"ASSESSMENT OF DEVELOPMENT OF ACCREDITED SOCIAL HEALTH ACTIVISTS IN EMPOWERED ACTION GROUP STATES OVER THE PERIOD OF NATIONAL RURAL HEALTH MISSION"

A dissertation submitted in partial fulfillment of the requirements

for the award of

Post Graduate Diploma in Health and Hospital Management

by

SUDEEP KESH

International Institute of Health Management Research

New Delhi – 110075

April,2011

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Under the guidance of

Dr. Rajani Ved. Advisor (Community Participation), National Health System Resource Centre, Ministry of Health and Family Welfare, Government of India	Dr. Sajjan Singh Yadav Director National Rural Health Mission Ministry of Health and Family Welfare, Government of India	Mr. Pawan Kumar Taneja Associate Professor, IIHMR, New Delhi.

International Institute of Health Management Research

New Delhi – 110075

April,2011

Certificate of Internship Completion

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Mr.Sudeep Kesh has successfully completed his 3 months internship in our organization from January10, 2011 to April 10, 2011. During this intern he has worked on ASHA assessment over the period of NRHM (Task performed) under the guidance of me and my team at National Health System Resource Centre.

……. (Any positive/negative comment)

We wish him/her good luck for his/her future assignments

(Signature)

_____ (Name)

_____Designation

Certificate of Approval

The following dissertation titled “Assessment of development of Accredited Social Health Activists in Empowered Action Group states over the period of National Rural Health Mission” is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of Post- Graduate Diploma in Health and Hospital Management for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name :

Signature :

_____ _____

_____ _____

_____ _____

Certificate from Dissertation Advisory Committee

This is to certify that Sudeep Kesh, a participant of the Post-Graduate Diploma in Health and Hospital Management, has worked under our guidance and supervision. She is submitting this dissertation titled "Assessment of development of Accredited Social Health Activists in Empowered Action Group states over the period of National Rural Health Mission" in partial fulfillment of the requirements for the award of the Post- Graduate Diploma in Health and Hospital Management.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr Rajani Ved	Mr Pawan kumar Taneja
Advisor, Community Participation	Associate Professor
NHSRC, MoHFW, GoI	IIHMR, New Delhi
Date:	Date:

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ABSTRACT.

INTRODUCTION.

The National Rural Health Mission (NRHM) in India 2005-2012 was launched to revitalize a crumbling public healthcare system. A cornerstone of the reforms was the introduction of a cadre of women from villages/hamlets called Accredited Social Health Activists (ASHA). The ASHA represents the latest in a long series of approaches by the government to incorporate a village level health worker.

The present set of reforms under NRHM must be viewed in the context of the global efforts to establish "Comprehensive Primary Healthcare" (CPHC). CPHC in concept involves equity in the access to health care, reducing vulnerability of communities to ill health through community empowerment and an attempt to address the social determinants of health. The overarching research question that we are seeking to answer is "How can the contributions of the ASHA to increase public health accessibility be strengthened".

OBJECTIVE.

General objectives.

To analyse the development of accredited social health activists[ASHA] for delivering better health services in empowered action group states over five years of NRHM by critically analysing the state programme implementation plan.

Specific objectives.

To assess the progress of trainings and skill development in ASHA and concurrent measures taken by the state in utilizing NRHM funds in mainstreaming the accredited social health activists.

METHODOLOGY.

Secondary data review of STATE PROGRAMME IMPLEMENTATION PLAN over five years of NRHM and cross sectionally analyzing the COMMUNITIZATION portion of NRHM flexi pool section of Empowered action group states. Extensive review of literature on Accredited Social Health Activists during the period of NRHM. Analysis was done based on graphical techniques and participatory methods.

RESULT & FINDINGS.

Some of the EAG states had performed better while some had underperformed in communitizing approach. Some of the states had excellent utilization of funds and training process while some lacked it. It clearly indicated that the planning process and management had a varied approach across the states.

LIST OF ABBREVIATIONS

ANM	Auxiliary nurse midwife
APHC	Additional primary health centre
ASHA	Accredited social health activists
BEMONC	Basic emergency obstetric and newborn care
BLA	Block level accounts manager
BPHC	Block primary health centre
BPL	Below poverty line
BPM	Block programme manager
CMO	Chief medical officer
CEMONC	Comprehensive emergency obstetric and newborn care
CS	Civil surgeon
CHC	Community health centre
CSO	Civil surgeon's office
DH	District hospital
EMRI	Emergency medical and research institute
EMOC	Emergency obstetric care
FRU	First referral unit
HMIS	Health management information systems
JSY	Janani suraksha yojana
LSAS	Life saving anesthesia skills
MVA	Manual vacuum aspiration
NSSK	Navjaat shishu suraksha karyakram
HIV	Human immunodeficiency virus
HR	Human resources
MO	Medical officer
MTP	Medical termination of pregnANCy
OBC	Other backward castes
PIP	Programe implementation plan

PPP	Public private partnership
RCH	Reproductive and child health
SC	Sub centre
ST	Scheduled tribes

Part I:

Internship Report

ORGANIZATION PROFILE

THE NATIONAL RURAL HEALTH MISSION (2005-12)

The Mission seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of

funds and infrastructure and strengthening delivery of primary healthcare. It seeks to revitalize local health traditions and mainstream AYUSH into the public health system. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health. It seeks decentralization of programmes for district management of health. It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure. It shall define time-bound goals and report publicly on their progress. It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

NATIONAL HEALTH SYSTEM RESOURCE CENTRE (NHSRC), NEW DELHI

NHSRC is committed to lead as professionally managed technically support organization to provide technical support to NATIONAL RURAL HEALTH MISSION, Ministry of Health and Family Welfare, Government of India. It is a Autonomous body under Ministry of Health and Family welfare, Government of India.

India is witnessing a major effort at strengthening public health systems in the form of the National Rural Health Mission. The goal of this mission is to lead to the attainment of a much higher level of health for its people. This it would achieve by a significant improvement in public health expenditures, by a better delivery of public health services, and by promotion of healthy life styles and convergent action on the social determinants of health. One of the major challenges the Mission faces is capacity development. Capacity development is needed for enabling communities, service providers and health administrators, to make and implement locale specific, evidence based and outcome oriented health plans. One important aid to such a massive capacity building effort is the creation of the National Health Observatory.

Aims: The Indian Health Observatory aims to be:

a) A tool meant for use by planners and decision makers for improving the effectiveness and efficiency of health planning and for making decentralized health planning a reality.

b) A knowledge repository for use by researchers and academicians and practitioners of public health.

c) A record of what is happening in the health sector in the states.

d) An access to communities for knowing about government health plans and programmes, which would be useful for social audit of the progress of health programmes.

e) A vehicle for promotion of networking between individuals and institutions working to improve the outcomes of health systems.

f) A focal point in the identification, documentation and dissemination of knowledge and experiences in health systems across countries and Indian states.

g) A channel for identifying and drawing in technical assistance.

h) A forum for sharing the outputs of technical assistance projects that are completed and to provide information on those that is ongoing, including the work of the National Health Systems Resource Centre.

Vision:

Committed to facilitate the attainment of universal access to equitable, affordable, and quality health care, which is accountable and responsive to the needs of the people.

Mission:

Technical support and capacity building for strengthening of public health systems.

Specific Objectives:

- Develop capacities in a network of institutions and individuals to improve the, efficiency, effectiveness and quality of health systems through interventions at the national, state, district and sub-district level
- Respond to technical assistance needs of the state and central health departments by mobilizing suitable agencies with necessary skills, by capacity development in technical assistance, institutions, by sharing of good practices and by training and orientation programmes.
- Facilitate the process of developing decentralized and accountable service delivery systems with community ownership and public participation in governance mechanisms.
- Assist states and national centres in establishing functional, effective, state-of-the-art Health Management Information Systems.
- Be a focal point in the identification, documentation and dissemination of knowledge and experiences in health systems and health program across the different states and across countries. Provide evidence-based insights on wider determinants of health outcomes and the choices in strategy available for health planning.

Thematic areas:

1. Public Health Administration
2. Community Participation
3. Health Care Financing And Public Private Partnership
4. Health Management Information System (HMIS)
5. Human Resource For Health
6. Legal Framework For Health
7. Public Health Planning
8. Quality Improvement

Job Responsiblities in the organization..

- Supportive supervision in High Focus districts.
- Appraisal of NRHM programme implementation plan.
- Preparation of Record of proceedings
- Co-ordination of National programme coordination committee meetings
- Reproductive and child health monitoring visits.

1.1 Area of engagement

COMMUNITY PARTICIPATION

The key objective of the Community Processes team in NHSRC is to provide technical support at state and national levels to the communitization component of the National Rural Health Mission, which includes the ASHA programme and the Village Health and Sanitation Committees, and the

development of sustainable strategies for NGO involvement. Technical support encompasses a range of functions, including enabling states to create support structures for the community processes components at state, district and block levels, developing and consolidating training systems for ASHA training, developing training and communication material, conducting evaluations to inform and strengthen programme implementation, supporting process documentation, and providing policy inputs in the form of developing measurable outcome indicators, and operational guidelines for implementation. Within NHSRC the division also anchors the Secretariat for the National ASHA Mentoring Group which serves as the national policy and advisory body for the ASHA programme. At the national level, the team is headed by an Advisor, with two consultants, one fellow and a secretarial assistant. The team is also supported by state facilitators in Orissa, Rajasthan, Jharkhand, Uttar Pradesh, and Bihar.

NRHM POLICY AND PLANNING, Ministry of Health and family welfare, NRHM division, Government of India.

The area of engagement in the organization during the internship was for the policy and planning of programme implementation plan and involve in detail analysis of communitization section of PIP and the NRHM flexipool section. Work also included various sub group appraisals, supportive supervision and RCH monitoring visits.

Reflective learning

- Practical issues involved in the various stages of the implementation which may result in deviations from the project plan.
- Preparation of comments on the appraisal of sub group PIP
- The various barriers observed during the different stages of implementation and the NRHM
- The basic workflow and coordination of the state in implementing NRHM.
- The various strategies to supportive supervise the districts for health care accessibility.
- The various techniques involved to ensure the end user participation throughout the implementation process in the PIP.
- Prepare ROP of the respective states
- Cross sectionally analyze the flexipool part and communitization process in the PIP.

PART 2

DISSERTATION REPORT.

BACKGROUND

NATIONAL RURAL HEALTH MISSION.

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

The Goal of the Mission is to improve the availability of and access to quality Health care by people, especially for those residing in rural areas, the poor, women and children.

PUBLIC HEALTH SCENARIO IN INDIA DURING THE LAUNCH OF NRHM

NATIONAL RURAL HEALTH MISSION – THE VISION

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.

It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare and seeks to revitalize local health traditions and mainstream AYUSH into the public health system. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health. It

seeks decentralization of programmes for district management of health and addresses the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure and It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

GOALS OF NRHM.

· Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)

· Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.

· Prevention and control of communicable and non-communicable diseases, including locally endemic diseases

· Access to integrated comprehensive primary healthcare

· Population stabilization, gender and demographic balance

.

· Revitalize local health traditions and mainstream AYUSH

· Promotion of healthy life styles .

COMPONENTS OF NRHM.

PLAN OF ACTION

COMPONENT (A): ACCREDITED SOCIAL HEALTH ACTIVISTS

• Every village/large habitat will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.

• ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.

• She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.

• She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.

• She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.

• She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and

medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.

• She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.

• Induction training of ASHA to be of 23 days in all, spread over 12 months On the job training would continue throughout the year.

• Cascade model of training proposed through Traini ng of Trainers State level modifications.
including contract plus distance learning model• Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

COMPONENT (B): STRENGTHENING SUB-CENTRES

• Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
• Supply of essential drugs, both allopathic and AYUSH, to the Sub-centres.
• In case of additional Outlays, Multipurpose Workers (Male)/Additional ANMs wherever needed, sanction of new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises will be considered.

COMPONENT (C): STRENGTHENING PRIMARY HEALTH CENTRES

Mission aims at Strengthening PHC for quality preventive, promotive, curative, supervisory and Outreach services, through:

• Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunization) to PHCs

• Provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH

• Observance of Standard treatment guidelines & protocols.

• In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of noncommunicable diseases, upgradation of 100% PHCs for 24 hours referral Service.

COMPONENT (D): STRENGTHENING CHCs FOR FIRST REFERRAL CARE

Operationalizing 3222 existing Community Health Centres (30-50 beds) as 24 Hour First Referral Units, including posting of anaesthetists.

• Codification of new Indian Public Health Standards, setting norms for infrastructure, staff, equipment, management etc. for CHCs.

• Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.

• Developing standards of services and costs in hospital care.• Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.

• In case of additional Outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

COMPONENT (E): DISTRICT HEALTH PLAN

• District Health Plan would be an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition.

• Health Plans would form the core unit of action proposed in areas like water supply, sanitation, hygiene and nutrition. Implementing Departments would integrate into District Health Mission for monitoring.

• District becomes core unit of planning, budgeting and implementation.

• Centrally Sponsored Schemes could be rationalized/modified accordingly in consultation with States.

• Concept of "funneling" funds to district for effective integration of all vertical Health and Family Welfare Programmes at District and state Programmes .

• Provision of Project Management Unit for all districts, through contractual engagement of MBA, Inter Charter/Inter Cost and Data Entry Operator, for improved programme management.

COMPONENT (F): CONVERGING SANITATION AND HYGIENE UNDER NRHM

• Total Sanitation Campaign (TSC) is presently implemented in 350 districts and is proposed to cover in all districts

• The District Health Mission would therefore guide activities of sanitation at district level, and promote joint IEC for public health, sanitation and hygiene, through Village Health & Sanitation Committee, and promote household toilets and School Sanitation Programme. ASHA would be incentivized for promoting household toilets by the Mission.

COMPONENT (G): STRENGTHENING DISEASE CONTROL PROGRAMMES

• National Disease Control Programmes for Malari a, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme shall be integrated under the Mission, for improved programme delivery.

• New Initiatives would be launched for control of Non Communicable Diseases.

• Disease surveillance system at village level would be strengthened.

• Supply of generic drugs (both AYUSH & Allopathic) for common ailments at village, SC, PHC/CHC level.

• Provision of a mobile medical unit at District level for improved Outreach services.

COMPONENT (H): PUBLIC-PRIVATE PARTNERSHIP FOR PUBLIC HEALTH GOALS, INCLUDING REGULATION OF PRIVATE SECTOR

In diverse country like India public sector and to provide necessary health care services the private sector has also to streamline and integrate with public sector to develop robust health care models to provide quality health care services.

COMPONENT (I): NEW HEALTH FINANCING MECHANISMS

Flexible financing mechanisms has to be adopted and there should be convenient flow of fund operationalised to carry out uninterrupted health care services as financial incentives are the key motivation. Pooling of funds for various developmental works is also necessary and flexible financial methods are adopted to carry out activities under NRHM

COMPONENT (J): REORIENTING HEALTH/MEDICAL EDUCATION TO SUPPORT RURAL HEALTH ISSUES.

To increase the productivity of public health professionals by giving them continous traning and refresher courses tied up with public health institutes and Medical colleges.

RATIONALE OF ASHA CONCEPT IN THE CONTEXT OF NRHM.

The baseline survey data from the PIPs of States compiled from 2006 onwards gives the status of Health coverage in terms of accessibility, equity and affordability.

The state-wise coverage in community involvement, intersectoral coordination as reported in the State PIPs since 2006 was not actively participated to improve the accessibility of Health care services. The situation is further compounded on account of manual scavenging prevalent particularly in rural areas. Lack of these basic amenities of sanitation has posed a serious health hazard and the recent epidemics and health disorders can be traced to unhygienic living conditions. Absence of safe drinking water combined with lack of proper sanitation have very often been important factors contributing to ill health and morbidity levels in the country.

The public health system in a sense has also not met the principle of equity in its delivery of healthcare services. This may be traced to a series of factors ranging from lack of medical personnel, drugs and equipment, inaccessible facilities or due to a poorly dysfunctional organization of the health system even where in some cases inputs exist and financial support is adequate and well-distributed. The National Health policy 2002 has highlighted the inequity in access to and availing of services by the disadvantaged groups. Infact the differentials in health status among socio-economic groups can be seen from the table below:

Table 3: Differentials in Health status among Socio-economic Groups

Indicator	Infant Mortality/1000	Under 5 Mortality/1000	% Children Underweight
India	70	94.9	47
Social Inequity			
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

Source: National Health Policy 2002. Table 1

Besides equity between different sections across the board, this has taken a toll on women and gender sensitive interventions not given adequate focus.

The key challenge continues to be the prevalence of high levels of inequity in health conditions across and within States and different strata of population. The multi sectoral determinants of health largely explain the variation in outcomes between different region/states. Malnourished children are easily susceptible to diseases and die from them. The environments in which we live particularly if it has no sanitation or poor sanitation provide a fertile environment for transmission of intestinal infections. Growth in vehicular traffic and primitive modes of cooking especially in rural areas give rise to a variety of respiratory diseases.

Inadequacy and ineffective public health services combined with a clear absence of convergence between different programmes and Departments have promoted implementation of a variety of initiatives within and outside the health sector without maximizing outcomes in a holistic and cost effective manner. Community participation is also not always clearly visible in several of our endeavor which is ubiquitous for the success of any intervention.

To bridge these gaps community mobilization and participation was need of the hour especially in the rural part of the country. Hence National Rural Health Mission came up with the concept of accredited social health activists which will

basically act as a community mobilize in driving the community towards a healthy environment by proper communication, involvement ,motivation, suitable IEC, monitoring and acting as a perfect interface between the community and health service providers. Gradually the roles and responsibilities of ASHA started bearing results in the community and participation of the community started strengthening for a healthy world and this whole thing made ASHA a key component in the journey of National Rural Health Mission.

SITUATIONAL ANALYSIS. AND ASHA SCENARIO IN INDIA.

The Accredited Social Health Activist (ASHA) is a major strategic intervention under NRHM. ASHA is envisaged as a trained woman community health volunteer who will inform, interact, mobilize and facilitate improved access to preventive and promotive health care and also provide basic curative care through her drug kit.

The selection and training process of ASHA has to be given due attention by the States in adhering to the criteria of selection as detailed in the guidelines from the Government of India. The States such as Chattisgarh, Jharkhand, Rajasthan and Uttar Pradesh have registered considerable progress in the selection and setting up of the training systems for ASHAs like the constitution and training of State Training Teams (STT), District Training Teams (DTT) and Block Training Teams (BTT). Till date, 100,000 ASHAs have been selected in the 10 high focus States. Capacity building of ASH is critical in enhancing here effectiveness. The training for ASHA shall be initiated by the states as soon as their selection is complete. The mechanism for monitoring ASHA will also need to be implemented.

The Anganwadi worker and ANM will be the mentors for ASHA and will work in close coordination. If any State desires to have a community based female voluntary health worker, it may be encouraged and the State may be advised to reflect the same in its PIP. As ASHA has been envisaged as a primary resource for the community on health issues, she needs to be actively engaged on development of village health plans panchayat, women's group members and other health

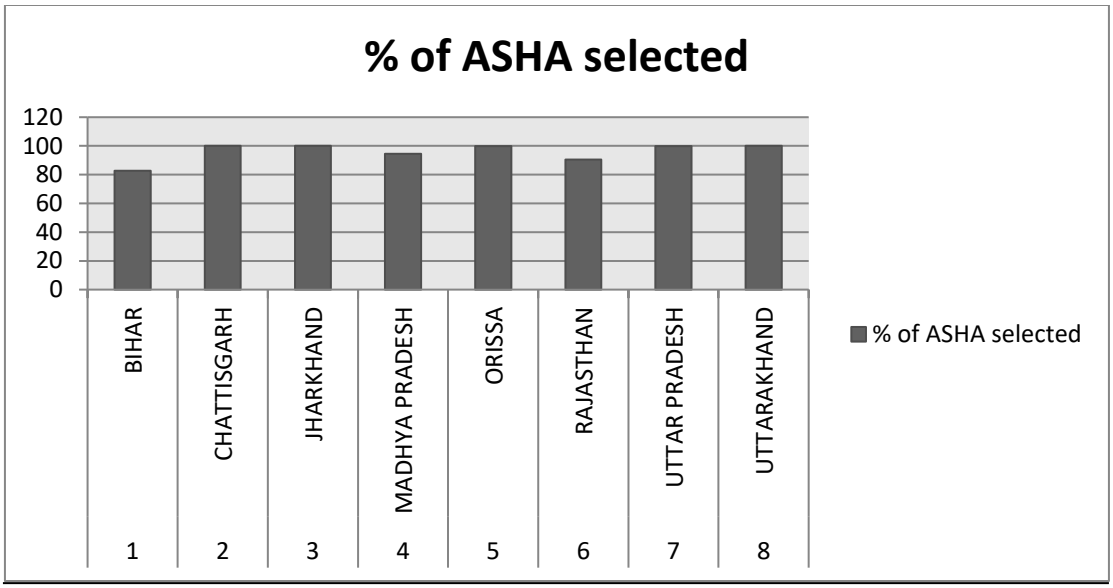
functionaries. Hence it is advised to organize joint training for the village health teams. Reputed NGOs working in State/districts should be involved in the training of ASHA as envisaged in the guidelines.

During the starting of NRHM, the norms of ASHA selection was decided as per single village catering a population of 1000 but there was high disparity noticed in following this guideline by the state. In states like Uttar Pradesh there was one ASHA for every 1131 people whereas in states like Chhattisgarh there was one ASHA for every 310 people. This clearly indicates how irrationally the ASHAs were deployed and there was underutilization of NRHM's key component. Trainings and other skill development rate in ASHAs varied from State to State. In some States the skill was high as the ASHAs were self motivated, completed up to 5th module training and had undergone various other EMOC trainings. In some states there were lot of challenges faced which included lack of training, delayed payments of incentives and lack of support from the service providers which resulted in high attrition rates. Although ASHA is playing a vital role in communitization still it is vulnerable to public health challenges, hence analyzing this component critically will provide a new direction towards achieving the desired targets of NRHM.

SITUATION OF SELECTION OF ASHAs IN EAG STATES.

State name	Proposed no. of ASHAs	Number of ASHA selected	% of ASHA selected
BIHAR	87135	72000	82.63
CHATTISGARH	60092	60092	100
JHARKHAND	40964	40964	100
MADHYA PRADESH	52117	49282	94.54
ORISSA	34324	34252	99.79
RAJASTHAN	48372	43789	90.52
UTTAR PRADESH	136268	136182	99.93
UTTARAKHAND	9983	9983	100

Table-2



[SOURCE : NRHM DIVISION,MOHFW,GOI,2011] fig-1

ALLOTMENT OF ASHAs AS PER THE POPULATION NORMS IN EAG STATES.

State name	Proposed no. of ASHA	Sanctioned number of anganwadi centre	Estimated rural population(2008)	Density of ASHA
Bihar	87135	81088	87679990	1:1006
Chattisgarh	60092	34937	18645601	1:310
Jharkhand	40964	32097	24184836	1:590
Mp	52117	69238	51611676	1:990
Orissa	34324	41697	34584474	1:1007
Rajasthan	48372	48372	51392259	1:1062
Up	136268	150727	154144864	1:1131
Uttarakhand	9983	9664	7121594	1:713

[SOURCE: ASHA UPDATE MODULE DEVELOPED BY NHSRC,2011] Table-3

The selection of the ASHA is highly diverse across the various states. States like Bihar and Orissa have slightly less of ASHAs as compared to their population norms where as states like Uttarakhand, Jharkhand and Chhattisgarh have high number of ASHAs compared to the population norms as per the ASHA guidelines. The state should work on this part for rationale allocation of ASHAs among the EAG states and focus on optimum utilization.

INTRODUCTION.

An Accredited Social Health Activists is a critical component of the National Rural Health Mission [NRHM] which was launched in 2005. It represents a woman community health worker, a resident in the village who would enable support to the health programme at community level. ASHA is the main interface between community and health care providers hence roles and responsibilities should be streamlined, strengthened and focused to deliver better services to the community. Concept of ASHA originated from "mitanin" and came into existence simultaneously with the starting of NRHM. One of the key strategies under the National Rural Health Mission (NRHM) is having a Community Health Worker i.e. ASHA (Accredited Social Health Activist) for every village with a population of 1000. The present study aims in assessing the development of skills in ASHA and their involvement in the health system to deliver quality healthcare over the five years of NRHM. From the beginning of NRHM, ASHA has been the most important component in driving NRHM towards its goal, it is the critical manpower awarded to the community in mobilizing the community to access healthcare services and the involvement of ASHA in various programmes in NRHM has increased the accesibilty of community towards healthcare services.

KEY ROLES AND RESPONSIBILITIES OF ASHA

- 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 utilization of health services.

- ASHA will counsel women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding

- ASHA will mobilize the community and facilitate them in accessing health and health related services in Anganwadi, PHC, CHC and SUB CENTRE

- ASHA will work with the Village Health Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan.

- ASHA will provide Primary Medical care and Minor ailments and will also act as a key observer in DOTS programe under RNTCP.

- ASHA will also act as a depot for essential provision like Oral rehydration therapy (ORS), IFA tablets, chloroquine, and disposable delivery kits.

- The overall function of ASHA depends on rate of training given to them and training initiatives taken by the state on various multi skilling techniques to make optimum utilization.

REVIEW OF LITERATURE.

Most of the health indicators of Low Performing states is too poor in comparison to other states. It is more so in rural areas and that's also specially in case of maternal and child health. The mission promises additional outlays for health, empowerment at state and district level, technical competencies and increased convergence of health with hygiene and sanitation. With the decentralization of the programmes and funneling of funds, it sets the stage for District Management of Health, akin to the Sarva Shiksha Abhiyan. For the underserved poor in the village level, the Mission spells hope in the form of a voluntary trained community health activist (ASHA) equipped with a drug kit; improved hospital facility at CHC level measurable as per the Indian Public Health Standards(IPHS); availability of drugs for generic common ailments at health centers; access to universal immunization; referral and escort services for institutional delivery; nutrition and medical care at Anganwadi level on a monthly basis on the health day, and through mobile medical unit at district level and availability of household toilets. The final vision is provision of comprehensive community health insurance to cover financial risks related to medical costs. Each stakeholder is an important link in the chain of delivery and has to be suitably equipped and motivated to capitalize on the opportunity provided by the Mission. One of the key strategies under the NRHM is having a community health worker that is ASHA (Accredited Social Health Activist) for every village with a population of 1000. The focal for every village with a population of 1000. The focal point in this mission is creation of a new band of village level social health activist designated as ASHA. These ASHAs has to be selected from the females of local community and by the local community as per prescribed guidelines. She should be preferably 25-35 years of age group and at least with a qualification of 8thclass. They will work voluntarily, but they will be paid some incentives for different types of health care activities. The review of findings from previous concurrent evaluation states that there is a high degree of variability across the states and low performing state almost share a common pattern of problem, further review of Outcome analysis

of state programme implementation plan clearly outlines that less than 25% of the allocated funds were utilized and most of the fund on ASHA head were uncommitted unspent with the state, which clearly indicate lack of planning and coordination from the state. Findings from previous studies points out that multiple ground problems like lack of training, lack of fund flow and lack of motivation was major hindrance to ASHA development in the EAG states.

RATIONALE OF THE STUDY.

ACCREDITED SOCIAL HEALTH ACTIVISTS [ASHA] is the most important component of NRHM and the role of ASHA in increasing accessibility of the community to health services has been appreciable but challenging especially in the Empowered Action Group States. In order to develop the skills of ASHA there has been various trainings undertaken, multiple modules designed and various multi skilling processes has been adopted and there has been a continuous fund flow in order to strengthen this component of NRHM both in technical and management prospective. The present study aims in providing an insight to the utilization of these resources over the period of NRHM.

OBJECTIVES.

General objectives.

To analyse the development of accredited social health activists[ASHA] for delivering better health services in empowered action group states over five years of NRHM by critically analysing the state programme implementation plan.

Specific objectives.

- To assess the progress of trainings and skill development in ASHA and concurrent measures taken by the state in utilizing NRHM funds in mainstreaming the accredited social health activists.
- To assess the number of ASHA in the EAG states, as per the population norms set by the Ministry of Health and Family Welfare, Govt. of India.
- To assess the accessibility of Drug Kits among the ASHA in the EAG states
- To assess the support services and initiatives adopted by the state in developing the ASHA programme in the state level.
- To assess the financial utilization of the state in ASHA programme

METHODOLOGY.

Secondary data review of STATE PROGRAMME IMPLEMENTATION PLAN over five years of NRHM and cross sectionally analyzing the COMMUNITIZATION portion of NRHM flexi pool section of Empowered action group states. Analysis of secondary data on ASHA module training from the Training Division, Ministry of Health, 2011 by graphical analysis technique. Review of outcome analysis of the Programme implementation plan to analyze the financial utilization of the state.

FINDING AND ANALYSIS.

CRITERIA 1

Analysis of proposed and selected ASHAs in the EAG states since the starting of NRHM

State wise analysis.

PROGRESS OF ASHA SELECTION IN BIHAR. Table-4.1

YEAR	ASHA PROPOSED	ASHA IN POSITION
2005-06	87135	36488
2006-07	87135	58246
2007-08	87135	66701
2008-09	87135	69124
2009-10	87135	72000
2010-11	87135	77255

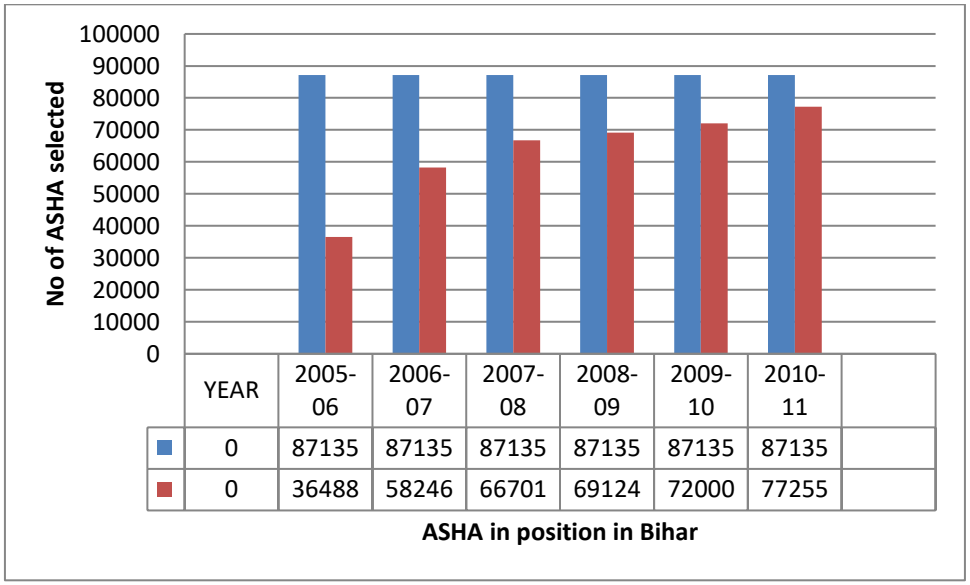


Figure-2.1

The number of ASHAs in Bihar are slightly high as compared to the number of ASHAs as per population norms. The starting years of NRHM witnessed a rapid growth in the selection of ASHA but gradually there was a decline in ASHA . The state witnessed attrition rate among the ASHAs due to lack of performance based incentives, lack of motivation and scarce of ASHA support mechanisms. The present number of ASHA in position as per 2011-12 state programme implementation plan is 78943 in the state. State must come up with new innovative ideas to fill the shortfall of ASHAs in the state. The state needs to urgently put attention to develop ASHA support structures in the state,which will increase the utilization of the ASHAs in the state.

PROGRESS OF ASHA SELECTION IN CHATTISGARH. Table 4.2

YEAR	ASHA PROPOSED	ASHA IN POSITION
2005-06	60092	5030
2006-07	60092	60092
2007-08	60092	60092
2008-09	60092	60092
2009-10	60092	60092
2010-11	60092	60092

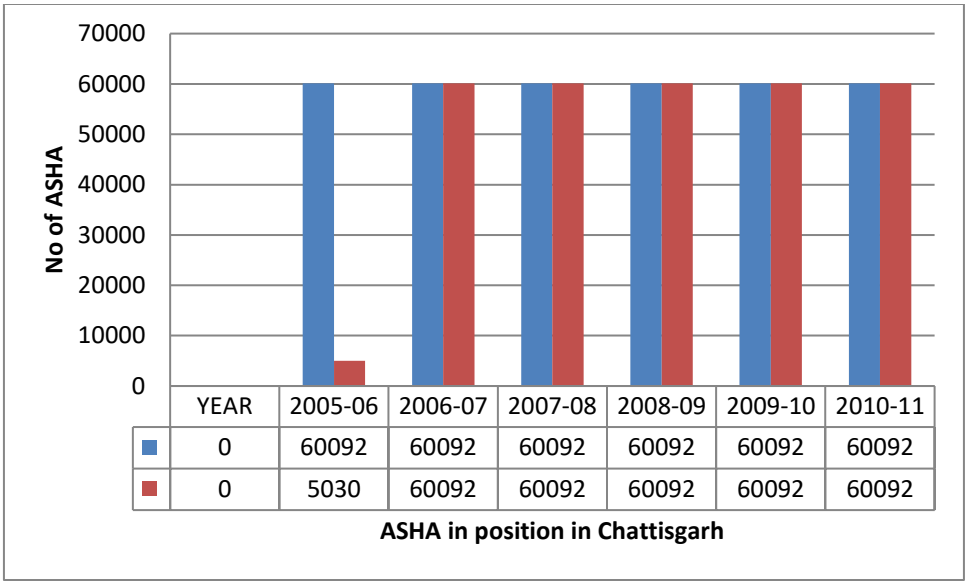


Figure-2.2

Chattisgarh has shown a remarkable progress in the ASHA selection and retention. The state has neglible attrition rates as the support mechanism adequately strengthens the ASHA working in the state. The activites of the ASHA are properly monitored by suitable ASHA support structures. Out of 60,092 ASHAs selected during the starting years of NRHM .still 58,894 ASHAs are in position as per the State programme implementation plan. which clearly signifies that state has developed suitable measures for the retention of ASHAs.

PROGRESS OF ASHA SELECTION IN JHARKHAND. Table 4.3

YEAR	ASHA PROPOSED	ASHA IN POSITION
2005-06	40964	1382
2006-07	40964	14425
2007-08	40964	38215
2008-09	40964	40788
2009-10	40964	40964
2010-11	40964	40964

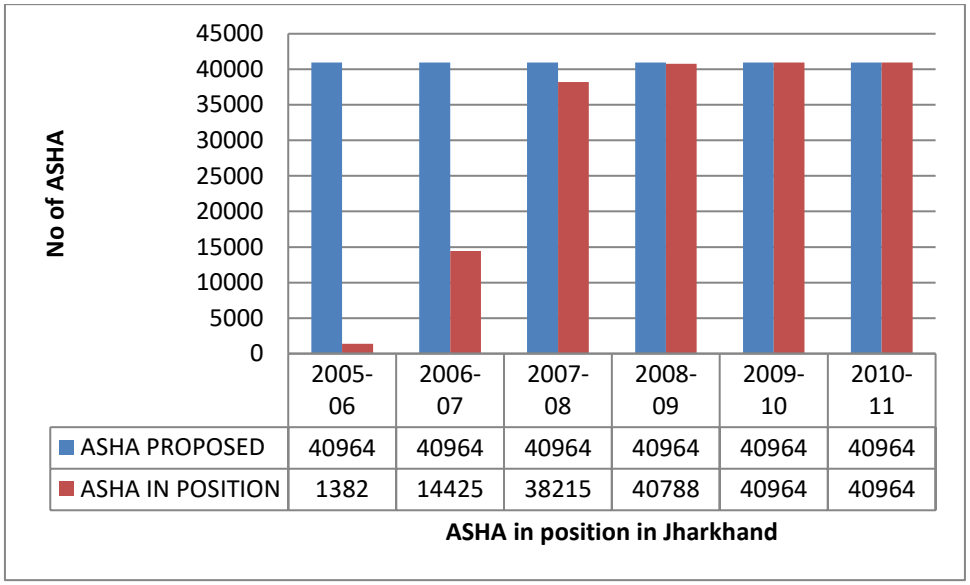


Figure-2.3

In case of Jharkhand the situation analysis signifies that the selection of the ASHAs are maximum in the starting years of NRHM and gradually decreases. Jharkhand has also worked well on retention of ASHAs and making continuous efforts in streamlining the ASHAs by involving suitable efforts from SHSRC and NHSRC. The total number of ASHAs selected till date were 40964 and out of this 39,264 are now in position as per State Programme Implementation plan 2011-1

PROGRESS OF ASHA SLECTION IN MADHYA PRADESH.

Table 4.4

YEAR	ASHA PROPOSED	ASHA SELECTED
2005-06	50113	16463
2006-07	50113	31870
2007-08	50113	40680
2008-09	50113	43218
2009-10	50113	49462
2010-11	50113	50093

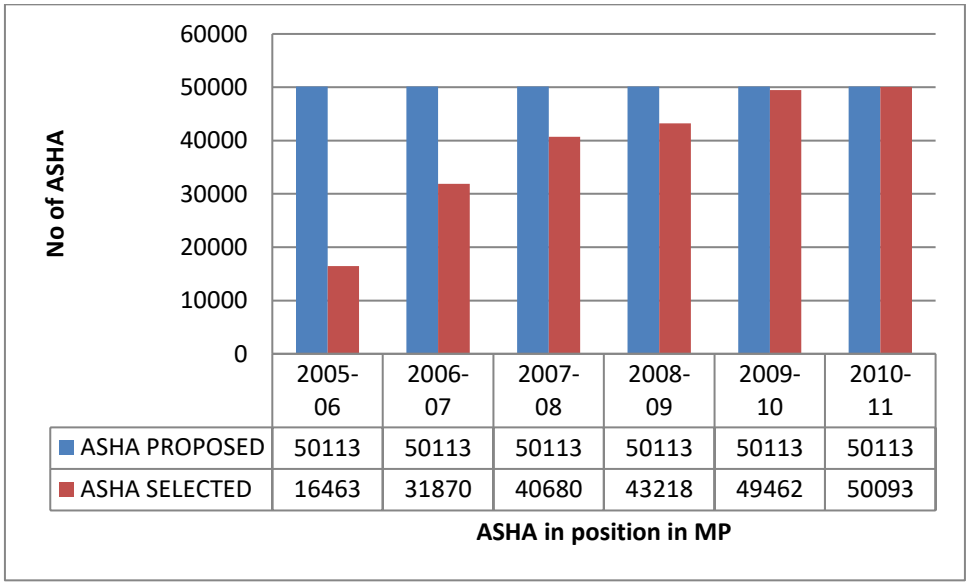


Figure-2.4

In case of Madhya Pradesh the number of ASHAs in the state is not as per the population norms. The number of ASHAs in the state should be around 69000 as per the population norms but only 50113 ASHA are selected over the five years of

NRHM and presently only 44344 ASHAs are in position which clearly signifies that the state has faced attrition of ASHAs. The state has not well developed ASHA support structures to support ASHA functional mechanisms.

PROGRESS OF ASHA SELECTION IN ORISSA Table 4.5

YEAR	ASHA PROPOSED	ASHA SELECTED
2005-06	41102	12730
2006-07	41102	33892
2007-08	41102	33892
2008-09	41102	33892
2009-10	41102	33892
2010-11	41102	40237

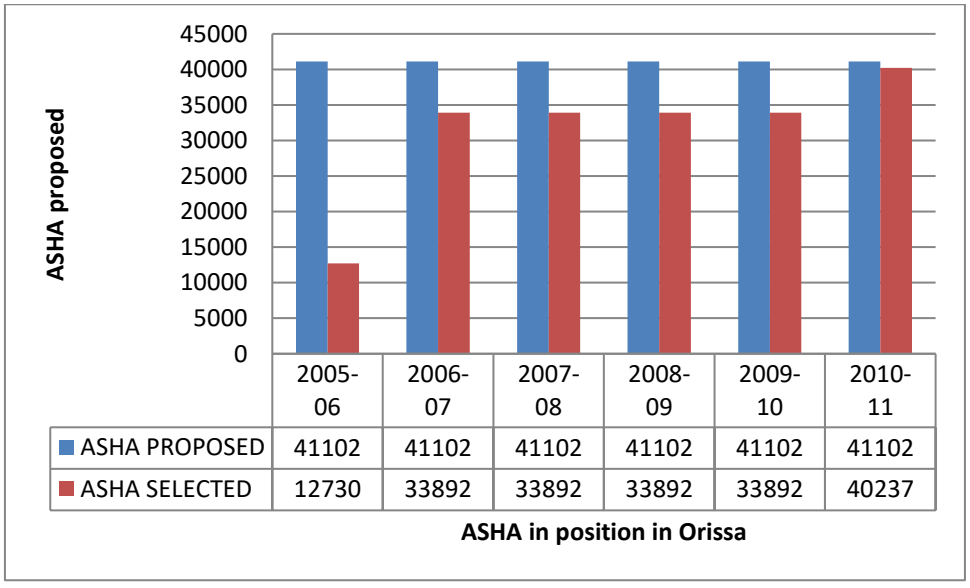
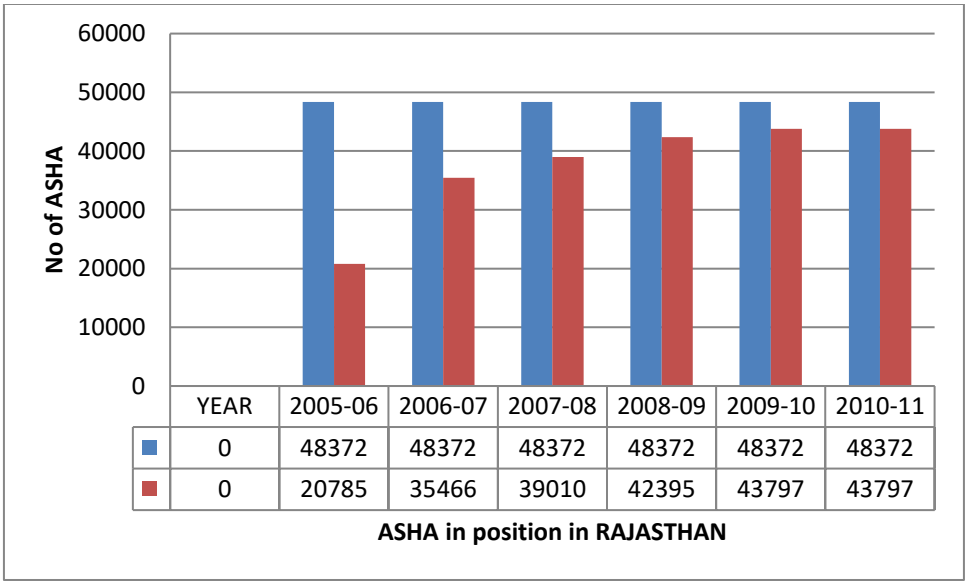


Figure2.5

The number of ASHAs in Orissa is as per the population norms and state has very less attrition rates of ASHA as compared to other EAG states. The state has well developed support structures like ASHA Resource centres, ASHA mentoring groups etc to properly provide technical inputs to the ASHAs periodically. There are totally 41102 number of selected ASHAs out of which 40597 are in position as per the State programe implementation plan 2011-12,which means that attrition rate is negligible.

PROGRESS OF ASHA SELECTION IN RAJASTHAN. Table 4.6

YEAR	ASHA PROPOSED	ASHA SELECTED
2005-06	48372	20785
2006-07	48372	35466
2007-08	48372	39010
2008-09	48372	42395
2009-10	48372	43797
2010-11	48372	43797



[ASHA selected in Rajasthan over the five years of NRHM]

Figure-2.6

PROGRESS OF ASHA SELECTION IN UTTAR PRADESH

Table 4.7

YEAR	ASHA PROPOSED	ASHA IN POSITION
2005-06	136268	19887
2006-07	136268	120073
2007-08	136268	129777
2008-09	136268	135522
2009-10	136268	136182
2010-11	136268	136268

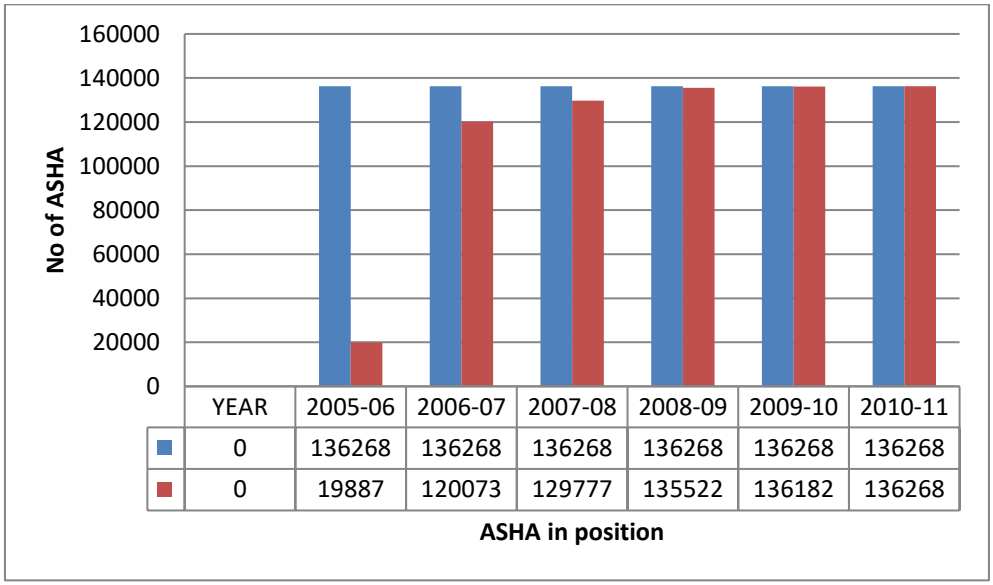


Figure-2.7

Uttar Pradesh has a well developed ASHA support system, till date the state has 136183 number of ASHAs in place out of 136268 number of ASHAs selected, which clearly signifies that the state is capable of retaining the ASHAs by providing them suitable training, motivation and incentives to them. The state has developed ASHA support bodies to periodically monitor them and provide technical inputs.

PROGRESS OF ASHA SELECTION IN UTTRAKHAND. Table 4.8

YEAR	ASHA PROPOSED	ASHA IN POSITION
2005-06	26268	5882
2006-07	26268	11980
2007-08	26268	21684
2008-09	26268	22989
2009-10	26268	22989
2010-11	26268	24844

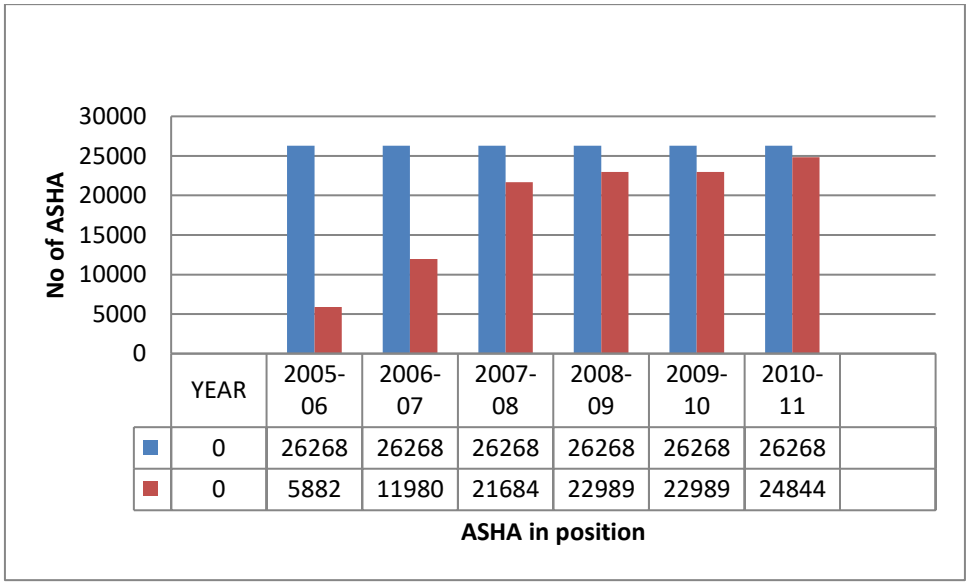


Figure-2.8

Skill analysis of ASHA over the EAG States.

CRITERIA 2

Completion of training modules by ASHAs across various states.

State name	ASHAs IN POSITION	MODULE 1 COMPLETED	MODULE 2 COMPLETED	MODULE 3 COMPLETED	MODULE 4 COMPLETED	MODULE 5 COMPLETED
BIHAR	87135	69402	35000	35000	35000	-
CHATTISGARH	60092	60092	60092	60092	60092	60092
JHARKHAND	40964	40115	39482	39214	35675	20785
MADHYA PRADESH	52117	45908	42153	41237	37969	-
ORISSA	34324	34117	33910	33910	33910	34124
RAJASTHAN	48372	40310	32652	32652	2847	-
UTTAR PRADESH	136268	135130	128434	128434	128434	-
UTTARAKHAND	9983	9975	9975	9975	9975	8978

Table 5

[SOURCE: CONCURRENT EVALUATION OF ASHA BY NHSRC 2011, MOHFW,GOI]

Module completion is the basic method of developing skills in ASHA. Module training is very extensively taken up by states in order to train the ASHAs, but still some States have failed to even complete the first module training completely. Jharkhand, Madhya Pradesh, Uttar Pradesh and Rajasthan have fallen short in completing the first module training to all ASHAs in position. Even states

like Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh have not initiated the module 5 training which clearly indicates that these states are lacking in imparting proper training to ASHAs.

Fig 3.1: Status of completion of Module in Bihar.

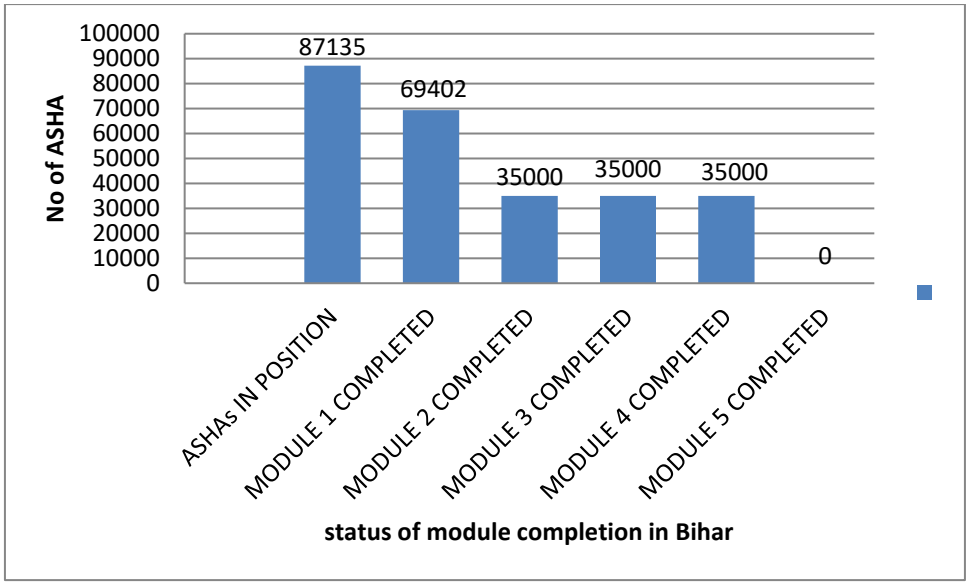


Figure 3.2: Status of completion of Module in Chhattisgarh.

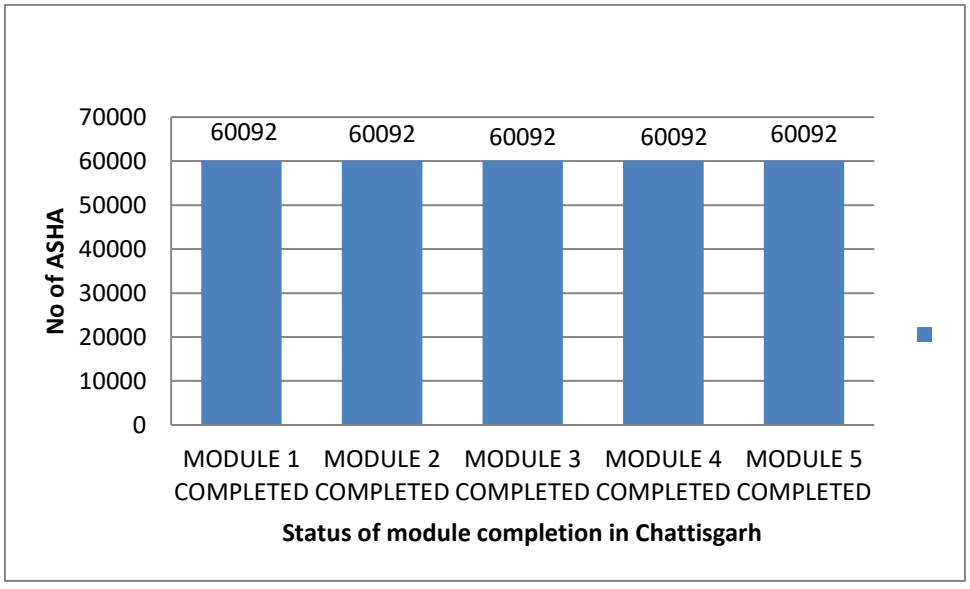


Figure3.3: Completion of MODULE in Jharkhand.

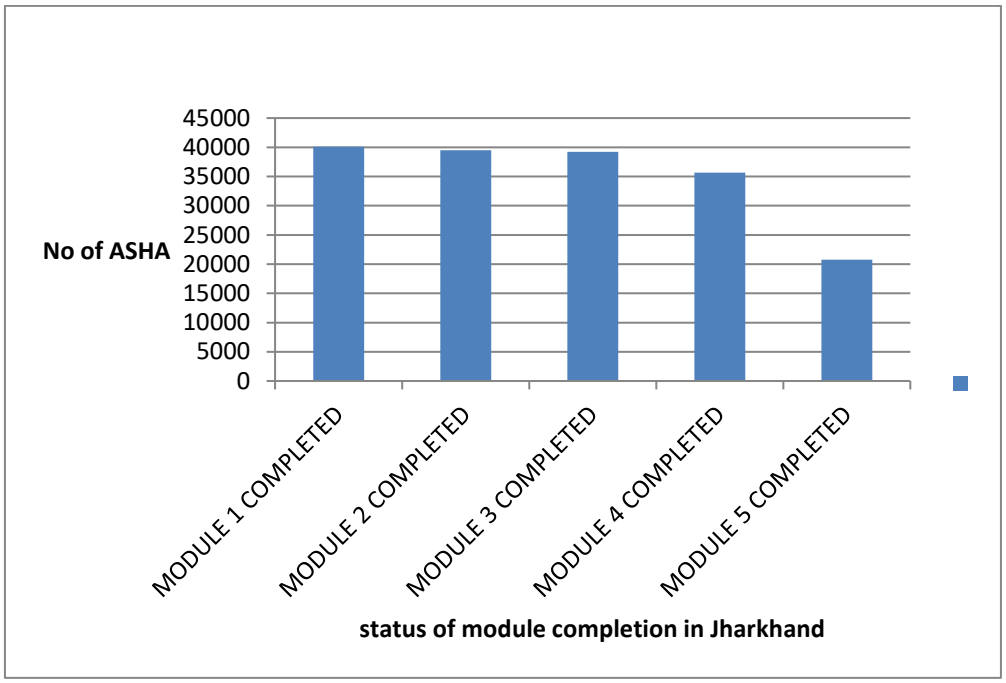


Figure3.4: Status of Module completion in Madhya Pradesh.

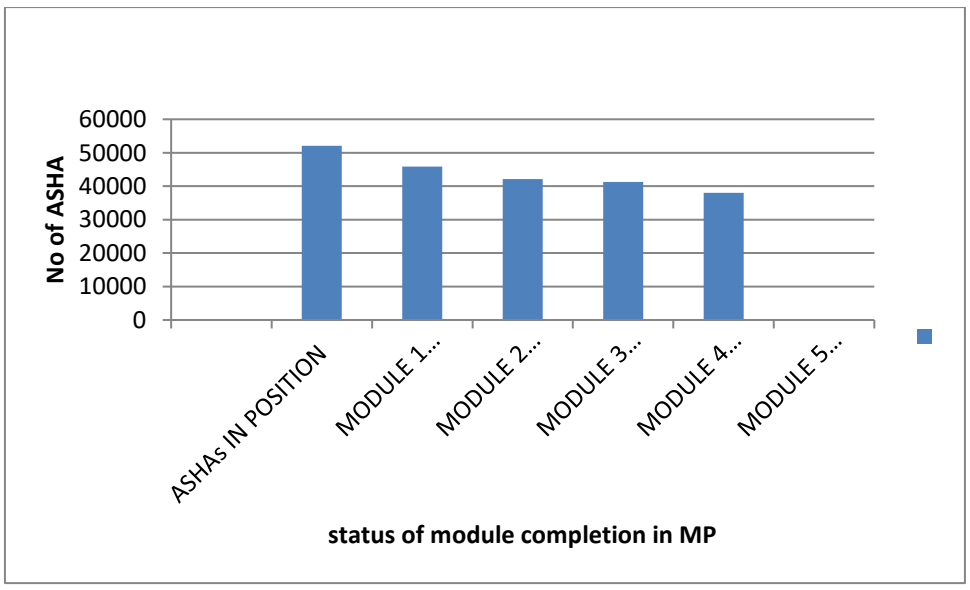


Figure3.5: Status of module completion in Orissa.

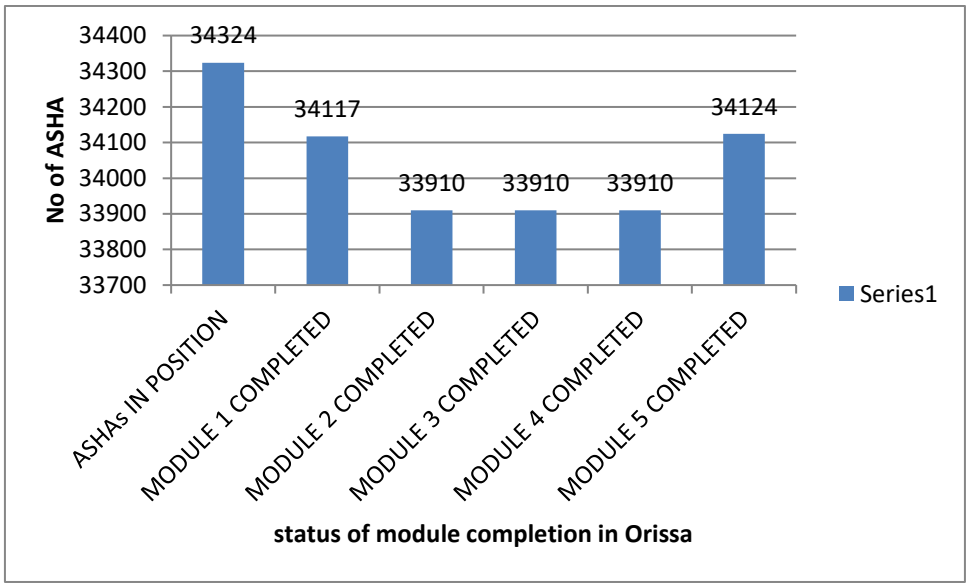


Figure 3.6: Status of module completion in Rajasthan.

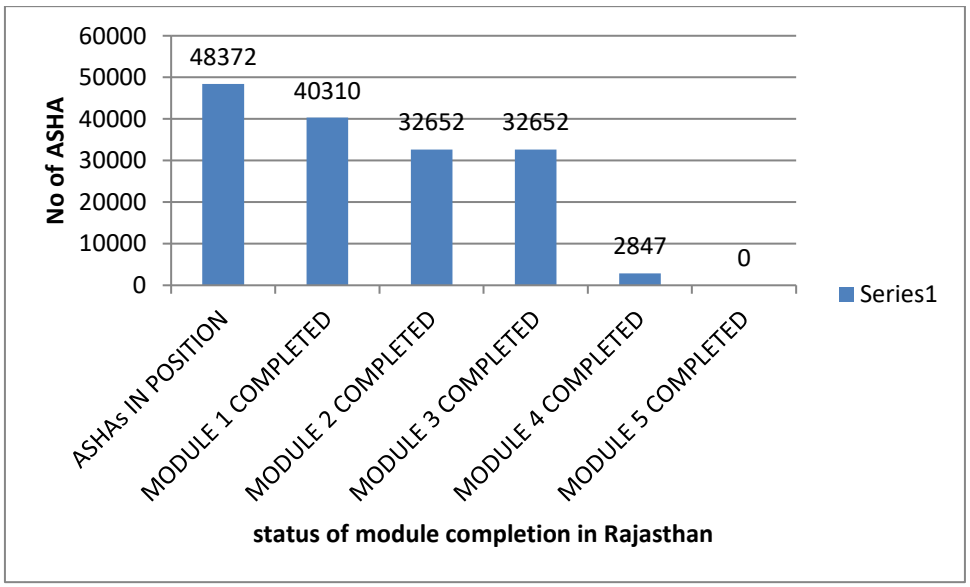


Figure 3.7: Status of module completion in Uttar Pradesh.

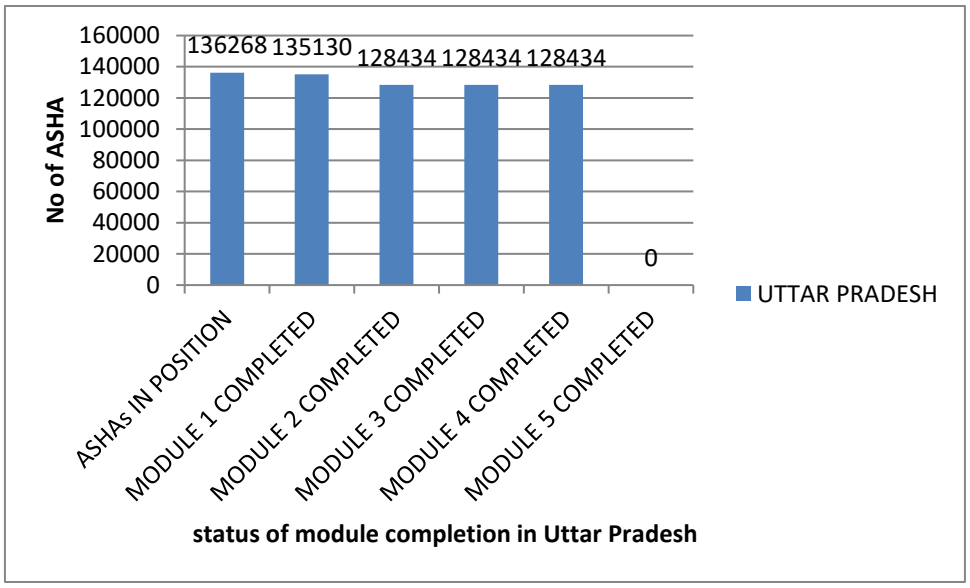
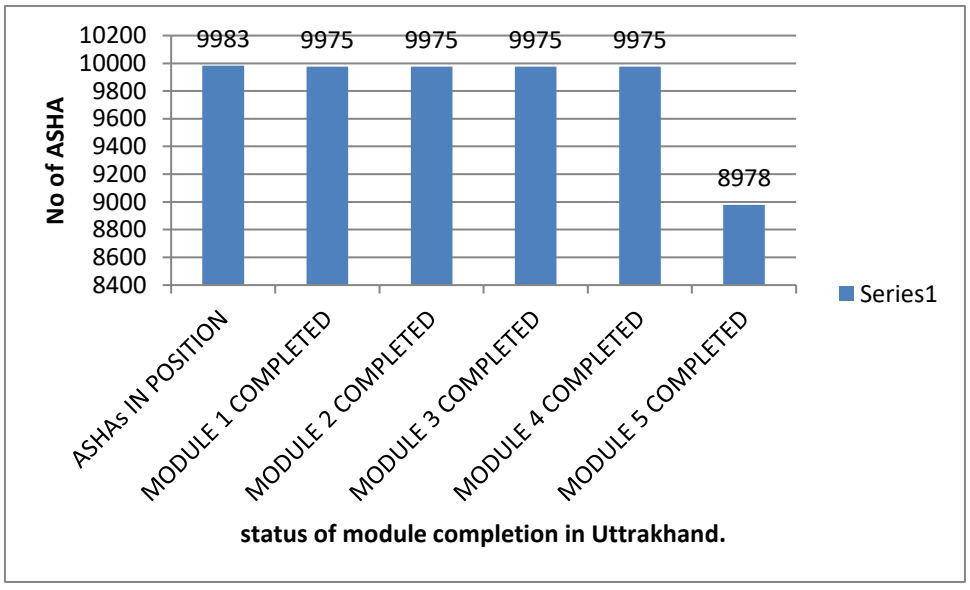


Figure 3.8: Status of module completion in Uttarakhand.



CRITERIA 3.

State wise availability of Drug kits to the ASHAs.

Name of the EAG state	ASHAs in Position	Available Drug Kits.
BIHAR	87135	0
CHATTISGARH	60092	60092
JHARKHAND	40964	35000
MADHYA PRADESH	52117	45971
ORISSA	34324	34214
RAJASTHAN	48372	32059
UTTAR PRADESH	136268	128434
UTTARAKHAND	9983	9975

Table 6

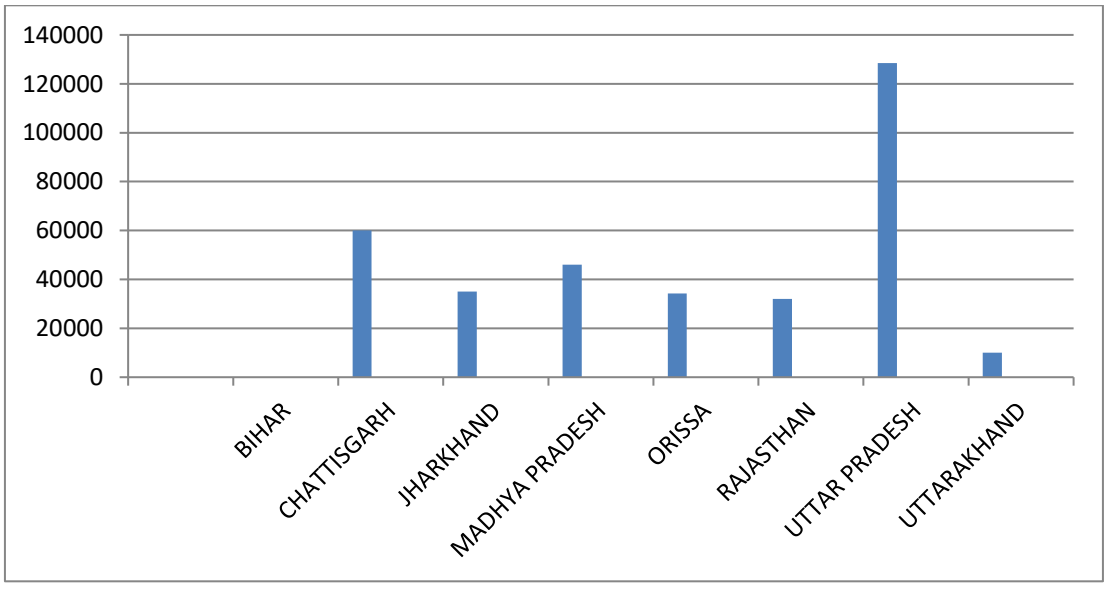


Figure 4:

Availability of Drug kits to the ASHA is only done after completion of MODULE 4. In Bihar the drug kits are not available because the procurement of Drug kits is going on.

CRITERIA 4.

State wise support services structure to the ASHAs.

Table 7.1: **BIHAR.**

Activity/programe status	Percentage of achievement at various levels till 2010.
STATE LEVEL	25%
DISTRICT LEVEL	0
BLOCK LEVEL	0
SECTOR LEVEL	0
DRUG REFILLING STATUS	0

Table 7.2: **CHATTISGARH**

Activity/program status	Percentage of achievement at various levels till 2010.
STATE LEVEL	100%
DISTRICT LEVEL	100%
BLOCK LEVEL	100%
SECTOR LEVEL	100%
DRUG REFILLING STATUS	50%

Table 7.3: **JHARKHAND**

Activity/programe status	Percentage of achievement at various levels till 2010.
STATE LEVEL	50%
DISTRICT LEVEL	50%

BLOCK LEVEL	50%
SECTOR LEVEL	50%
DRUG REFILLING STATUS	25%

Table 7.4: **MADHYA PRADESH.**

Activity/programe status	Percentage of achievement at various levels till 2010.
STATE LEVEL	0
DISTRICT LEVEL	50%
BLOCK LEVEL	0
SECTOR LEVEL	0
DRUG REFILLING STATUS	75%

Table 7.5: **ORISSA.**

Activity/programe status	Percentage of achievement at various levels till 2010.
STATE LEVEL	50%
DISTRICT LEVEL	100%
BLOCK LEVEL	100%
SECTOR LEVEL	0
DRUG REFILLING STATUS	75%

Table 7.6: **RAJASTHAN.**

Activity/programe status	Percentage of achievement at various levels till 2010.
STATE LEVEL	75%
DISTRICT LEVEL	75%
BLOCK LEVEL	0
SECTOR LEVEL	0

DRUG REFILLING STATUS	50%

Table 7.7: **UTTAR PRADESH.**

Activity/programe status	Percentage of achievement at various levels till 2010.
STATE LEVEL	0
DISTRICT LEVEL	100%
BLOCK LEVEL	0
SECTOR LEVEL	0
DRUG REFILLING STATUS	25%

Table 7.8: **UTTRAKHAND**

Activity/programe status	Percentage of achievement at various levels till 2010.
STATE LEVEL	50%
DISTRICT LEVEL	50%
BLOCK LEVEL	0
SECTOR LEVEL	0
DRUG REFILLING STATUS	0%

[SOURCE: TRAINING DIVISION, MoHFW,GOI]

CRITERIA 5

Table 8: **Constitution of ASHA resource centre by the respective states,**

Name of the EAG state	ASHA resource centre available	Supporting body

BIHAR	Yes	
CHATTISGARH	No	State Health system resource centre
JHARKHAND	Yes	
MADHYA PRADESH	No	No body to provide support
ORISSA	No	Community process resource centre
RAJASTHAN	yes	
UTTAR PRADESH	No	No body to provide support
UTTRAKHAND	yes	

From the above table it is clearly analyzed that EAG states like Chhattisgarh, Madhya Pradesh, Orissa and Uttar Pradesh have not constituted ASHA resource centre and are rendering technical skills to the ASHA by coordinating with SHSRC and CPRC. ASHA resource centre is the technical support body constituted by the state to provide in service trainings to the ASHAs and other associated trainings to develop skills of the ASHAs. Uttar Pradesh is completely lacking it.

CRITERIA 6.

ASHAs receiving less than 23 days of training per year in EAG states.

As per the guidelines of NRHM, it is mandatory for every ASHA across the country to minimum attend a 23 days of training. These trainings are conducted by the respective State Government with collaboration with the technical bodies and resource centers. In these training sessions Technical trainers are arranged to upgrade the skills of the ASHA.

Table 9

Name of the EAG state	% ofASHA registered to received 23 days of	Remarks

	training in 2010	
BIHAR	72%.	72% of total ASHAs in position registered for this training and 97% of them received training upto 16 days only.
CHATTISGARH	100%	
JHARKHAND	92%	92% of the ASHAs enrolled for the training and out of that 50% received training upto 10 days.
MADHYA PRADESH	NA	
ORISSA	100%	54 % of the ASHAs received more than 23 days of targeted training.
RAJASTHAN	69%	69 % of the ASHA came for the training and out of that only 31% completed 15 days of training.
UTTAR PRADESH	NA	
UTTRAKHAND	NA	

The service trainings of Chhattisgarh and Orissa was appreciable as the attrition rate of the ASHAs was very less during the trainings and state like Rajasthan and Bihar initiated the training process but were failed to impart the training to all the ASHAs as most of the ASHAs left before 16 days of training.

CRITERIA 7

Table 10.1: **Financial utilization of the ASHAs across EAG states in 2009-10.**

Name of the EAG state	Approved amount of ASHA [Rs in lakhs]	Utilized amount by the states[Rs in lakhs	% of expenditure
BIHAR	5702	835.44	14.6
CHATTISGARH	2390	1872.44	78.35
JHARKHAND	2153	503.5	23.33
MADHYA PRADESH	3464	768.57	22.18
ORISSA	3578	850.37	23.75
RAJASTHAN	2790	1638	58.70
UTTAR PRADESH	13583	2945.88	21.68
UTTRAKHAND	195	41.27	21.16

Figure 4.1

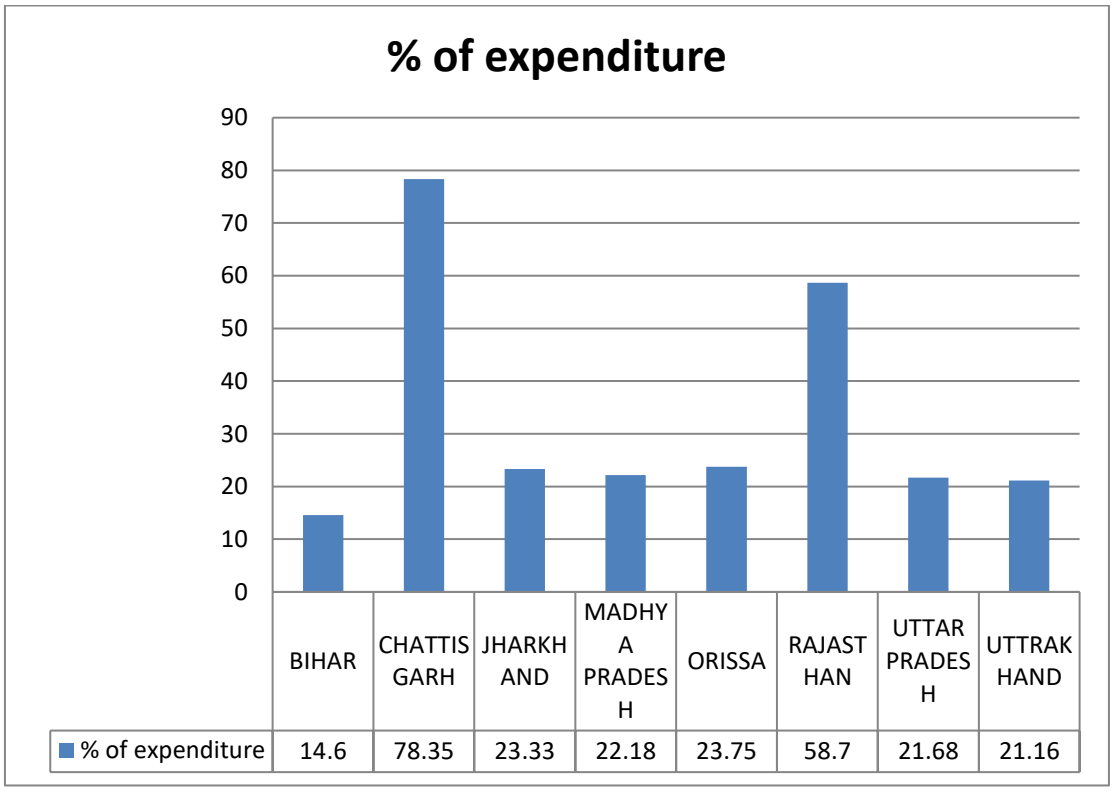


Figure 4.1

Table 10.2: **Financial utilization of the ASHAs across EAG states in 2005-10.**

Name of the EAG state	Approved amount of ASHA [Rs in lakhs]	Utilized amount by the states[Rs in lakhs	% of expenditure
BIHAR	10507	2408	22.92
CHATTISGARH	3581	3832	107.01
JHARKHAND	4685	30.1	64.25
MADHYA PRADESH	6720	2548	37.92
ORISSA	5648	3265	57.81
RAJASTHAN	7916	3246	41.01
UTTAR PRADESH	29635	8515	28.73
UTTRAKHAND	2130	1364	64.04

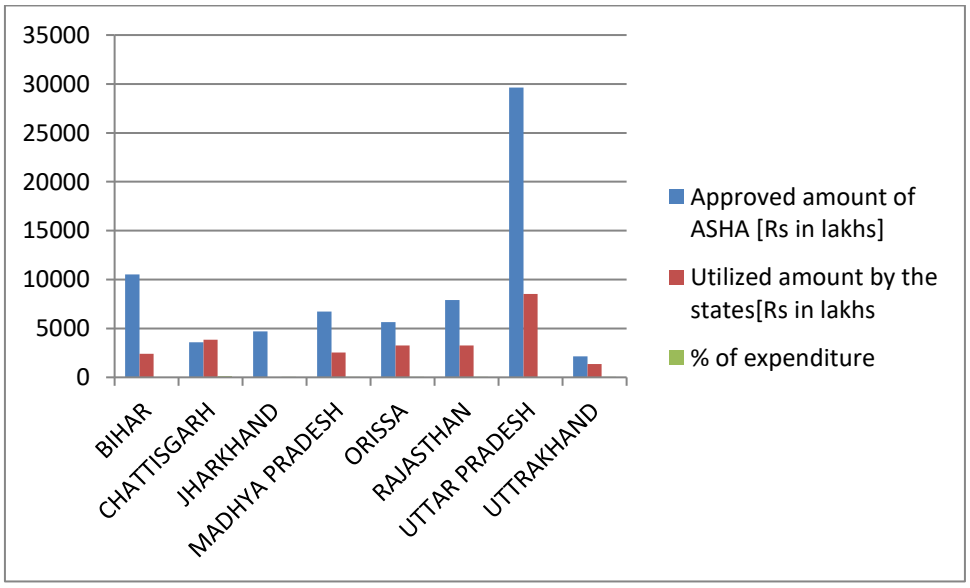


Figure 4.2

From the above graphical analysis it clearly signifies that Chhattisgarh and Rajasthan had a better expenditure and utilization of ASHA funds compared to other EAG states. States like Bihar, Madhya Pradesh, Orissa and Jharkhand were only able to utilize less than one fourth of the allocated budget. This clearly indicates that there was complete lack of planning and management on the ASHA part. These states were lacking proper planning to utilize the funds on ASHA hence the percentage of expenditure was really low.

KEY DISCUSSION ABOUT THE STATES.

BIHAR.

ASHAs in position in the state are less compared to population norms. Financial utilization for the ASHAs is not up to mark as less than 15% of the total allocated funds. 72% of total ASHAs in position registered for the ASHA training sessions happening in the state. ASHA resource centre available in the state ,but ASHA support service structure is only available at the state level, still the support services are not available in the district and block level. Drug kits procurement is in pipeline as a result the ASHAs have not yet been provided with drug kit.
None of the ASHAs in Bihar have been trained on module 5.

CHATTISGARH.

Financial utilization for the ASHAs is upto mark as it is approximately 78%, 100% ASHA had undergone training session of the ASHAs.

ASHA resource centre is highly functional in the state to provide technical support services to the ASHAs. The ASHAs in position are as per the population norms and the training processes are satisfactory.

JHARKHAND.

Financial utilization of ASHA is less than 25% of the allocated amount, which indicates that state has not formulated sufficient planning for complete utilization of resources. ASHA support structures in the state are also not well developed especially in the district level and block level and drug refilling status is also not satisfactory.

MADHYA PRADESH.

Fund utilization on the ASHA head is less than 22% which is the second lowest utilization among all the states. The state has not developed proper resource centre to provide technical inputs.

The penetration of technical support is lacking in the grass root levels

The training sessions are not well maintained and co-ordinated as a result the attrition is high in these sessions.

ORISSA.

In Orissa the fund utilization on the ASHAs is approximately 23.78% which is comparatively high compared to other EAG states, but not satisfactory, state has well equipped ASHA resource centre to provide technical support to the ASHAs.

The trainings have a good response rate and incentives are been given to create motivation.

The state has substantially taken corrective measures to develop the ASHA cadre in the state.

UTTAR PRADESH.

The state has lowest fund utilization on the ASHA part which clearly states that states need to work on more planning and policies to strengthen to ASHA

system. The support structures of the ASHA are not at all well developed to provide proper technical support and attrition rate is also high in the state.

UTTRAKHAND

The state has done well in the fund utilization on the ASHA head. The state has good status in the training of ASHAs and drug filling status. The state has a satisfactory support structures on ASHA.

Ground problems of the ASHAs

- Lack of job specification and functional clarity.
- Assessment should be carried out to screen their theoritcal and practical knowledge.
- Lack of refresher trainings
- Political involvements
- Irregularities in monetary compensation.

Results:-

On the basis of above parameters and analysis, EAG states have started working more on the communitization area and ASHA strengthening has witnesses a substantial improvement over the period of NRHM but the improvement can be more accelerated. There is high disparity among various EAG states .states like Chhattisgarh and Orissa have performed better in this aspect where as Bihar still has not provided drug kits to the ASHAs. Fund utilization is appreciable in Chhattisgarh and Rajasthan where as it is under expectation in Uttar Pradesh and Madhya Pradesh. But all in all this study marks the overall improvement of ASHA in the EAG states over the period of NRHM.

Conclusion:-

The mapping of essential actions does not rule out for flexibility and further adaptation by the states and districts. There is enough space for innovations and fresh thinking. For example the ASHA and BLOCK extension educators may be involved in conducting learning sessions on health care activities and working out more planning approaches to strengthen the communitization. The mother NGOs may be roped in BCC and environment building activities. States and districts are encouraged to take inputs from stake holders, public health professionals and health care providers and community in implementing the strategy keeping in the mind to develop implementation in the district and block levels. For example, inputs from technical support structures both in state level and central level should be considered in developing resource materials. There can be several other option that states and districts have to explore. Flexible method of financing from various channels should be prioritized and more planning is required to technically equip the EAG states for rationale fund utilization on the ASHA head. Training sessions should be more strengthened and more focus to be given on availability of proper incentives and kits to the ASHA which will further increase the motivation of the ASHAs. The necessary recommendations to improve the ASHA activities in the state is to strengthen the support structures in the district and block level and ensure a perfect monitoring system to review the activities. Technical support and financial incentives should be continuously provided from centre and state level to ensure the perfect motivation level. All major stake holders and professionals in the Health system should rationally involve making this system a prospering one to deliver better health services in the country. Development Partners, external funding agencies and NGOs should join hands with the present system to increase flexibility and maximum utilization of the fund and human resources in addressing the challenges of Health care in the country. Proper training, incentives and adequate support can definitely increase the productivity of the ASHA to deliver better services for the community.

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ANNEXURES.

Table 3

State name	Proposed no. of ASHAs	SANCTIONED NUMBER OF ANGANWADI CENTRE	ESTIMATED RURAL POPULATION(2008)	DENSITY OF ASHA
BIHAR	87135	81088	87679990	1:1006
CHATTISGARH	60092	34937	18645601	1:310
JHARKHAND	40964	32097	24184836	1:590
MADHYA PRADESH	52117	69238	51611676	1:990
ORISSA	34324	41697	34584474	1:1007
RAJASTHAN	48372	48372	51392259	1:1062
UTTAR PRADESH	136268	150727	154144864	1:1131
UTTARAKHAND	9983	9664	7121594	1:713

Table 6

Name of the EAG state	ASHAs in Position	Available Drug Kits.
BIHAR	87135	0
CHATTISGARH	60092	60092
JHARKHAND	40964	35000
MADHYA PRADESH	52117	45971
ORISSA	34324	34214
RAJASTHAN	48372	32059
UTTAR PRADESH	136268	128434
UTTARAKHAND	9983	9975

TABLE 4

State name	Proposed no. of ASHAs	Number of ASHA selected	% of ASHA selected
BIHAR	87135	72000	82.63
CHATTISGARH	60092	60092	100
JHARKHAND	40964	40964	100
MADHYA PRADESH	52117	49282	94.54
ORISSA	34324	34252	99.79
RAJASTHAN	48372	43789	90.52
UTTAR PRADESH	136268	136182	99.93
UTTARAKHAND	9983	9983	100

ASHA TRAINING STATUS (Up to August, 2009) (EAG States + NE States)

Name of state	Total ASHA target	Total ASHA selected	Total ASHA completed Training (Module Number)					% of ASHA Trained (selected)	Status of Module -V
			1 (7 days)	2 (4 days)	3 (4 days)	4 (4 days)	Total days completed		
Uttarakhand	9923	9873	9873	9873	9873	9873	7+4+4+4	100%	85.2% ASHAs trained (8395)
Jharkhand	40788	40788	40115	39482	39214	34412	7+4+4+4	81%	
Rajasthan	46862	43111	40361	40361	40361	40361	6+10*+4	95%	
Orissa	34,324	34252	34117	32832	32786	32352	7+4+4+4	94.4%%	Rolling out Module V
MP	62253	53038	48734	45147	45126	23379	7+4+4+4	52%	
UP	1,35832	13,4434	129056	109443	109443	109443	7+4+4+4	92%	
Bihar	74,389	67,506	57362	11080	11080	11080	7+4+4+4		
Tripura	7357	7119	6961	6767	6348	6228	7+4+4+4	87.48%	45% ASHAs trained (3202)
Meghalaya	6258	6258	5946	6059	5174	5199	7+4+4+4	83%	Rolling out Module V
Nagaland	1700	1700	1700	1700	1700	1700	7+4+4+4	100%	Rolling out Module V
Mizoram	943	943	943	943	943	943	7+4+4+4	100%	Rolling out Module V
Manipur	3878	3878	3225	3225	3000	3000	7+4+4+4	77.35%	Rolling out Module V
Sikkim	636	636	636	636	636	636	7+4+4+4	100%	Rolling out Module V
Arunachal Pradesh	3862	3508	2764	2764	2764	2764	7+4+4+4	77.41%	Rolling out Module V
Assam	26247	26225	26225	26225	26225	26225	7+4+4+4	100%	52% ASHAs trained (14910)
Chhattisgarh****	29347	29347	29347	29347	29347	29347	7+4+4+4+4	100%	
Total	484599	462466 (95.43%)	437365 (94.57%)	365884 (79.11%)	364020 (78.71%)	336942 (72.85%)			

TABLE 4.1-4.8

Concurrent Evaluation: High Focus Non NE States (Except HP)											
Data gathered in April to December 2008 --Published 2010.											
Progress of Key Parameters: **The ASHA programme and the VHSC (data relates to last quarter of 2008)**											
		Bihar	Chhattisgarh	Jammu & Kashmir	Jharkhand	Madhya Pradesh	Orissa	Rajasthan	Uttar Pradesh	Uttarakhand	code
1	% of ASHAs who have received training in module 1	97.6	97.9	94.1	98.3	83.7	98.6	91.1	86.9	93.9	B. ASHA.2.1.
2	% of ASHAs who have received training in module 2 or more	43.5	97.9	80.4	73.3	87.5	98.1	89.9	84.6	100	B. ASHA.2.2
3	% of trained ASHAs who received drug kits.	34	87.5	67.9	54.2	70	93.1	45.5	83.1	94	B. ASHA.3..
4	% of married women- 15 to 49 who reported ASHAs provided medicines free of cost.	14	81.4	24	45.7	38.8	64.1	57.3	46.1	43	B. ASHA.7.
5	% of ASHA received pregnancy testing kit	63.3	79.2	0	23.6	41.5	75	74.5	63.2	78.6	B. ASHA.4.2
6	% of ASHA who are DOTS providers	40.2	13.5	12.5	15	33.3	35.2	43.4	63.4	48	B. ASHA.4.3
7	% of ASHA received Family planning incentives	45.5	35.4	1.8	1.7	46.9	44.9	42.7	42.6	40	B. ASHA.4.5
8	% of ASHA received VHND incentives	1.9	77.1	1.8	0	17.8	61.1	46.9	6.2	30	B. ASHA.4.6
9	Average monthly JSY registered by ASHA	2.9	1.3	1	1.5	2.1	2.3	2.2	2.2	2.3	B. ASHA.6.1
10	Average monthly JSY cases taken for Institutional delivery by ASHA	2.1	0.8	0.7	0.5	1.7	1.8	1.1	1.7	1.9	B. ASHA.6.2
11	Average amount received per month by ASHA(Rs.)#	769	320	106	36	432	588	840	384	1056	B. ASHA.5.0
12	Sample size of ASHAs	209	96	56	120	213	216	113	383	50	B. ASHA.2.1
13	% of ANMs reporting ASHA in position	96.4	100	100	100	94.1	100	90.5	98.9	97	C.1.2.
14	% of GPs reporting existence of VHSC in village	4.4	54.2	5.9	19.4	91.9	56.5	83.3	76.6	10	B.1.1
15	% of GPs reporting VHSCs received untied funds	0.9	43.8	2.9	4.2	24.8	38.9	70.2	48.3	0	B.1.3
16	% of GPs perceiving "NRHM brought improvement"	69.9	83.3	32.4	44.4	60.5	76.9	89.3	83.6	73.3	B.1.6

BUDGET & FINANCIAL MECHANISMS FOR TRAINING ASHAs

For an unit of 100 ASHAs (appox. for a block)

(Amount in Rs.)

Selection process	**Facilitators role- visit and meeting expenses. They may make upto 2-3 trips.**	**Rs 100 per visit for upto 3 visits for 100 villages.**	**30,000**
	Mobilization/committee formation and meetings i.e. for arranging focus group discussions and meetings of village Health Committee	**Rs.250/village for 100 villages**	**25,000**
Training of ASHA (camp based)	**Training expenses). The training meetings will be for 25 days in a year**	**Rs 100 for to and fro travel: 6 times in the first year for 100 ASHAs = Rs.100*6*100**	**60,000**
	Training compensation	**DA for 25 days of training for 100 ASHAs @ Rs.100 per day**	**2,50,000**
	Training material	**Rs 300* 100 ASHAs**	**30,000**
	Honorarium to Trainers of ASHAs	**4 batches (of 25 ASHAs each) * 5 trainers * 25 days * Rs.100 per trainer per day**	**50,000**
Training of trainers	**Training expenses**	**5 trainers* 30 days*100 per day food +travel**	**15,000**
	Training material	**5 Trainers * Rs300**	**1,500**
	Training honorarium to Resource persons of Trainers	**5 trainers * Rs 100/day* 240 days**	**1,20,000**
Drug kit		**600* 100**	**60,000**
Village untied Fund		**1000*100**	**1,00,000**
	TOTAL		**7,41,500**