Minutes of National ASHA Mentoring Group (NAMG) Meeting

1. The Ninth meeting of the National ASHA Mentoring Group was held on February 16, 2012 at the National Health Systems Resource Center, (NHSRC) New Delhi, which serves as the secretariat of the National ASHA Mentoring Group. The list of participants is at Annexure 1 and the agenda for the meeting is at Annexure 2. Dr. T. Sundararaman, Executive Director, NHSRC welcomed the group. Four members were not able to attend on account of other commitments. Dr. Nayak from the division managing the ASHA programme represented the MOHFW. Dr. Sajjan Yadav, Director-NRHM, had confirmed his participation, but was unable to attend owing to another commitment. Dr. J.P. Mishra, Executive Director, State Health Systems Resource Center, (SHSRC) Chhattisgarh, had nominated Mr. Sameer Garg in his stead. ED NHSRC noted that except for the ex-officio membership for the Executive Director of State Health Resource Centre (Chhattisgarh), all other representatives of the NAMG were nominated to the group in their individual capacity rather than their organizational affiliation. The ED SHRC Raipur, has been made ex-officio member of NAMG so that the NAMG can benefit from the experiences and learning of the Mitanin program implemented by SHRC in Chhattisgarh.

2. Dr. Rajani Ved updated members of the group on progress of the ASHA and VHSNC programme since the group last met in July 2011. She also drew the attention of participants to the list of background papers for the meeting. The proposal to create Community Health innovation, Learning and Training Sites and the proposal for ASHA certification had been circulated before the meeting. Dr. Shyam Ashtekar had circulated a note with his concerns on the ASHA programme to the Medico Friends Circle (MFC) list serve. Since not all members of the mentoring group are members of the MFC list serve, and because these issues primarily pertained to the ASHA programme this note was also circulated to the group.

3. Highlights of discussion and key decisions:

3.1 Training

- Dr. Shyam Ashtekar said that in Maharashtra both AWWs and ASHAs have been trained in Integrated Management of Newborn and Childhood Illness (IMNCI). This created confusion at the level of field functionaries on specific roles. Dr Rajani Ved circulated the recently issued guidelines by the Government of India on IMNCI training, based on MOHFW's review of field experiences, which stipulated that ASHAs would henceforth be trained only in Module 6 and 7. The order also suggests that the ASHA training in Modules 6 and 7, be called IMNCI plus, a point on which several members expressed reservations.

- Members suggested that in addition to the regular channels of information flow, policy guidelines that have relevance for operationalization be made available through other NGOs and other routes, to the operational levels such as districts and blocks.

- Dr. Indu Capoor shared the example of Gujarat where both ASHA and AWWs were trained on Nutrition and Adolescent Health. Her suggestion on joint training of ASHAs and AWW, was also echoed by some other members particularly in content areas where both have a role, needs to be conducted and specific responsibilities explained.

- Ms. Neidonuo Angami emphasized the need to strengthen national and state training sites with their own pool of trainers in order to build ownership and responsibility of state. She stressed that especially in areas like the North East, it is important that the training of trainers be undertaken in the region itself so that capacity is built in the region.

- Dr. Nupur Basu raised a concern that in the state of West Bengal the state training sites depended primarily on external resource persons both for classroom training and also for the field level mentoring. Other members also concurred that state training sites should have core faculty rather than rely on external resource persons.

- Ms. Indu Capoor and Dr. Nupur Basu said that alongside the roll out of training, monitoring the quality of training is an essential requirement and suggested that states allow for observation and support by external resource persons.

- Dr Rajani Ved discussed the need for expansion of pool of National / State trainers, given the attrition among the pool of national and state trainers. She shared the example of Deepak Foundation Baroda, which has provided their trainers to the pool of national trainers. She requested all members to help in identifying more such organizations and trainers to add to the existing pool. Dr. Vandana Prasad said that she was willing to commit support both at the individual level and from Public Health Resource Centre (PHRN) state offices. She asked that NHSRC circulate the criteria for selection of trainers.

3.2 Role of ASHA in Home visits – Home Based Newborn Care

Ms. Shilpa Deshpande raised concerns about the conditionality that Rs. 250 is to be paid to ASHA for the set of home visits to new-born, only if the mother and child are alive. Members also brought up the issue of another conditionality linked payment to the ASHA in the instance of complete immunization citing that in many instances immunization schedules are not completed in time because of the inability of the health system to provide regular immunization services. The members expressed the view that the outcome criteria for payment to ASHA under HBNC guidelines should be reviewed. When performance monitoring guidelines are issued, they should reflect the concerns of members on conditionalities.

3.3 Second ASHA

ED NHSRC shared that a proposal for a second ASHA is being discussed at different levels of policy discussions as part of the Twelfth plan process. Dr. Abhay Bang also shared that the High Level Expert Group (HLEG) has considered the need for expanding the scope of work of ASHA to include non-communicable diseases into her work profile. Members discussed various issues regarding the second ASHA: What would be the range of services that are being considered to be included in ASHA's work? If a second ASHA is put in place what would each do? Would one ASHA focus more on mobilizational work and the other one on service delivery? Would the second ASHA focus mainly on new roles like non-communicable diseases? Mr. Alok Mukhopadhyay said that at this juncture, it is important that we assess the existing situation, its strengths and weaknesses, reflect on what needs to be modified, and do so, before the second ASHA is introduced into the programme. Members agreed that while being open to the notion of a second ASHA the priority is in strengthening the first.

3.4 Certification and Accreditation Process

The issue of ASHA certification has been under discussion in several meetings. NHSRC had prepared a draft proposal on ASHA certification which was shared with members. There was extensive debate on this issue and the following points emerged:

- The objective in introducing a certification process should be to improve the quality of training and ensure desired program outcomes. The term "certification" should be used in preference to "accreditation," because accreditation implies that those who do not get certified cannot work as ASHAs.

- An important question is: 'Should certification be mandatory?' if it is not to be, why would ASHA like to get certified, especially if there is no definite benefit attached, as she will still remain an ASHA. Certification must become a part of the training, as in school or university system.

- Dr. Vijay Aruldas said that the proposal should reflect a clear focus on a single objective which was to ensure quality. All other objectives were at best secondary.

- Dr. Abhay Bang said that certification must be seen as an "assurance to the community". Competencies can be certified. We need an independent body to certify ASHAs, independent of those training or managing the programme. Certification is important not only for legal reasons but also for the community's safety. Not all ASHAs would pass the test after training is completed, but they do clear the test sooner or later. It is important that every ASHA be able to demonstrate her skills.

- Dr Nerges Mistry said that the rural community has the right to be treated by a skilled person/Community Health Worker. Certification would ensure that a minimum component of competency is delivered. Certification is to be seen as being a step in

providing career opportunities for the ASHA; we cannot hold back her progress (growth as a community health worker). We have to develop a mechanism for certification and provide for three additional chances for ASHAs who do not clear requirements in the first round. ASHAs who do not pass the necessary tests or meet requirements could be retained and deployed with due recognition of their strengths and weaknesses so that they do not put the community or their clients at risk

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- Samir Garg and Shilpa Deshpande were not for certification, and were apprehensive that it would create more problems than it would solve. One concern was on what would happen to the ASHAs if they fail to clear the requirements for certification? A second one was that certification would imply discrimination against those not certified. The main fear is what happens to the morale of ASHA who fails to get certified. She would be very vulnerable to the hostility of the system where everyone is more qualified than her, and the system is generally hostile to her.

- Dr. Shyam Ashtekar said that in the Nasik experience (Yashwantrao Chavan Maharashtra Open University-YCMOU), credits are given for completed lessons, not a "pass" or "fail". In this programme there was a textbook with about 200 practical exercises of which 80 to 100 had to be completed under the ANM's supervision. Training centers can also function as self-learning centers. He also said that the YCMOU would be ready to serve as the certifying body.

- Dr. Abhay Bang proposed a certification system specific to a set of skills, as an assurance to the community on the quality of services being provided by ASHA. He shared the evaluation system being undertaken as part of the ASHA Module 6 and 7 training at all levels. He cautioned that that linking the certification process as a step to a career path is putting the ASHA along the uncertain path of seeking a government job. His view was that the ASHA should not be seen as being at the bottom of the career ladder, and aspire to become an ANM as the next level in the ladder. .Her role should be viewed as being unique and indispensible for the community, and she should not be encouraged to move out of her village - though she should not be barred.

  It was suggested by some members that certification could serve as a part of the training process itself like a school examination on course completion instead of an external assessment. The focus should be on building competencies of ASHA, by strengthening quality of training, and a sturdy system of training and re-training / refresher training. This should be done by trainers themselves rather than an external agency. Dr. Prashanta Tripathy cautioned that that involving external bodies into this process will bring-in bureaucracy and will go against the spirit of decentralization. He also emphasized accreditation of trainers in addition to undertaking ASHA certification, to ensure that the training imparted to ASHAs is effective.
- Dr. Vandana Prasad reflecting on PHRN's experience with IGNOU said that unless there was clarity in the role of National Institute of Open Schooling (NIOS), involving them would be difficult.

3.5 One possible consensus was that a certification system could be built at several levels. A first level would be for all ASHAs, to act as an identity mechanism and which recognizes her role in facilitation and mobilization. This level of certification will involve building competencies of ASHA for undertaking and also facilitating mobilization, since mobilization also needs capacity building. An intermediate level of certification would be for those ASHAs who achieve the skills taught in modules 6 and 7 and encompass counseling for nutrition, home visits for newborns and mothers, etc. An advanced certification course could be developed based on context and local needs to certify ASHAs for different sets of skills related to varying service delivery roles. It is also a possibility that different ASHAs are certified for varying sets of skills. Thus for example one among ten ASHAs could be trained and certified for playing the care-givers role in mental health. **Sharing of experiences/perspectives by members**

- Ms. Alison Dembo Rath from the DFID supported programme in Orissa presented the key findings from an evaluation of the ASHA programme in two districts of Orissa. A copy of the report was also circulated to the members.
- Ms. N Angami shared her experiences from North Eastern States, and said that though NE States have put in place a good support system up to the block level, their functionality is weak. She shared her observations from village visits undertaken in 5 districts of Nagaland, to check how VHSNCs were holding their monthly meetings. She shared that it was found that even after 5-6 yrs. of NRHM some ASHAs were not involved in the VHND, which likely reflects weakness in the support structures. .
- Dr Vandana Prasad shared her experience from the state of Jharkhand that targets for sterilization are being given to ASHAs. On this issue Ms. Shilpa Deshpande shared that incentives for sterilization were not being given to ASHA in many cases even when she has motivated and escorted the sterilization cases, because ANM was appropriating this incentive.
- Dr Shyam Ashtekar said that this meeting was the final meeting for the current phase of NRHM which comes to an end in March 2012. He shared his concerns about the future of the ASHA program, and recalled how past CHW programs have been phased out by the government. He referred to his note which was circulated to the members on his issues with the ASHA programme. He read out the issues he had raised in the note. In brief, this includes: converting the ASHA into paramedics using flexi learning mechanisms, moving to a blended system of payment which included regular payment and performance based reimbursement, payment for care of illness, and the supply of a basket of primary care by ASHA with more than ten drugs, since she has to be a provider of services, and accreditation through NIOS/Open Universities in the states. His view was that the current design was very weak. He also requested that members articulate their opinion on each of these issues. Some members felt that several of these issues had been discussed in the group and that for the rest, the articulation of opinions would not be appropriate. Discussion on some of these issues would require a substantiated and evidence based basis, and mere individual opinions would not be effective or productive.

- Dr. Vandana Prasad brought to the notice of the group that in the state of Jharkhand, in some of the most unreached tribal groups being called 'Particularly Vulnerable Tribal Groups' 100 additional ASHAs have been put in place at the level of the lowest habitation, and an honorarium of Rs. 500 per month has been sanctioned for them. The members agreed that such a strategy can be useful for outreach vulnerable communities.

3.6 Community Health Innovations Learning and Training Sites (CHILTS) –

NHSRC had circulated a proposal on setting up centers in the states where innovations in community processes could be fostered, and which could also serve as sites for learning and training. Centers would test new strategies and program frameworks. While at the present time this was proposed for government funding, CSR (Corporate Social Responsibility) funds could also be leveraged. Given that the High Level Expert Group (HLEG) and other policy fora are looking at the programme from a ten year perspective, the "CHILTS centers" may provide the new models for program intervention. These could be linked to the Innovations Council Funds also.

- Members felt that this would be useful. Mr. Alok Mukhopadhyay said that such centers would need to dovetail it with existing Regional Resource Centres (RRCs). He also said that it was important to assess which existing organizations could play this role.

- Dr. Vandana Prasad said that these centers would act as 'pace-makers' for health care at all levels. She suggested that instead of expecting every such centre to perform all the functions, centers should select tasks based on competencies and local needs and further strengthen and build up on them. She underscored the need for state level autonomy in the process of creating such centers with good field level demonstration sites. She suggested that these centers should not be limited to state capitals and should rather be located in the grass-roots organizations outside the state capital. Endorsing this argument strongly, Dr. Prasanta Tripathy also underscored the need for involving organizations working in outreach areas and made an observation that the 'Periphery should be the Centre'.

- Ms. Indu Capoor suggested undertaking an analysis of existing institutions with capacity or potential to be developed in such centers. She suggested that RRCs particularly in Gujarat and Rajasthan can be considered for establishment of such centers. She also referred to her e-mail circulated earlier in this regard with her suggestions on the issue. She also said that we must emphasize on the nutrition aspect of health care as well.

- Dr. Nupur Basu observed that there is overlap between the functions of a state ASHA training site and CHILTS. However the focus of the former is on training while CHILTS will also serve to demonstrate innovative models. However innovations come into picture only when states are able to generate the knowledge chain.

- Members expressed the view that these centers would need to function autonomously, analogous to universities.

Action:

(i) NHSRC to review and modify the performance appraisal note and reflect members' concerns on conditionalities in payment of ASHA incentives

(ii) NHSRC to circulate the model criteria for selection of training sites and state and district trainers to all members.

(iii) Members to send in names of organizations and individuals so that NHSRC could develop a list of national and state training sites, and trainers, in addition to Deepak Charitable Foundation and the Public Health Resource Network state chapters suggested by members.

(iv) NHSRC to discuss the certification proposal with the MOHFW articulating the views of the members, and circulate a revised version of the proposal to the group. The reservations expressed by NAMG members on renaming of the ASHA Module 6 & 7 as 'IMNCI Plus' need to be shared with MOHFW.

Annexure 1:

List of Participants
National ASHA Mentoring Group Meeting,
NHSRC New Delhi, 16 February, 2012

Sl. No.	Name	Designation, Name of Organization and Address	E-mail ID	Phone/Cell No.
1	Dr. Shyam Ashtekar	Bharat Vaidyaka Sanstha, 21, Cherry Hills Society, Anandwalli, Pipeline Road, Nashik - 422013	shyamashtekar@yahoo.com	9422271544, 0253-2342447
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5	Dr. Alok Mukhopadhyay	CEO, Voluntary Health Association of India (VHAI), B-40, Qutab Institutional Area, New Delhi- 10016	vhai@vsnl.com	011-26518071/72
6	Dr. Abhay Bang	SEARCH (Society for Education, Action and Research in Community Health), Shodhgram, PO & District- Gadchiroli (Maharashtra)- 442605	search@satyam.net.in	07138-255407, 9422150966
7	Dr. Prasanta Tripathy	Ekjut, Plot 556 B, Potka, Chakradharpur, West Singbhum Jharkhand - 833102,	prasanta.ekjut@gmail.com	06587-239625, 9431153434
8	Mr. Samir Garg	Program Manager SHRC, Chhattisgarh, Kali Badi Chowk, Raipur, CG	koriya@gmail.com	0771-2535305, 94255583395,

9	Dr. Vijay Aruldas,	Christian Medical Association of India (CMAI), Plot No. 2, A-3 Local Shopping Centre, Janakpuri New Delhi 110 058	varuldas@cmai.org	011-2599991/92/92, 9811208375
10	Dr. Vandana Prasad	National Convener, PHRN, 5A, Jungi House, Shahpur Jat, New Delhi	chaukhat@yahoo.com	9891552425
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12	Mrs. Shilpa Deshpande,	Jindal University, Sonepat, Haryana,	forshilpadeshpande@gmail.com	9050009185 9823381420
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19	Dr. Garima Gupta	Consultant (CP), NHSRC, New Delhi	drguptagarima@gmail.com	9899114279
20	Mr. Biraj Kanti Shome	Regional Coordinator, Regional Resource Centre for North Eastern States (RRC-NE), Assam Medical Council Bhawan, Sixth Mile, Khanapara, Guwahati – 781022	birajshome@yahoo.com	9435172953
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Annexure 2:

Agenda for National ASHA Mentoring Group Meeting

National Health Systems Resource Center (NHSRC)

Thursday, February 16, 2012

Time - 10:00 am to 5:00 pm

Welcome

1. Update on ASHA programme

- Report on progress of ASHA and VHSNC programme
- Launch of ASHA update: January 2012

2. ASHA and VHSC evaluations

- Report of findings from ASHA evaluations in Uttar Pradesh, Uttarakhand, and Madhya Pradesh
- The role of the frontline worker in underserved districts: Findings of a study from Odisha

3. Sharing by AMG members

- Experiences from states/other visits

4. Which way forward?- ASHA and Community Processes Component in the Twelfth Plan

- Discussion on Community Processes in the 12th plan