926/952 facilitators (at PHC level) in tribal districts 1418/1496 (at PHC level) posted in non Tribal districts.
Punjab	AMG does not exist ARC does not exist but two consultants work with SHSRC for ASHA Programme	DCMs in all 20 districts	None	898 ASHA Facilitators
TamilNadu	The formation of AMG is in process Institute of Public Health, Poonamallee is working as ARC	Existing staff	Existing staff	Existing staff
West Bengal	AMG formed and meetings held regularly ARC outsourced to CINI	Existing staff	Existing staff	Existing staff

TABLE 3D : 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 does not exist ARC doesn't exist and SPMU manages the programme	Existing staff	Existing staff	Existing staff
Dadra and Nagar Haveli	AMG and ARC do not exist SPMU is managing the ASHA Programme	Not Applicable	Not Applicable	Existing staff
Lakshadweep	AMG and ARC do not exist Medical officer is in-charge of Island is the nodal officer for the Programme	Not Applicable	Not Applicable	Existing staff
Chandigarh	AMG and ARC does not exist Formation of SHSRC is under process and ASHA support staff will work under it PGI Chandigarh is mentoring the programme	None	Existing staff	Existing staff

TABLE 3E: Status of Drug Kit distribution in EAG states

State	Status of Drug Kit distribution
Bihar	All 100% selected ASHAs (82522) have been given drug kit once till now. Replenishment in current year under process.
Chhattisgarh	Distributed to all 60092 Mitanins (100%) on an annual basis. Refilling for current year completed.
Jharkhand	Distributed to 35000 (85.44%) Sahiyas in 2008. New Drug Kit is being distributed to ASHAs in current year along-with other IEC material and Bag and Umbrella in ASHA Sammelans, 47% have received till now. Drug refill being done on quarterly basis from PHC.
Madhya Pradesh	Drug Kit distributed once to all 52393 (100%) ASHAs . Drug Kit distribution for current year under process, replenishment is done from block PHC on monthly basis as per the demands of ASHAs.
Orissa	Drug kit distributed on annual basis. Kit sanctioned in FY 2010-11 distributed in June 2011 to all 40948 ASHAs (100%). In current FY no separate sanction for drug kit, approval given for drug replenishment from drugs allocated for Sub-centre, refill being done on quarterly basis as per demands of ASHAs.
Rajasthan	One round of Drug Kit distribution done to 38056 (76%) ASHAs. Replenishment not being done on regular basis but as per demand by ASHA from PHC.
Uttar Pradesh	Drug Kits distributed only once to 128434 (94.31%) ASHAs in year 2009-10. No distribution in FYs 2010-11 and current year. Refill of only some drugs is done as per requirement from PHC.
Uttarakhand	Drug kit distributed on annual basis since FY 2008-09. In FY 2009-10 Homeopathic Drug-kit was also distributed. Drug Replenishment from PHC level on quarterly basis as per requirement.

TABLE 3F: Status of Drug Kit distribution in North East states

State	Status of Drug Kit distribution
Arunachal Pradesh	Drug Kit distributed on annual basis, given to 29172 (100%) ASHAs in current FY. No replenishment system in place.
Assam	Drug Kit distributed on annual basis, given to 27855 (94%) ASHAs in current FY. Replenishment from PHC on quarterly basis as per requirement.
Manipur	Drug Kit distributed on annual basis, given to 3878 (100%) ASHAs in current FY. No replenishment system in place.
Meghalaya	Drug Kit distributed on annual basis, given to 6250 (100%) ASHAs in current FY. No replenishment system in place.
Mizoram	Drug Kit distributed on annual basis, given to 987 (100%) ASHAs in current FY. No proper replenishment system in place, some refill given from PHC.
Nagaland	Drug Kit distributed on annual basis, given to 1700 (100%) ASHAs in current FY. No replenishment system in place.
Sikkim	Drug Kit distributed on annual basis, given to 641 (95%) ASHAs in current FY. Replenishment from PHC on quarterly basis as per requirement.
Tripura	Drug Kit distributed on annual basis, given to 7367 (100%) ASHAs in current FY. Replenishment from PHC & CHC on quarterly basis as per requirement.

TABLE 3G : Status of Drug Kit distribution in Non High Focus states

STATE	STATUS OF DRUG KIT DISTRIBUTION
Andhra Pradesh	Drug Kit distributed once to all 70700 (100%) ASHAs, no sanction in FY 2010-11 but 8 drugs supplied from PHCs. In current FY drug being replenished on monthly basis.
Delhi	Drug Kit distributed once to 3435 (92%) ASHAs, refill being done from health centre of the area on regular basis as and when required.
Gujarat	Drug Kit distributed once to 29731 (103%) ASHAs, (it includes the drop-out ASHAs). Drug refill is being done from health centre of the area on regular basis as and when required.
Haryana	No Drug Kit distributed till now. UNOPS has been engaged to procure and supply drug kits, distribution planned to be done before March 2012.
Jammu and Kashmir	Drug Kit being distributed annually since 2007. In FY 2010-11 distributed to 9500 ASHAs, current FY not done yet,
Karnataka	Drug Kit distributed to 33105 (100%) ASHAs, refill being done from PHC of the area on monthly basis as required.
Kerala	Drug Kit Distributed to 23,350 (73.27%) ASHAs, replenishment from PHC of the area on monthly basis as required
Maharashtra	Drug Kit distributed on annual basis. In FY 2010-11 given to 58394 (98.49%) ASHAs. Replenishment from PHC as and when required.
Punjab	Drug Kit distributed annually, given twice till now. Kit sanctioned in FY 2010-11 distributed to 16463 (98.27%) ASHAs in March 2011. Replenishment from SC by ANM, needs strengthening.
Tamilnadu	Distributed to 1639 (61.84%) tribal ASHAs, Replenishment from PHC as and when required.
West Bengal	Drug Kit distributed annually. Distribution of Kits sanctioned in FY 2010-11 is on, 13034 (30.15%) ASHAs have received. Replenishment from PHC as required.

TABLE 3H : Status of Drug Kit distribution in Union Territories

Union Territory	Status of Drug Kit distribution
Andaman & Nicobar Island	Distributed to 407 (100%) ASHAs.
Dadra and Nagar Haveli	Distribute to 85 (79.43%) ASHAs.
Lakshadweep	Distributed to 85 (100%) ASHAs
Chandigarh	No drug kit distributed. ASHAs are existing AWWS.

The Chhattisgarh experience with community process components

Section IV

1. Village Health Planning

Chhattisgarh's community processes programme provides many valuable lessons for the rest of the country. The state has, over the past four years worked to strengthen Village Health Sanitation and Nutrition committees, and today it is perhaps the only state in which convergent planning of village level action on health, sanitation, nutrition and development issues is being undertaken at scale.

The development and implementation of village health plans is undertaken by Village Health Sanitation and Nutrition Committees. VHSNCs meet every month for this purpose. Apart from designated members of the VHSNC, other residents are also encouraged to participate in these meetings. The meetings are facilitated by the Mitanin Facilitator.

The focus of the monthly VHSNC meeting is to identify gaps in health and health related areas and plan to resolve these gaps. The action-plan is defined in terms of the key tasks for the community, which also includes ensuring action by government at various levels. It is not a one-time exercise of drawing up a comprehensive plan for purposes of submission to the state. Utilising the untied grant is seen more as a facilitating factor, rather than as the sole purpose of the VHSNC. The VHSNC plans focus on gap assessment and resolution in health services, health status or health related behaviour, nutrition, food security, sanitation, gender, and livelihoods. In each monthly meeting, about two or three issues are discussed and plans for resolution are drawn up.

Inputs/support for Village Health Planning

Two rounds of five day trainings are held for the Mitanin and her facilitator. This includes three days jointly with PRI/VHSNC members.

The facilitators (one for every 20 Mitanins) must attend and facilitate every VHSNC meeting under her area (which is usually about 6 VHSNCs), and the 'Fixed day plan of VHSNC meetings' is matched and integrated with fixed day plan of the facilitators.

The Mitanin and female Ward level PRI representatives are joint bank signatories (and also the perceived leaders) of VHSNC. This greatly helps the process.

The meeting process

The discussion is facilitated by a facilitator (in the Chhattisgarh case it is the Mitanin Facilitator) by asking a series of questions to the assembly, and follows these steps:

Step1 - Identifying the problem: The facilitator leads the discussion by asking the group, "what are the main (health) problems in your habitation?". Sometimes there is an answer from some members, But in some meetings, no issue gets identified this way. In such cases the facilitator starts the discussion by using the list of 32 issues. (Table 1)

Step 2 - Identifying the habitation/s where the problem is more severe: The situation (with respect to the issue identified through the above step) of each hamlet in the village is discussed in order to finalize the habitations for which action needs to be planned immediately.

Step 3 - Analysing the problem - Identifying the main cause(s) of the problem: The facilitator asks further questions to enable the VHSNC to identify the causes which need to be addressed to solve the problem. E.g. if a habitation has a big gap in immunization, the cause may be irregular VHND, distance, non-functioning Anganwadi, lack of information regarding dates of VHND or reluctance of families for immunization as it gives their children fever.

Step 4 - Deciding the solution: The solution is defined in terms of actions that the community can take to steer progress in the direction of a solution. E.g. if a habitation has a gap in immunization due to irregular VHNDs, the VHSNC may decide to talk to the concerned ANM to resolve the issue. When the related service provider is present in the same meeting, it is often the case that the service provider commits to corrective action, and the issue gets resolved.

Step 4 – Deciding who is responsible: For each action decided, volunteers are called for. They are then designated as the persons who would be responsible for leading the action on behalf of the community.

Step 5 – Deciding the time-frame: For each action, the person volunteering to lead also commits to a time-frame for taking the steps decided.

Recording the plan: The above plan is recorded in the VHSNC meeting register. HA facilitator initially helps the VHSNC in recording the plan. The plan is recorded usually in the following format:

Gap (weak aspect)	Weak habitation (where the gap is severe)	Cause of the problem	Action (that village would take)	Responsible Person (Person who volunteers to lead the action)	Time Frame (for completing the action recorded in previous column)	Review (in the next meeting – on progress made)

Reviewing the progress on items planned in previous/earlier meeting: In the subsequent meeting of the VHSNC, the progress made on the actions planned in the last few months is reviewed. In case of an action with a successful outcome, there is applause for the team and the individual in the gathering. Usually, if a VHSNC plans for three issues is a meeting, around one issue is successfully resolved in a month. In some cases, the planned action is taken but the outcome is not successful. In such cases, further planning is done to decide on the next action required to solve the issue. There are situations when the action is not even attempted. In such cases, the steps of fixing responsibility and time-frame are reviewed/re-decided. The facilitator keeps the attention of the VHSNC on the success rather than on failures. This helps in keeping the morale of the group high.

Most VHSNCs of the state have completed the training and about 1.15 lakh VHSNC members have been trained (5-6 members from each VHSNC). One block coordinator has been placed exclusively to coordinate this planning process, in each of the 70 blocks of state (of the total 145 blocks of state). As of now about 10,600 VHSNCs are regularly conducting this process of monthly village planning, and then process has reached a stage of maturity in about 5000 VHSNCs where regular meetings are held and follow-up actions are undertaken on a sustained basis. In the remainder incremental gains are being made.

TABLE1: List of issues discussed for Village Health Planning

Sl	ISSUE
1	Fully immunized children of 12-36 month
2	Ante-natal care
3	Institutional delivery (in sub-health center, primary health center, community health center, district hospital)
4	Delivery at home assisted by qualified health personnel (Doctors/ Nurse/ ANM)
5	Weighing of newborn on the day of birth
6	Breastfeeding within half an hour
7	Supplementary food to children of 6-18 months
8	Availability of chloroquine
9	Use of mosquito net
10	Effectiveness of Mitanin in Maternal Health
11	Incentives to Mitanins
12	Effectiveness of Mitanins in Neonatal and Child Survival
13	Effectiveness of the Panchayat health Committee
14	Effectiveness of Women's Health Committee
15	Stagnant Water
16	Safe Drinking Water
17	Use of Toilet
18	Anganwadi Coverage(Children from 6 months to 6 years old)
19	Midday Meals
20	Functioning of the Public Distribution System
21	Antyodaya Yojna
22	School Enrolment
23	Rojgar Guarantee Yojana
24	Malnutrition
25	Low birth weight
26	Under-Age marriage of girls
27	Spacing of birth

28	Family planning/ Access to sterilization
29	Still Birth
30	Infant death
31	Outbreak of water borne diseases
32	Malnutrition amongst Adolescent girls

2. Mitanin Welfare Fund: An Initiative for Comprehensive Social Security for Mitanins in Chhattisgarh

The Mitanin Welfare Fund or the Mukhyamantri Mitanin Kalyan Kosh (MKK) was set up by Government of Chhattisgarh for instituting measures for social security of Mitanins. The purpose of MKK is to recognize the social contribution made by Mitanins as yet another pathway to empowerment.

Consultations were held with more than 500 Mitanins in 14 meetings organized in Bastar and Sarguja divisions in April 2011, and the outcomes provided inputs for the design of the MKK. Considering the voluntary nature of Mitanin Trainers and Block Coordinators, they have also been included as beneficiaries the under MKK along with Mitanins.

Components of MKK:

The components operationalised under MKK are:

Social security support for all Mitanins

Health related Livelihoods Skills for Mitanins

Social Recognition

Social Security Measures:

The social security measures being implemented under the Kosh include:

Life insurance cum scholarship scheme coverage: It provides life insurance cover (through the Life Insurance Corporation2) of Rs.40,000 to Mitanin in event of death of the Mitanin's husband. For Mitanins who do not have a husband, the Mitanin herself has been insured. Along with life insurance, this scheme provides Rs.1200 scholarship per annum to Mitanin's children studying in classes 9-12. The premium charged by LIC is Rs.150 per Mitanin. This scheme is a combination of Aam Admi Bima Yojana and Janashree Bima Yojana of the Government of India (GOI) . It allows benefits of around Rs. 240 lakh (Rs. 168 lakh as scholarships to around 14000 children and Rs.72 lakh as insurance claim for around 180 deaths) per annum to reach Mitanins. Against these benefits, the annual cost of this entire activity is around Rs.92 lakh. The State Health Resource Center (SHRC) acts as the nodal agency for this scheme. SHRC has compiled a Mitanin Database which has been used to cover all Mitanins under this scheme with effect from 1st July 2011.

Support for education of Mitanins: Mitanins are being given cash incentives to encourage them to study further. Any Mitanin who passes Class 8 after the commencement of the scheme is awarded Rs.2,000. Mitanins passing Class 10 and 12 are elgible for awards of Rs.5,000 and Rs.10,000 award respectively.

Maternity Benefit for Mitanin Trainers and Block Coordinators: There was no provision of leave for Mitanin because they are considered as volunteers who are compensated for wage loss for each day of work done by them. Under the MKK a maternity benefit of Rs.15,000 has been included to allow maternity leave of around 6 months.

Health Insurance (RSBY) coverage to families of all

Mitanins: All Mitanins irrespective of their BPL/APL status have coverage under the Rashtriya Swasthya Bima Yojana (RSBY), with the premium for non-BPL Mitanins being borne by MKK. SHRC has provided the list of Mitanins to RSBY and the enrolment is under progress.

Emergency support: An emergency support fund has been set up under MKK for Mitanins and their families. It covers emergencies such as serious illnesses or disasters. Mitanins are being actively supported to use existing schemes of Government. The children of two Mitanins have been successfully operated for heart ailments under the CM's Heart Protection Scheme.

Free OPD care: The MKK Order includes provision of free OPD care to Mitanins (treatment not covered under RSBY) by waiving-off all charges for treatment of Mitanins in government run hospitals.

Health related Livelihoods skills for Mitanins:

The purpose of this component is to create opportunities for Mitanin to earn their livelihood through activities which contribute to better health outcomes for their communities. This would require provision of vocational training and facilitating the required linkages. Mitanins have suggested a number of skills in which they would like to get trained. The thematic areas around which the trainings are being designed are:

Health related enterprise – Manufacture of sanitary napkins, cultivation of Ayurvedic herbs, sale of bednets etc.

Food related enterprise – Vegetable cultivation, Mushroom, Piggery, Systemic Intensification of Rice etc.

Social Audits of Government Programmes – A training programme is being designed to train 1-2 Mitanins per Gram Panchayat as Facilitators for Social Audits of Government programmes like NREGA, PDS, ICDS, JSSK, Community Audits of deaths related to Fever, Diarrhea or Child deaths. This will not only help in building stronger accountability in social sector programmes of Government but also in raising the stature of Mitanin. The first draft of the training module is ready. Two resource persons from SHRC have attended a national training on Social Audits at National Institute of Rural Development, Hyderabad.

For the above training and linkage activities, suitable NGO partners are being identified by SHRC.

Support Structure for MKK

A state level steering committee has been formed under leadership of the Health Minister of Chhattisgarh. SHRC has been given the responsibility of handling day to day operations of MKK. MKK is being operationalised by a MKK cell set up by SHRC. The MKK funds are being handled by SHRC through a separate bank account.

Budget

The average annual budget requirement is around Rs. 4 Crores. Currently, funds have been pooled from EUSPP and State Budget for this purpose. Some components of MKK (Life Insurance, Education Incentive) are being proposed to be funded under NRHM.

1. *The material for both studies was contributed by Sameer Garg from the State Health Systems Resource Center, Chhattisgarh*
2. *India's largest public sector insurance company*

ANNEXURE: Abbreviations and equivalent terms

ABBREVIATIONS
AMG – ASHA Mentoring Group
ARC- ASHA Resource Centre
APM - ASHA Programme Managers
BC- Block Coordinators
BCM- Block Community Mobiliser
BF- Block Facilitators
BPM- Block Programme Manager
BAC- Block ASHA Coordinators
CPRC- Community Processes Resource Centre
DCM- District Community Mobiliser
DAC - District ASHA Coordinators
DNO- District Nodal Officer
DDA – District Data Assistant
DPM- District Programme Manager
DRP – District Resource Person
MGCA- Mentoring Group For Community Action
SHRC – State Health Resource Centre
VHSRC- Village Health Sahiya Resource Centre

NATIONAL RURAL HEALTH MISSION

Ministry of Health and Family Welfare
Government of India, New Delhi