**National Consultation of Mentoring Group for ASHA**
**National Institute of Health & Family Welfare, New Delhi**
**16th May, 2008**

National Consultation of the Mentoring Group for ASHA was held on 16th May'08 at National Institute of Health and Family Welfare (NIHFW), New Delhi under the Chairmanship of Mr. Amarjeet Sinha, Joint Secretary, Ministry of Health & Family Welfare (MoHFW), Government of India (GoI). The meeting was attended by the members of the ASHA Mentoring Group, officials from the Ministry of Health & Family Welfare, National Health System Resource Centre and also invited officials from NIHFW, GoI. The participants list is at annexure-I.

Mr. Amarjeet Sinha, welcomed all the participants. He informed that Empowered Committee on NRHM has decided to extend the ASHA intervention all across the country and it is expected that in the next meeting of the Mission Steering Group (MSG), the decision taken by the empowered committee will be ratified. He also highlighted some issues on which he sought the mentoring group opinion: Adequacy of ASHA training and integrated compensation package for ASHAs; Mr. Amarjeet Sinha shared with high concern the alarming situation of child malnutrition in the country. He wanted suggestions from the Mentoring Group members for addressing the child malnutrition issue. He congratulated CHETNA, for designing the fifth training module of ASHA. He suggested that the cascaded training design of ASHA is highly time consuming and even results high transmission loss and suggested that large scale NGO involvement could be useful for alternative approaches.

Dr. Thelma Narayan, from Center for Health and Equity, Bangalore said that the meeting the ASHA mentoring Group has to be more frequent so that all the members as a group / team can deliver, what they are expected to contribute to ASHA scheme nationwide. Dr. Alok Mukhopadhaya from VHAI highlighted that different committees under NRHM have to work more in synergy so as to get expected result. The District level management and the PHC level management has to be strengthened in the process, in terms of effective program management otherwise after few years there will be no support system and thus no one will be there to handhold ASHAs. He also suggested about streamlining the existing infrastructure instead of creating new infrastructure. The state should be given more liberty to implement the program in the way the state system is comfortable with. Another member suggested that the Regional Resource Centre for NGO intervention can be the state ASHA Resource Centre and the Mother NGOs (MNGO) can be the District ASHA Resource Centre.

Dr. I. P. Kaur, Deputy Commissioner (Training) made a presentation on the status of ASHA in different states. This presentation was followed by the presentation of Dr. Manoj Kar, Advisor,

Community Participation, NHSRC on the highlights of issues related to ASHAs in different states. The major issues presented as specific to different states were;

- Procurement of Drugs for ASHA Drug Kit and timely replenishment of drugs;
- Integrated Compensation template for ASHA;
- Development of ASHA Activity Calendar and ASHA Diary;
- Initiation of Monthly Review of ASHAs at PHC level;
- Orientation of Gram Sabha and VHSC on effective linkage with ASHA support system;
- Preparation of comprehensive training calendar;
- Formation of ASHA Resource Centre (ARC) and state specific TOR for ARC;
- Timely availability of information and guidelines/office order at grassroots;
- Ensuring effective engagement of NGOs in ASHA support system;
- Constitution of the ASHA Mentoring Group and convening of state level meeting
- Untimely availability of JSY payments

Ms Angami, another member wanted that for northeast states at the regional level there should be one ASHA Resource Centre instead of going for ASHA Resource Centre at each and every state of northeast. She also proposed to hold a regional level meeting of ASHA Mentoring Group for northeastern states so as to discuss issues related to ASHAs in the northeast and to draw up a road map clearly for intervention of ASHA as issues specific to each of these states. It was decided that the RRC-NE can organize such regional level workshop, where members of the national ASHA mentoring Group can also invited to attend. Book 5 of the ASHA series had been published by CHETNA and this was released formally on the occasion. All members appreciated the effort. CHETNA agreed to provide the training of state level trainers for this book 5.

Thereafter, a presentation was made by Mr. Shyam Ashtekar on ASHA Program in Uttar Pradesh. He noted that most ASHAs were not getting compensation in time. He also mooted constructing a four component compensation package for ASHAs. His presentation was followed by the presentation of Dr. H.Sudarshan on the progress of ASHA in Arunachal Pradesh. For Arunachal Pradesh, he strongly advocated for fixed honorarium + performance based incentive. The next presentation was made by Dr. Nupur Basu Das from CINI, Kolkata on the ASHA progress in West Bengal and in Jharkand. Dr. Thelma Narayan while making presentation, on her field visit experience at Madhya Pradesh, called for role clarity between dai, ANM and ASHA, which is leading to considerable problems. ASHAs have hardly any place to stay at CHC once they bring pregnant mother for institutional delivery. Dr. Nargese Mistry, from FRCH, another member while sharing her experience of Maharastra said that selection of ASHA was done by both sarpanch as well as by the community in the state. The training quality is a major concern for

the state. There was long gap between the ASHA training and the ASHA gets in to her practical work, which has been affecting the program. The NGOs, which does not have much experience of working in the health sector should not be entrusted with the responsibility of training ASHAs, she opined. The NGOs, which have experiences of working in the health sector, should be given this job of training ASHAs. Ms. Seema Gupta, sharing the experiences of Jammu & Kashmir said that in the state, ASHA selection has been poor . Training quality is another gray area. Most Health Centers are not in a position to handle delivery, and so cases are sent at district hospital and in that case ASHA can not escort the mother and thus she does not get any incentive, which de-motivates her. Dr. Sharad Iyengar, from ARTH, Rajasthan, said that ASHA (in Rajasthan state they are called ASHA Sayhogini) have been contributing a lot in Janani Suraksha Yojana. Dr. Iyengar suggested that out of the total ASHA budget, at least 15% - 20% of the budget should be used for effective supervision and monitoring. The university, institution, NGOs of repute can be given the responsibility of ASHA support system. The guidelines, which are issued from Government of India about state / district / block level support system have not yet reached or been implemented.

Dr. Sundararaman, Executive Director, NHSRC, drew the attention of the members to the regular monitoring of the processes being put in place in each state and sought the help of the members in taking this forward. It was important to put the support structure in place within three months and get the first 20 days training completed within the next six months.

He also outlined the fellowship programme initiative that many NGOs in the mentoring group were taking up. This was a programme of strengthening NGOs who have been involved by the state in various community participation programmes of the NRHM. SEARCH, CHC, PHRN, FRCH are some of the NGOs who are raising funds from NGO funding agencies to recruit and support fellows who would work with the NGOs. Agencies approached by these NGOs, for funds included Tata trusts, ICCHN, Mac Arthur Foundation, etc. The role of the NHSRC would be in facilitation- in locating funding sources, in finding and training fellows, in helping them locate with suitable NGOs etc and to the extent that mentoring group members found it useful, this could be formalized. However there is no funding from government or funding to NHSRC for this purpose. This is a parallel stream of strengthening capacities in NGOs to respond to the opportunities that NRHM provides. Currently no NGO had as yet started this, and it was only an idea being developed. The NHSRC would discuss the possibilities of this with each mentoring group member.

Dr. Arun Gupta, representing ‘Breast Feeding Promotion Network of India’ to the meeting shared his work experiences to popularize breast feeding in the selected districts of Uttar Pradesh. Also, he requested all members of the ASHA Mentoring Group to give priority to the

exclusive breast feeding. Dr. Abhay Bang while sharing his observation stressed that the ASHA program is the 2nd biggest program in terms of workforce engagement after the barefoot doctor program of China. So, the program has to be planned fully designed to make the intervention successful. One positive thing about ASHA program, which he shared, was that at the community level ASHAs have generated hope and creating hope by ½ million workforce is undoubtedly an achievement to be lauded. The need of the hour is to re-define the vision of the ASHA program after 2 years of starting the program. The role specifications on re-defining of ASHAs are also very important, he opined. Dr. Bang advocated for increasing the number of training days for ASHAs from 23 days per year to 150 – 180 days over a period of 3 – 5 years. Present perspective of seeing ASHA as lowest strata, as functionaries of health delivery system have to be changed. Presently, ASHAs are contributing to mainly in the JSY, immunization and certain vertical program implementation but the community's need is wide and they follow more than these few services. Dr. Bang proposed that the ASHAs should be in the job of sick child treatment also since if any villager is asked to prioritize the need then the person would normally say that treatment of sick child is priority and not the immunization.

Mr. Amarjeet Sinha thanked all the participants for their suggestions as forwarded by different members and stressed about necessary attention will be considered while framing any guideline on ASHA intervention and NHSRC would act as a supportive agency for pushing forward of these suggestions strategically.

It was decided that in between formal meetings of the mentoring group, a technical advisory group could meet, which could discuss and decide on specific programme improvement measures. The same afternoon some members would stay back to initiate this process, but an early meeting of the technical advisory group supported by an e-group should be initiated soon by NHSRC.

The post lunch session began with the identification of key issues for follow up. Four of these – the functioning of the mentoring group, the payments issue, the fellowship programme and accreditation of ASHAs and itself was taken up for discussion.

For effective coordination among ASHA Mentoring Group members, it was decided that the NHSRC would create an e-group to facilitate effective coordination on a regular basis. E-group can be useful for all the members so as facilitate more active interaction on ASHA specific issues, strategies or decisions regarding the suggestions of the Mentoring Group. While informing the function of the secretariat of the ASHA Mentoring Group, Dr. Sundararaman said that the secretariat is supposed to release T.A. & D.A. of the members, calling the meeting, giving information about the meeting to the members with at least 15 days prior notice,

clearing house function for repository of resources and specific documentation support etc. Dr. Indu Kapoor, from CHETNA suggested that the meeting needs to be held on rotation basis at different places. Dr. Iyengar suggested to call for a special meeting of ASHA Mentoring Group at any northeastern state so that the northeastern states do not feel alienated from the mainstream intervention. Ms. Angami suggested that in the ASHA Mentoring Group meeting few ASHAs should be asked to attend to share their feelings from their respective village. The following were agreed to:

a> Starting up of an e-group.

b> Regular meetings of the mentoring group.

c> One meeting for the NE to be held in the NE.

Dr. Shyam Astekar, suggested a four fold model of ASHA incentive (1) task based incentive- the same as available now, (2) Retainer ship fee of ASHA to be paid by the VH & SC (may be 25% of the average earning of ASHA may be paid), (3) earnings from health insurance, (4) Service cost recovery i.e. the family, which will avail services through ASHA will pay a token amount to ASHA and for that a coupon scheme can be thought of. Dr. Shyam Astekar further opined that the ASHA program should not be state dependent, it has to be owned by the community and as a visible out put of community ownership, community can give a token amount to ASHA for seeking services from her. Dr. Sundararaman said that whereas on three of the points there would be consensus, on point 4, this could be viewed as user fees and privatization and could create a division of opinion in civil society support which was critical to the outcomes of the programme. It was suggested that a sum of Rs 200 to 300 per month from the VHSC could be earmarked for ASHA payment to make a beginning and this could be against a simple list of activities that the ASHA would carry out and that the VHSC would monitor. The NHSRC would prepare a draft proposal for this.

On fellowship programme, Dr. Thelma Naryan suggested that the NHSRC should take up this on priority and get in touch with different donors to get funding support. Dr. Thelma also stressed that the fellowship program should not only work on ASHA program but also it should work on entire communitization process involving VHSC, PRI and Untied fund etc. The objective of the fellowship program is to transform learning / energy of good NGOs / donors (which are mostly functioning in non EAG states) from non EAG states to EAG states and in the process number of NGOs, which understand public health in true sense will increase and that will help in ensuring better program implementation as well as effective involvement of NGOs in program management. The NHSRC should formally facilitate this and the NGOS involved in this should meet and plan the programme in a coordinated manner. Dr. Sundararaman shared that it is expected by July'08 the fellowship program would start. And that Mr. Arun Srivastava , NHSRC has been asked to be the contact person for the follow up on the fellowship

program so that the program can be started forthwith. By July all mentoring group members would be contacted for this programme.

Dr. Abhay Bang also suggested that after training all the trained ASHAs should go to an accredited training centre, where ASHAs will have to undergo competency test and if ASHA pass out the test then ASHAs will be given more training incentive and if ASHA fails to perform up to expected level then she would not get the training incentive. Dr. Manoj Kar, Advisor, NHSRC has been given the task of finding out institutes, which are ready to join the ASHA program for accrediting ASHAs. In this context, commissioning of a feasibility study is suggested and the entire process would take 3 – 4 months to complete and suggest necessary steps to follow up the recommendations. Dr. Syham Astekar, also volunteered that within 5 – 6 days, a concept paper on accrediting ASHAs would be submitted, which will carry preliminary information regarding names of the institutes, which can accredit ASHAs. The NHSRC can work on the concept paper and can finalize the concept paper to commission the study. Dr. Shyam Astekar suggested the use of multimedia in ASHA training as an effective learning package. Ms. Angami proposed to carry out study on 'ASHAs in-effectiveness', which she said may be due to two reasons, (1) lack of support from the community in ASHA functioning and (2) lack of support from the health delivery system. So, to know the in-effectiveness of ASHAs, it is equally important to understand what has made an ASHA in-effective and once the root cause is known then proper action can be taken to improve the situation. If, an ASHA is found in-effective, then throwing out that ASHA from the system is not the answer, rather handholding for those types of ASHAs has to be strengthened, she explained.

A proposal for accrediting ASHAs would be developed and brought before the technical group meeting of the ASHA mentoring group and then to the mentoring group.

**Summary of action points/decisions for follow up:**

**ASHA Mentoring Group-**

- Creation of e-group of national ASHA Mentoring Group NHSRC to facilitate continuous interaction of the members
- NHSRC will play the role of Secretariat support for national ASHA MENTORING GROUP. It will also facilitate state visits of the mentoring group members.
- Meeting of national mentoring group with tentative agenda has to be informed 15 days in advance of the commencement of meeting to the members.
- Separate regional level ASHA Mentoring Group may be convened for NE states with the support of NE-RRC.
- Some selected ASHAs could be invited to participate in the mentoring group meeting to share their direct information on ASHA implementation in the respective states.

- Technical Advisory Group consisting of various sub-groups on selected themes/issues can be convened and sharing of their suggestions can be discussed before the national ASHA Mentoring Group meeting. This could be a one or two day workshop which would then feed into the ASHA mentoring group meeting where the Mission Director or Joint Secretary is present.

**Compensation/Incentive-**

- Payment of ASHA could be made from VHSC fund to ensure her accountability with the community than the usual health administration system.
- Information about integrated compensation package with the mentioning of 'incentive attached to specific services', should be made available to all ASHAs
- Payment modalities can be arranged from village funds, both performance based for specific tasks, and on monthly basis for certain specified routine work.
- Standing advance with ASHA to meet the expenditure of transport for institutional delivery.
- Arrangement for stay of ASHA when they escort the pregnant woman to the hospital needs to be made. More attention given to cases referred by her, especially to give her a feedback.

**ASHA Fellowships-**

- Interaction with selected and potential donors and NGOs will be followed up b NHSRC
- Focus of fellows' activities would be on entire gamut of communitization than ASHA only.
- Every mentoring group member would be briefed about the programme and this could be discussed further in the technical advisory group.

**Accreditation for ASHAs-**

- Preparation of background document on Accreditation
- Discussion with IGNOU and selected State Universities and National Open School on accreditation.

**Training of ASHAs-**

CHETNA would arrange to provide the training of trainers at the state level for book 5.

**Accelerating Progress of the programme:**

Priority would be given to starting up the support structures in the state and the mentoring group members' help for this would be taken. The training on first five books should be completed in most states by the end of the year, if not earlier.

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**National Consultation of Mentoring Group for ASHA**
**National Institute of Health & Family Welfare, New Delhi**
**16th May, 2008**

**Annexure I**

**LIST OF PARTICIPANTS**

| S. no | NAME & DESIGNATION | OFFICE ADDRESS | OFFICE PHONE | RESIDENCE PHONE | E-MAIL ADDRESS |
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| 38. | Mr. S. C Garg | NIHFW Staff (RCH) | | | |
| 39. | Dr, Y L Takere | NIHFW Staff | | | |
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| 44 | Mrs. Renuka | NIHFW Staff (RCH) | | | |

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| 45. | Mr. Anant Vijay Singh | DLHS (RCH) NIHFW Staff | | | |
| 46. | Dr. Rajni Bagga | NIHFW Staff | | | |
| 47. | Dr. Khan | NIHFW Staff | | | |

No. of Participants as per Categories –
Ministry (MOHFW) – 4
ASHA Mentoring Group Members – 10 (Excluding Dr. T. Sundararaman)
Special Invitee to AMG – 2
NHSRC Team - 10
NIHFW Team – 20
AMG members' organization team member – 1 (from VHAI)

**Annexure – II**

**Issues before the Technical Advisory Group (sub-committee) of the Mentoring Group –**

(A) Expediting training schedules & ensuring quality of training.
(B) Addressing ASHA dropouts & assessing functionality of ASHA
(C) Drug Kits
  – Issues in organizing the kits
    - Issues related to refill of kits
    - Need to emphasize refilling of kits rather than repeated distribution of kits
(D) Payments:
  - Methods to streamline incentive payments
  - Other suggestions for enhancement etc.
(E) Role and Formation of ASHA Resource Centre and Regional Resource Centres – Overlaps and synergies, creation of this centre
(F) Strengthening NGO capacity to contribute to
  - NRHM / NGO program
  - ASHA support group with NGOs at block and district level
  - ASHA fellowship program
(G) Integration with neonatal and child survival priorities. Developing state specific focus, including development of state level training method.
(H) Accreditation of ASHAs

**N.B.-** ***All members of the Mentoring group would be invited for the technical advisory group meeting.***