Training Programme

10.1 INTRODUCTION

One of the key components of the "architectural correction' envisaged under NRHM is to strengthen community participation in all health programme.

10.2 ASHA PROGRAMME

ASHAs are a central feature of National Rural Health Mission's community process component. The programme has evolved rapidly over the past seven years. Today it is widely accepted as the most visible face and one of the most successful components of the NRHM.

During this period 8,66,726 ASHAs have been selected, trained and deployed across the country. The ASHAs role has emerged as a mix of facilitation, activism and community level care. Their work includes counselling on improved health practices and prevention of illness and complications, and appropriate curative care or referrals in pregnant women, new born, young children as also for malaria, tuberculosis and other conditions. Other than this, ASHAs have also been engaged in the social marketing of products such as sanitary napkins and spacing contraceptives.

To enable ASHAs to perform these roles, most states have established the institutional structures required for training and support, but more needs to be done in strengthening these structures to perform effectively. During the year 2012-13, the following steps were taken towards addressing this concern:

- ***Establishing an ASHA Database in all states:*** To enable maintaining a track of ASHAs with details of their entry, education levels, training inputs and performance and drop outs
- ***Introducing a system for outcome monitoring***: To assess the functionality and effectiveness of ASHA on set of ten indicators , for block, district and state levels
- ***Introducing Handbook For ASHA Facilitators***: For capacity building of ASHA Facilitators (1 per 20 ASHA) who provide the immediate field level support and mentoring to ASHAs
- ***Instituting a Grievance Redressal Mechanism for ASHA***: To provide ASHAs with a forum to voice their issues related to delayed payments and work situations.

A key challenge for the programme as demonstrated in successive reviews and evaluations: ASHAs are effective in reaching about 70% of the population with their services but a substantial 30% still remain unattended. To address this concern a training booklet on *Reaching the Unreached* was disseminated to the states to enable skill building for the ASHA in reaching marginalized populations of her geographic area.

Incentive package for ASHAs has been increased and measures to streamline payments are being emphasized.

The important information on programme specific advancements and findings from the key programme evaluations shared during this period is detailed in sections ahead.

10.3 ASHA SELECTION

Table 1: Complete Status of ASHA Selection as on 30.9 2012

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
High Focus States	496837	489266	98.48
North East States	54411	53785	98.85
Non High Focus	356291	322977	93.7
Union Territories	742	698	94.07
Total	**908281**	**866726**	**95.42**

About 95% of the selection target has been achieved for the entire country. In most high focus states except Rajasthan and to a certain extent in Madhya Pradesh, the required number of ASHA as per the 2001 population, are already in place. In the North Eastern (NE) states, 99% of the ASHA have been selected. In the non- high focus states, Delhi, Karnataka, West Bengal, Tamil Nadu and Gujarat are in the process of selecting additional ASHAs to meet the target.

10.4 ASHA TRAINING

More than 80% of ASHAs in most high focus, and nearly all in the North East states have been trained up to Module 5. To expedite the process of completing Module 5 training in Bihar, contents of Module 5 have been merged with Module 6 and 7, and the length of the training has been increased from 20 days to 24 days, to be conducted in four rounds of six days each. Except Maharashtra and Tamil Nadu all Non High Focus states have completed training more than 70% ASHAs in module 5.

In 2012-13 almost all states initiated training in Modules 6 and 7, except in Kerala and Tamil Nadu, where the states are developing state specific skill training modules for ASHA. ***Details on training status of ASHAs are included in Appendix-I to IV.***

Training of State trainers in Round I and Round II for Modules 6 and 7 is complete in almost all states. A total of 388 state trainers have been trained at the three national training sites and of this about 288 state trainers were accredited for Round 1 and 202 for Round 2. 4893 ASHA trainers, who train the ASHAs at sub district levels, have been trained across the states except Uttar Pradesh. Round I ASHA Training is underway in all the high focus states, except Uttar Pradesh[1]. Uttarakhand has completed training of ASHAs in three rounds.

All North Eastern states except Assam have completed two rounds of Module 6 and 7 for ASHAs or it is underway. Round 3 training of ASHAs has been initiated in Manipur. The states of Jammu and Kashmir and Delhi are yet to initiate training ASHAs in Modules 6 and 7. In the Non-High Focus states, Gujarat and Karnataka have completed training ASHAs in the first phase of Round 1 and 2 and have commenced training for Round 3 and 4 as well. Maharashtra, Punjab and West Bengal are in various stages of completing training of ASHAs in Round 1 and Round 2.

10.5 ASHA SUPPORT STRUCTURE

As on 30th September 2012, most high focus states have established support and supervisory mechanisms at state, district, block and sub block levels. While some states such as UP and MP have no State ASHA Resource Centres, there is a dedicated team, which undertakes the functions related to the ARC. Madhya Pradesh is in the process of appointing district and block community mobilizers.

In North East, state level support mechanisms are in place across all states except Mizoram and Sikkim. At the district level, barring these two states and Nagaland support structures for ASHA Programme are in place. All North East states except Nagaland are yet to establish the block level support mechanisms. However considering their small numbers of ASHAs, management by existing structures appears to suffice.

ASHA facilitators are an integral part of the ASHA programme and are to be deployed before the selection of the ASHA. They were intended to facilitate the community led selection of the ASHA. While some states did appoint them for the selection, they tended to drop them after the ASHA were in place. Most of the High Focus and North East States have engaged ASHA facilitators.

The Non high focus states like Punjab, tribal districts of Maharashtra and Gujarat have district level support structures and have started appointing ASHA facilitators. Others have no support systems below the state and not even at the state in several cases, but are using the existing programme structures to manage and support the ASHA programme.

[1] The state of Uttar Pradesh has opted to launch training of ASHAs in an adapted version of Module 6 and 7 to avoid duplication of the content covered in Comprehensive Child Survival Programme (CCSP) training.

10.6 DRUG KIT FOR ASHAS

Drug Kit is provided to all ASHAs on completion of Training in Module. All states have completed or are in the process of completing the distribution of Drug Kits. Delays have been primarily on account of the cumbersome tendering processes in the states. Regular replenishment is not streamlined in all states. It is occurring in all North East states and amongst the High Focus States only Chhattissgarh, Odisha and Uttarakhand have done this. In the Non-High Focus states annual replenishment is seen in Jammu and Kashmir, Punjab, Maharashtra and West Bengal. Mechanisms of refill are mostly need based which are done either on a quarterly or monthly basis in some states. Most states are also in process of distributing an equipment kit to ASHAs for providing home based new born care.

Key Findings from recent Programme Evaluation

A) A study was conducted by Institute of Economic Growth and commissioned by the Planning Commission on Evaluation National Rural Health Mission in seven states with an objective of evaluation and assessment of the availability, adequacy and utilization of health services in the rural areas, the role played by ASHAs, AYUSH in creating awareness of health, nutrition among the rural population and to identify the constraints and catalysts in the implementation of the NRHM programmes. The external evaluation further affirms that- ASHAs play an important role in increasing awareness about the key health care initiatives of NRHM. Increase utilization of maternal and child care services have been attributed to ASHAs. The main conclusions drawn on the functioning of ASHAs have been summarized in Box-1 below.

BOX : 1

FUNCTIONING OF ASHA[2]

ASHA is functional in undertaking home visits which is evident from more than 65% beneficiaries confirming that ASHA visits them between 15-30 days. Higher figures of about 65-70% were reported from Jharkhand, Odisha and Assam on this aspect, while MP and UP performed slightly low. ASHA visiting the households with drug kits was highest in Odisha, UP and MP at 80 %, 70 % for Assam and Jammu and Kashmir but these figures were low for Jharkhand at only 55%.

80% beneficiaries reported that ASHA provided free drugs from her drug kit. A bivariate analysis on role played by ASHA in motivating pregnant women for utilization of antenatal care from public health care facilities points - 60% of women who availed antenatal care services in government facility confirmed fortnightly visits by ASHAs. Similar analysis when extended to view the institutional delivery pattern further reveals that about 65% beneficiaries going for institutional delivery reported regular fortnightly visits by ASHAs.

Visits by ASHAs when used as a predictor variable for Multinomial Logit Regression technique to study results for ANC Utilization Behaviour further highlights-

"ASHA's role in motivating pregnant women for utilization of antenatal care from public health care facilities turns out to be positive and highly significant. All the variables pertaining the ASHA's role and responsibilities/activities like visit to households carrying and distribution of free medicines and sensitizing/counselling with women on sanitation and obstetric care depict positive and highly significant impact on the utilization of antenatal care from the public sector health care facilities. Interestingly, the ASHA's role does not depict any negative impact on the utilization of private health care facilities for obstetric/ANC care in the rural areas. Apparently ASHA's role in motivating rural women for utilization of public health care facilities for obstetric care turns out to be very important"

[2]Excerpted from Evaluation Study of National Rural Health Mission (NRHM) in 7 States Programme Evaluation Organisation Planning Commission, Government of India- February 2011

"Use of contraceptive methods was reported by 56% of the couples and out of the users we found that 88% had availed government health facilities for contraception services. Interestingly we found majority of the users were motivated by ASHA and 46% out of 88% had reported the source of contraception to be ASHA/ANM/VHW".

Adjusting probabilities of women seeking Delivery Care from Public and Private Health Care facilities to program factors like visits by ASHAs, it was found that-

"ASHA's regular visits to households, while accounting for other predictor variables, improves the probability of utilization of public health facilities from 0.54 to 0.71. Interestingly, ASHA's visit to household becomes responsible for a significant shift from no-use to use of public health facilities and depicts marginal impact on change in probability of use of private health facilities for the delivery care. So ASHA's role in motivating women for public sector institutional deliveries turns out to extremely important".

- Awareness about ASHA scheme was much higher than NRHM, which clearly reflects that JSY and role of ASHA has brought much higher awareness about the NRHM initiatives.
- In relation to payments, 72% of the ASHAs reported to be paid compensation for the services rendered by them except for few ASHAs who reported being paid very low in UP (23/75) and Jharkhand (25/50). ASHAs are supposed to have some advance money for emergency transport but only 25% of them from all states reported to having the advance money.
- The study also co relates ASHA visits to chronic disease concerns:- "Role of ASHA seems to be important as patients from households which are visited more frequently and where free medicines get distributed depict higher tendency of using public compared with private health facilities for treatment of chronic diseases. Similarly households where general counselling on health matters is provided by ASHAs and other health functionaries report higher utilization of public health institutions for the purpose of treatment".

B) Internal Evaluation of ASHA Programme in three states:- Madhya Pradesh, Uttar Pradesh, Uttarakhand[3]

Key Findings

The population coverage of ASHAs varied across and within states. However, majority of the ASHAs in five of the sample districts reported covering between 501- 1000 population. The density was reported to be higher in the three districts of UP – Hamirpur, Sonbhadra and Aligarh where ASHAs reported covering between 1001- 2000 population.

Majority of ASHAs reported being functional on promoting institutional deliveries and Immunization. About 82-95% ASHAs across the three states reported accompanying women at the time of delivery, 72-82% reported providing counselling to pregnant women and 87-92% said that they promoted and coordinated the immunization days. Regarding household visits 68% of ASHAs in UP, 53% in Bhind District of MP and fewer than 40% in Uttarakhand(UK) and Raisen district of MP, reported making such visits. Newborn visits were reported by 81% ASHAs in Aligarh, 52-62% in Bhind, Udhamsingh Nagar and the three remaining districts of UP as compared to only 37% in Raisen and Paurigarhwal.

In terms of coverage, as reported by Service Users A, access to ASHA services was highest in Paurigarhwal and Hamirpur with 88%. In the remaining districts this was 65-75% except for Raisen district where coverage was reported to be lowest with 44%. The functionality

[3] The evaluation of the ASHA Programme was commissioned by the National ASHA Mentoring group and coordinated by the NHSRC. In the second round, the ASHA programme was evaluated in the three High Focus states of Madhya Pradesh (MP), Uttar Pradesh (UP) and Uttarakhand (UK). Realist Evaluation methodology was used, and two districts were purposively selected in each state. One district was chosen for its good performance and the other for its high proportion of scheduled castes/scheduled tribes. In Uttarakhand, Udhamsingh Nagar and Pauri Garhwal were chosen. In Madhya Pradesh, Raisen falls into the first category and Bhind in the second. Given the size of the state, four districts (Sohanbhadra, Hamirpur, Aligarh and Lakhimpur) were selected in Uttar Pradesh. One additional factor that was considered in the district selection in UP, was the training of ASHA in a state specific module, the Comprehensive Child Survival Programme (CCSP) in 18 of 72 districts. Thus two of the four districts, (Aligarh and Lakhimpur) where CCSP training has been completed were selected based on the above mentioned criteria

of ASHAs in terms of promoting institutional delivery and counselling during ANC was 70% in UK as compared to 56% in UP and 48% in MP. However, only 56% of Service Users A in UP, 44% in MP and 29% in UK reported getting three or more ANCs, which reflects the poor outreach services. A high proportion of Service Users A reported delivered in institutions, - 89% in MP, 79% in UP and 70% in UK, and over 70% cited ASHAs as the main motivator, while more than three quarters reported that ASHAs accompanied them to the institution.

For post- partum care ASHA functionality on knowledge of an important message such as foul smelling discharge as a sign of post- partum complication drops considerably, with about 32 % ASHAs in UK, and less than 20% in UP and MP.

Coverage by ASHAs in case of a sick child was highest in UK with 41% followed by 32% in UP and 17% in MP. The functionality of ASHAs i.e, service user Bs who reported that ASHAs helped them in managing the child hood illness was between 78-93% across states, while it was highest in UK with over 90%. However, this is not translated in to high levels of effectiveness as ASHAs were able to give ORS to in only 46-56% of cases. This reflects problems with supply and replenishment. In cases where she was not able to supply ORS directly she was referring the child for treatment, even then about 22% to 37% children who had diarrhoea did not get ORS from any source. In case of ARI about 98% of the Service Users B sought treatment reflecting high referral rates of ASHAs. The knowledge of ASHAs about identifying chest in drawing as a danger sign for ARI and about making ORS was found to be low in UP and MP, and about 54% and 65% in Pauri Garhwal and UdhamSingh Nagar respectively in UK.

Clearly, in Madhya Pradesh and Uttar Pradesh there is a great urgency to rapidly establish and strengthen support structures and step up the pace of the programme. In Uttarakhand the priority is for the state to take ownership of the programme and work closely with the NGO support structures to make them more effective, by enabling quality standards of skill based training and effective performance monitoring. All three states also need to institutionalize a system of monitoring the functionality and outcomes of the ASHA programme. This is even more important in UP and MP, in order to identify and support poorly performing ASHAs, where the selection of ASHAs in the early phases was not community led and was influenced by vested interests. All three states, and more particularly MP and UP states stand to benefit greatly from having a skilled ASHA at the community level to promote maternal, new born and child health, and family planning.

Appendix-I

Training Status for High Focus States

State Name	Training Status Number of ASHAs Trained in			
	Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Bihar	52859 (63%)	52859 (63 %)		➢ 19 state trainers trained in round 1 and 14 trained in round 2 ➢ 4 State Training sites established with NGOs ➢ 736 District Trainers trained ➢ Module 5 Training of 4 days merged with 4 rounds of Module 6 & 7 training, making it 4 rounds of 6 days each, Round 1 training of 6 days completed for 35699ASHAs (42.3%) ➢ 1826(2.16%) trained in Round 2
Chhattisgarh	60092 (100%) Mitanins trained in Module 1 to 12.			➢ 55630 Mitanins (92.6 %) trained on 13th module. ➢ 53300 Mitanins (88.7 %) trained on module 14th and 15th module ➢ 50989 Mitanins (84.8 %) trained on revision round Module 16
Jharkhand	39214 (95.73%)	35675 (87.9%)	40964 (100%)	➢ 13 State trainers trained in Round 1 and 14 in Round 2 ➢ 413 District Resource Persons trained in round 1 and Round 2 ➢ 28990 ASHAs (70.7%) trained in Round 1 of Module 6&7 and 585(1.43%) trained in Round 2
Madhya Pradesh	47022 (83.4 %)	45777 (81.72%)	42405 (75 %)	➢ 29 state trainers trained in Round 1 and 20 in Round2 ➢ 586 district trainers trained in Round 1 ➢ 23909 (42.7%) ASHA Trained in Round 1 and 200 trained in Round 2
Orissa	43372 (99.6%)	43373 (99.6%)	41560 (95.5%)	➢ 16 state trainers trained in round 1 and 12 in Round ➢ 186 District Trainers trained in Round 1 ➢ 39615 (76.92%) ASHAs trained in Round 1.
Rajasthan	34776 (67.8%)	45110 (87.6 %)	34921 (67.8 %)	➢ 11 state trainers in Round 1 & 9 trained in Round 2 ➢ 800 District Trainers trained in Round 1 and 457 in Round 2 ➢ 5905 ASHAs (11%) trained in Round 1

State Name	Training Status Number of ASHAs Trained in			
	Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Uttar Pradesh	129150 (95%)	129150 (95%)	121580 (89.3 %)	➢ 22 State Trainers Trained in Round 1 ➢ District TOTs and ASHA trainings being planned
Uttarakhand	11086 (100%)	11086 (100%)	8978 (81%)	➢ 6 state trainers trained in Round 1 and 5 in Round 2 ➢ 231 District trainers trained in Round 1 and 203 in round 2 ➢ 544 out of total 550 (99%) ASHA facilitators trained in Round 1 and 2 (7 Days) & 539 trained in Round 3 ➢ 10313 ASHAs (93%) trained in Round 1, 10064 (91%) in Round 2 & 10209 (92%) in Round 3 of five days each.

Appendix-II

Training Status for Non-High Focus States

State Name	Training Status Number of ASHAs Trained in			
	Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andhra Pradesh	30 days training as the programme preceded NRHM, but covered women's and children's health.			➢ 12 State trainers trained in Round 1 and 11 in Round 2 ➢ 386 District Trainers trained in Round 1 ➢ 41444 (59%) ASHAs trained in Round 1
Delhi	Module 1-4 clubbed as Module 1, 2, 3 – 2298 (51.1%) ASHAs trained		Module 5 as Module 4 – 1926 (42.8%) ASHAs trained	➢ State is planning to initiate training of State trainers
Gujarat	26803 (86.5%)	26596 (86%)	25177 (82%)	➢ 4 state trainers trained in round 1 and 2.Five trainers from Deepak Charitable Foundation trained in Round 2 ➢ 160 district trainers trained in Round 1 ➢ 26371 ASHAs (85%) trained in Round 1 & 21323(69%) in Round 2 ➢ 14213 ASHAs (46%) trained in Round 3, 12347 (40%) in round 4
Haryana	13730 (99.8%)	13289 (96.6%)	11112 (80.3%)	➢ 12007 ASHAs trained in 2 days training of HBPNC module - Phase 1, supported by NIPI. ➢ 9 state trainers trained for Module 6 & 7
Jammu and Kashmir	9500 (88.93%)	9000 (84.25%)	8300 (77.69%)	➢ 5 State Trainers trained in Round 1 and 6 in round 2 ➢ 225 District Trainers trained in round 1
Karnataka	Up to Module 5 -33750 (100 %)			➢ 15 State Trainers trained in round 1 and 10 trained in round 2 ➢ 240 District Trainers trained in round 1 ➢ 21,500 ASHAs (63%) trained in a combined ten days training of Round 1 and 2

State Name	Training Status Number of ASHAs Trained in			
	Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
				➢ 7450 ASHAs(22%) trained in a combined training of ten days for Rounds 3 and 4
Kerala	28205 (88.5%)	25673 (80.56 %)	22992 (72.1 %)	➢ State is planning to train ASHAs in a state specific module.
Maharashtra	56923 (96%)	55124 (93%)	27029 (45.9%)	➢ 15 state trainers trained in round 1 and 13 trained in round 2 ➢ 322 District trainers trained in Round 1 and 233 trained in Round 2 ➢ 10353 ASHAs (17.6%) trained in Round 1 & 5619 (9.4%) trained in Round 2
Punjab	16214 (96.5%)	16214 (96.5%)	16403 (97%)	➢ 5 State trainers trained in Round 1 ➢ 326 District Trainers trained in Round 1 ➢ 16533 ASHAs (98.7%) trained in Round 1
Tamil Nadu	1639 (42%)	1639 (42%)	1639 (42%) Module 1-5 trainings done only in tribal districts	➢ State will train ASHAs in specific areas based on local issues, such as blindness, malaria, new born care, etc.
West Bengal	42211 (90 %)	39163 (83.34%)	37577 (80%)	➢ 17 State Trainers trained in Round 1 and 13 trained in round 2 ➢ 480 District trainers trained in Round 1 ➢ 10528 ASHAs (22.4%) trained in Round 1 & 3380 (7.19%) trained in Round 2

Appendix-III

Training Status for North Eastern States

State Name	Training Status Number of ASHAs Trained in			
	Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Assam	28544 (97.85%)	28497 (97.7%)	28422 (97.43%)	• 17 State trainers trained in round 1 and 14 trained in Round 2 • 54 District trainers trained in Round 1 • 13895(47.63%) ASHAs trained in Round 1
Arunachal Pradesh	3559 (95%)	3606 (96%)	3635 (97%)	• 4 State trainers trained in Round 1and 4 trained in Round 2 • 28 District trainers trained in round 1 • 3627 ASHAs (96.54%) trained in round 1 and 1708 (45.46%) trained in Round 2
Manipur	3878 (100%)	3878 (100%)	3878 (100%)	• 3 State trainers trained in Round 1 and 2 • 62 District trainers trained in Round 1 and 2 • 3878 (100%) ASHAs trained in Round 1, 2 and Round 3
Meghalaya	6250 (99.9%)	6250 (99.9%)	6250 (99.9%)	• 3 State trainers trained in Round 1 and 2 • 66 District trainers trained in Round 1 • 5732 (91.6%) ASHAs trained in Round 1 & Round 2 • 280 ASHA Facilitators trained in Round 1 & 245 in round 2
Mizoram	987 (100%)	987 (100%)	987 (100%)	• 3 State trainers trained in Round 1 and 2 • 28 District trainers trained in round 1 • 987 (100%) ASHAs trained in round 1 & 739 (74.9%) in round 2
Nagaland	1700 (100%)	1700 (100%)	1700 (100%)	• 3 State trainers trained in Round 1 • 60 District trainers trained in Round 1 • 1576 (91.6%) ASHAs trained in round 1 & 1571 (92.4%) in round 2

State Name	Training Status Number of ASHAs Trained in			
	Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Sikkim	666 (100%)	666 (100%)	666 (100%)	• 3 State trainers trained in Round 1 and 4 trained in Round 2 • 20 District trainers trained in round 1 • 666 (100 %) ASHAs trained in round 1 & 2
Tripura	7367 (100%)	7367 (100%)	7367 (100%)	• 5 State trainers trained in Round 1 & 2 • 89 District trainers trained in round 1 • 7257 (98.5%) ASHAs trained in round 1 & 7009 (95.14%) in round 2

Appendix-IV

Training Status for UTs

State Name	No. of ASHAs Selected	Training Status Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andaman and Nicobar Island	407	100%	100%	100%	• State has not yet made plans to train ASHAs in Modules 6 and 7.
Dadra and Nager Haveli	208	85 (41 %)	85 (41 %)	85 (41 %)	• 45 ASHAs have been trained in Round 1 of Module 6 and 7 training
Lakshadweep	83	83	-	-	• No data available
Daman and Diu					• State has recently introduced the ASHA programme

10.7 CENTRALLY SPONSORED SCHEME OF "BASIC TRAINING OF ANM/LHV"

Availability of qualitative services to the community depends largely upon the efficacy with which health functionaries discharge their responsibilities, which, in turn would depend mainly upon their education and training. Department of Family Welfare had recognized the crucial role of training of health personnel in providing effective and efficient health care to the rural community from the very beginning of the Five Year Plans. The pre-service and in-service training for different categories of health personnel are imparted through the following schemes/ activities:

ANMs/LHVs play a vital role in MCH and Family Welfare Service in the rural areas. It is therefore, essential that the proper training to be given to them so that quality services be provided to the rural population.

For this purpose 319 ANM / MPHW (Female) schools with an admission capacity of approximately 13,000 and 34 promotional training schools for LHV/ Health Assistant (Female) with an admission capacity of 2600 are imparting **pre-service training** to prepare required number of manpower to man the Sub centers, PHC, CHC, Rural Family Welfare Centers and Health posts in the country. The duration of training programme of ANM is 1&1/2 years and minimum qualification required for this course is 10+2 pass. Senior ANM with five years of experience is given six months promotional training to become LHV/ Health Assistant (Female). The role of Health Assistant (Female) is to provide supportive supervision and technical guidance to the ANMs in sub-centres. Curricula of these training courses are provided by the Indian Nursing Council. The financial pattern of assistance was last revised on 7.2.2001.

Funds under the scheme are replenished by Family Welfare Budget Section on the basis of audited accounts submitted by States. Rs. 9724.57 lakhs has been released till December, 2012.

10.8 CENTRALLY SPONSORED SCHEME OF "BASIC TRAINING FOR MULTI PURPOSE HEALTH WORKER (MALE)"

The Basic Training of MPHW (M) scheme was approved during 6th Five-Year Plan and taken up by GoI in 1984, as a 100% Centrally Sponsored Scheme. There are 49 basic training schools of MPHW (Male). Duration of course is 1 year and on successful completion of the training, the candidate is posted as MPHW (M) at the sub-centre. The financial pattern of assistance was last revised on 7.2.2001.

Funds under the scheme are replenished by Family Welfare Budget Section on the basis of audited accounts submitted by States. Rs1500.48 lakhs has been released till December, 2012.

10.9 CENTRALLY SPONSORED SCHEME OF "MAINTENANCE OF HEALTH AND FAMILY WELFARE TRAINING CENTRE"

49 HFWTCs were established in the country in order to improve the quality and efficiency of the Family Planning Programmes and to bring the change in the attitude of the personnel engaged in the delivery of health services through in service training programmes. These training centres are supported under Centrally Sponsored Scheme of "Maintenance of HFWTCs".

Key role of these training centres is to conduct various in-service training programmes of Department of Family Welfare. Apart from in-service education some of the selected centres has an additional responsibility of conducting the basic training of MPHW's course where MPW training centers are not available. The financial pattern of assistance was last revised on 7.2.2001.

Funds under the scheme are replenished by Family Welfare Budget Section on the basis of audited accounts submitted by States. Rs 2344.78 lakhs has been released till December, 2012.

10.10 REPRODUCTIVE AND CHILD HEALTH TRAINING

National Institute of Health & Family Welfare (NIHFW) has been identified as the Nodal Institute for training under RCH-II till 31st March 2012. An evaluation by an independent agency is being conducted to consider its further extension meanwhile an extension uptill 31st March 2013 has been granted.

NIHFW has been co-ordinating and monitoring the performance of various trainings under NRHM with the help of 18 Collaborating Training Institutions (CTIs) in various parts of the country. Specific activities of the RCH Unit of the Institute include:

- Central Training Plan (CTP): Final Central Training Plan (CTP) for 2012-13 was uploaded on NIHFW's website. Coordination with the states and relevant training centres for implementation of the CTP and monitoring the progress as well as quality check of the on-going trainings are going on.
- Monitoring Visits: As part of monitoring visits under NRHM/RCH-II, 12 districts representing high focus, were visited from 28 States/UTs.
- Preparation of district-wise training data base has been initiated to ensure the availability of appropriately trained health manpower at every level of health facilities.
- Monthly as well as quarterly training progress reports received from all the states has been analysed and feedback is sent for improvement in the training.

Consolidated thematic area wise total training achievement is given in the following table:-

CONSOLIDATED THEMATIC AREA WISE TOTAL TRAINING ACHIEVEMENTS IN THE COUNTRY RCH-II / NRHM (2012 - 2013)

THEMATIC AREAS	Annual Training Load (2012-13)	Training Achievement (Apr. - Sep.2012)	GAP	% of Achievement
MATERNAL HEALTH	120416	16039	104377	13.32
CHILD HEALTH	423160	36275	386885	8.57
FAMILY PLANNING	67033	6563	60470	9.79
ARSH	122554	8109	114445	6.62
NATIONAL DISEASE CONTROL PROGRAMME	356803	4859	351944	1.36
OTHER TRAININGS	274347	55496	218851	20.23