Minutes of the meeting of the National ASHA Mentoring Group (NAMG)
National Health Systems Resource Center (NHSRC), New Delhi
Wednesday, April 7, 2010

The sixth meeting of National ASHA Mentoring Group was held at NHSRC on April 7, 2010 (Annexure 1). Dr. T. Sundararaman, Executive Director, NHSRC, welcomed the participants. Dr. Rajani R Ved, Advisor, Community Processes (CP), NHSRC, shared the day's agenda. (Annexure 2). The minutes document the highlights of the discussions and key decisions taken during the meeting.

I. Update on the ASHA program

Mr. Nongyai, NHSRC presented the current status of the ASHA programme on key parameters; selection and training of ASHA, support structure and drug kit distribution. Dr. Thelma Narayan stated that while quantitative data was useful, presentation of qualitative data would illustrate the strengths and challenges of the programme. Dr. Rajani Ved informed the group that NHSRC was planning a bi-annual ASHA update report. The first of this series was published in October 2009, and the next one is due in April 2010. The ASHA update report would include numerical parameters as well as brief reports on the ASHA/CP programme in each state and highlight strengths and challenges.

Dr. Dinesh Baswal, Training Division, MOHFW, informed the group that the Ministry was now keen on enabling the creation of ASHA support structures in all states. He said that although operationalization takes time, ASHA Resource Centers need to be set up and block facilitators need to be recruited. He also shared the major issues discussed during the ASHA consultation called by Secretary, Health on December, 4, 2009 at the MOHFW. Among the highlights of the meeting were: the development of effective training, support and supervisory structures, clarity on the role of ASHA which would now include the provision of first contact care in addition to a mobilization role, and the development of measurable indicators. He also said that the MOHFW was considering the inclusion of Male Health workers in the programme. The view of some of the members was that even if more workers are required at the village level, addition of more human resources should be done after a rational HR plan was made. He also said that in some states there was confusion on roles between the ASHA, AWW, and ANM and in some states such as Madhya Pradesh, the Dai. Clarifying roles for each worker was needed. He informed the group that the MOHFW had identified 235 poor performing districts (based on RCH indicators) for which priority action was needed to review and strengthen the status of ASHA programme. Of the 235 backward districts, 125 districts have been identified as those requiring greater focus. In addition he spoke about the follow up action being undertaken in relation to the role of ASHA in social marketing of health products. Some of the AMG members who were also present at the December 4 meeting took exception to this and said that the consensus was that ASHA was not be seen as a mechanism for the distribution of products like sanitary napkins procured centrally. Their voluntary participation in marketing locally manufactured sanitary

napkins, is one thing, but to be sales agents for centrally procured goods would change the character of purpose and her local image. After discussing these notes with suggestions were endorsed by the group. The members were requested to write directly to the Ministry on this issue.

II. Preliminary findings from the ASHA evaluation

Dr. Rajani Ved made a presentation on framework and design of ASHA evaluation, and the preliminary findings from ASHA evaluation phase-1 in 8 states; Assam, Andhra Pradesh, Bihar, Jharkhand, Orissa, Rajasthan, Kerala and West Bengal. The evaluation has three Phases. Phase I aims to understand the programme narratives as understood by systemic functionaries based on the variations of contexts, mechanisms and outcomes, the underlying rationale of the realist mode of evaluation. Phase II aims to generate quantitative data on the programme through the interviews with the ASHAs, AWW, ANM, PRI members and beneficiaries (mother with children less than 6 months, and mothers with children 6 months to 2 years of age). Findings from Phase I and II would be consolidated, and in Phase III, this information would be shared with different stakeholders at the state level. Several AMG members had formed part of the evaluation and were able to clarify some of the evaluation findings. The evaluation approach and progress were discussed in detail and enclosed. The report would be ready by May end and would be discussed in the next AMG.

III. Presentation by AMG members and inputs by JS (AS)

Dr. Nerges Mistry, FRCH presented the findings from her visit to Uttarakhand. She said that NGOs involved in the ASHA programme, were overburdened with commitments, with a mismatch between infrastructure and resources. It appears that drop out could be to the extent of 15%. ASHA facilitators are being recruited. Some of the concerns that she shared includes; disjoint between SHSRC and ARC, weak infrastructure and limited HR, and parallel contracting between Futures Group, and other agencies.

Mr. V.R. Raman, presented an update on the Sahiyya programme in Jharkhand. He explained the progress on setting up of VSRC in Jharkhand and the development of different training modules, such as Sahiyya leadership module and VHSC training module. Challenges to the programme include ensuring proper fund flows, regularity of payments, and strengthening the mobilizational role of the Sahiyya. Another issue of concern is that the signatory authority of ASHA in VHSC has been removed.

Dr. Nupur Basu made a presentation of the status of the ASHA programme in West Bengal. Of the 27,000 ASHA training is ongoing, and 1350 trainers have been created so far. CINI is the training resource center.

Shri Amarjeet Sinha, JS (Policy), MOHFW made the following points

- There is an urgent need to reassess and strengthen the communitization aspects of the programme. He also said that it was important to situate ASHA vis a vis support structures, VHSC and Community monitoring.

- The Ministry is committed to ensuring this and a key step is in ensuring funds to the states by providing funds in PIPs of all states on community processes and community monitoring. Regarding the ASHA support systems, the budget allocations have increased in the PIPs.

- In enabling the community processes component, NGOs have a major role to play. The MOHFW with support from NHSRC is developing guidelines for various sub schemes for NGOs to support this. He also stated that the present MNGO scheme was also being modified. He requested NHSRC to share the draft guidelines with the AMG members for their inputs.

- ASHA cannot survive only as an activist and over time, her role needs to transition into that of a service provider and adequate capacitation and support was necessary. 'Home Based New Born Care' and tackling malnutrition were some of the key issues on the Ministry's agenda.

- Currently the Population Foundation for India (PFI) served as the secretariat for the Advisory Group of Community Action (guidance and policy oversight to the community monitoring, *inter alia*). Since community monitoring was part of the broader community processes component, and the mandates were similar, the Ministry was considering merging the AGCA with the AMG and having NHSRC serve as the secretariat.

- Payments to the ASHA both in terms of mechanisms and tasks were areas that needed review and modifications. The NRHM implementation framework had mandated that the ASHA would be paid by the community but the current reality was that payments were being made at the level of the health system, mostly because VHSC are only now becoming operational and that too in a few states. He also explained that currently there are 78 tasks proposed by states for which ASHA could potentially receive incentives. Wherever possible states should move to the model of the VHSC making payments and in particular emphasized the role of elected women representatives in making the payment.

Response of AMG members on various issues related to the points:

ASHA Payment: Dr. Antony said that while getting the VHSC to pay the ASHA was a form of strengthening local ownership, male panchayat members deemed it a "favour" to give the ASHA her due. He suggested that the payment be divided into two categories- tasks such as mobilization, health education, and enabling community participation at VHND

could be paid for by the VHSC and "health related functions such as JSY, smear preparation, sputum examination, and home based newborn care, to be paid by the health system. Dr. Abhay Bang raised the issue of incentive payment to ASHA for motivation for institutional delivery. He felt that since there was now widespread community awareness ASHA incentive could possibly be discontinued. Another point of view was that since there was substantial support for fixed payment for ASHA and many states were actually doing this, a "blended" alternative could be considered. This could include making a fixed payment from the VHSC and making the performance based incentive payment through the health system. There were apprehensions in the group that operational feasibility of such a mechanism needed to be tested through a few pilots. However the payment through Mahila Panch found favour. Dr. Vandana Prasad raised the concern that competition for incentives between cadres of workers was a challenge.

Support Structures for ASHA: Dr. Thelma Narayan was concerned that while so much was being made of support for the ASHA, there was little effort at providing mentoring and support to the frontline worker- ANM and PHC staff. There is a need for orientation workshops on behavioral aspects of staff at health facilities such as DHs, CHCs, and PHCs. Ms. Shilpa Deshpande observed that since ASHA was serving as a bridge between the community and the health system, there was a danger of the health providers retreating into facilities, and not engaging with communities. Another mechanism that was proposed to strengthen ASHA support structure was a grievance redressal mechanism for her to be institutionalized by all states. Some states like Assam already have this in place. Several participants observed that the amount of funds budgeted for the support structure needed to be increased from the current Rs. 3000 to Rs. 20,000. Dr. Bang observed that while an ANM was paid over Rs. 12,000, a block facilitator was paid Rs. 3000, and the disparity was wide.

Pace of ASHA programme and implications for working in backward districts: Dr. Vandana Prasad said that the pace of training, drug kit distribution and replenishment was very slow in most states. It was urgent to prioritize task and fast track the programme in the backward districts. Dr. Prasanta Tripathy also emphasized that we need to have definite time frame and prioritize actions in the backward districts.

Convergence between ASHA, PRI and NGO programmes: Ila Vakharia of Chetna raised the issue of convergence between the MNGO/RRC programme and the ASHA programme and said that while it was taking pace in some states, in most states this was not happening. She also said that the last RRC meeting was held over three years ago and there appears to be little support for the MNGO scheme. Participants raised the issue of building capacity of PRI if they are to play an active role in VHSC and ASHA programme. In this context the methodology of training was also discussed. The possibility and importance of using audio visual aids and e-learnings in ASHA training was discussed. Involvement of nurses was also to be prioritized. The Nursing Council needs to be involved in training of ASHA as the training is expanded to include skills and competencies. The urgent need of finishing back

log training, and establishment of ARCs in all the states was also highlighted by the AMG members.

IV. ASHA training beyond Module 5 (discussion on Modules 6 and 7) and note on measurable outcomes.

The ASHA modules 6 and 7 were placed for discussions. Few states such as Uttar Pradesh and Rajasthan had already initiated training on these topics through some of the development partners, such as NIPI and UNICEF. NIPI was rolling out a five day module on newborn care in three districts in three states. In Uttar Pradesh, the National Child Survival Support Programme was being rolled out with the support of partners such as MCH Star, JHPIEGO, and UNICEF. Chattisgarh too had focused on this.

Several AMG members had sent comments on the modules. Some members felt that the modules were timely and provided the type of input to ASHA which they now required. Some felt that given the wide variations in the states, (particularly in some of the high focus states) issues such as ASHA readiness for these modules, trainer availability, and availability of appropriate training aids, would need to be addressed before scaling up. Participants suggested inclusion of chapter in counseling, real life success stories of ASHA, revisions in the chapter on infectious disease (TB and Leprosy), role of ASHA in treatment compliance and in improved home care practices, including complementary feeding. Members also observed that to roll out these modules, training/support structure in the state like ARC and established training team at all level, and field training sites were preconditions. AMG members felt that these modules may be more easily roll out in states where support structures for training are effective. Dr. Rajani Ved clarified that the revised modules would be circulated soon. Trainer modules would also be developed.

Dr. Abhay Bang shared the trainer modules for HBNCC that were developed by SEARCH on GOI's mandate. He also the visual aids, communication material, and a booklet of inspirational stories about women workers who worked on HBNCC. It was also decided that while basic technical content in the modules should be standardized, to broaden the ownership, states should decide appropriateness of training aids and communication material kit, and case studies, in their contexts.

V. Role clarity and measurable outcomes

The note on role clarity of ASHA, (given the shift in role to a provider of first level care) and measurable outcomes of ASHA program was shared with all. The note was endorsed except for the payment issue. As far as financial package/incentives for ASHAs are concerned, it was suggested that ASHA may be given a fixed amount for other activities and in addition incentives for JSY and immunization. For other tasks, an adequate incentive should be provided to

compensate for wage loss. Dr. Sundararaman requested participants to send in their feedback based on which the note would be revised.

VI. Follow up actions to the AMG

1. NHSRC to finalize ASHA modules, NGO guidelines and measurable outcomes note after receiving further comments/inputs from members and circulate.
2. Completion of ASHA evaluation and circulation of report.
3. Next AMG meeting focus on assistance to poor performing districts.
4. Continue providing state visits to strengthen ASHA programme.
5. Finalization and release of progress report on ASHA programme.

Annexure-1: List of participants

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Annexure 2: Agenda

Agenda for National ASHA Mentoring Group Meeting
National Health Systems Resource Center (NHSRC)
Wednesday, April 7, 2010,
Time - 9:30 am to 6:00 pm

Issues for discussion

1. **Update on ASHA programme**
    - Annual report on progress of ASHA program
    - State level issues
    - Measurable outcome for ASHA program

2. **Preliminary findings from ASHA evaluation**
    - Evaluation design
    - Phase 1 findings from state level evaluations
    - Perspectives of AMG members on the evaluation
    - Phase 2 evaluation update

3. **Presentation by AMG members**
    - Experiences from state visits
    - Non EAG state issues

4. **ASHA Training beyond Module 5**
    - ASHA competencies and role clarity
    - Modules 6 and 7 for states in need of MNCH/disease specific inputs
    - Training strategy for rolling out module 6 and 7
    - State specific modules beyond module-5
    - Database of training institutions and trainers
    - Trainer accreditation and ASHA certification