



# Guidelines for ASHA and MAHILA AROGYA SAMITI in the Urban Context

MINISTRY OF HEALTH AND FAMILY WELFARE  
GOVERNMENT OF INDIA

NATIONAL URBAN HEALTH MISSION



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NATIONAL URBAN HEALTH MISSION



केशव देसिराजु  
सचिव  
KESHAV DESIRAJU  
Secretary

Tel. : 23061863 Fax : 23061252  
E-mail : secyhfw@nic.in  
k.desiraju@nic.in



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण विभाग  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
Government of India  
Department of Health and Family Welfare  
Ministry of Health and Family Welfare  
Nirman Bhawan, New Delhi- 110011

## Message



The launch of the National Urban Health Mission marks an important milestone in the country's march towards Universal Health Coverage. The underlying principle of the NUHM framework is that activities will be designed so that the health needs of the disadvantaged - the homeless, the destitute and other vulnerable categories are addressed even as we endeavour to enable universal access. Actualizing this principle will need substantial effort, and should not be underestimated. The health needs of the urban poor and strategies to address them are substantially different from the needs of the urban poor and strategies to address them are substantially different from the needs of the community in rural areas.

In particular, addressing community processes interventions in urban areas will need careful attention to selection, training, and support of ASHA and building an active Mahila Arogya Samiti. Preconditions to this are a sound understanding of who the vulnerable are, their specific needs and their habitations. This will call for creative partnerships, and states must make use of existing resource in urban areas including medical colleges, NGOs and other civil society organizations. Effective convergence with institutions charged with addressing environmental and social determinants of health will be critical.

India's challenge to implementing community processes in urban areas will only grow in the coming years, but a good beginning will lay the foundations to address this issue. The Community Processes guidelines for the NUHM layout the programme principles for implementation and also provide guidance on specific roles and responsibilities of the key players. States are encouraged to adapt the guidelines to specific contexts and to work jointly with the Ministry in building upon and refining these to ensure improved coverage and access of the urban poor and in particular, the marginalized, to primary health care.

  
(Keshav Desiraju)



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**Anuradha Gupta, IAS**

Additional Secretary &  
Mission Director, NRHM

Telefax : 23062157

E-mail : anuradha-gupta@outlook.com



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## Foreword



Eight years ago, when India launched the National Rural Health Mission, we made a commitment to ensure that community processes would become an integral part of the Mission. The National Urban Health Mission, a sub mission of National Health Mission, renews and deepens this commitment, and recognizes that the ASHA and the community collective or Mahila Arogya Samiti, are critical components towards achieving health outcomes, particularly with respect to addressing action on social and environmental determinants.

The challenges in urban areas are very different from those in rural areas. These differences related to community composition and their needs are striking. One significant challenge is that of social inclusion and ensuring that health interventions reach the most marginalized of all. There cannot be more effective vehicle to facilitate this than a strong community processes intervention.

The Framework for Implementation for the NUHM lays out the institutional norms and requirements for the ASHA and Mahila Arogya Samitis. These guidelines lay down principles for implementing interventions relating to community processes in urban areas. They build not only on the experience in NRHM but also from a body of knowledge in states where initiatives in community based urban health are underway.

NRHM shows us that key to effective functionality of the ASHA are strong training and support systems, a mechanism for regular payments, social recognition and a supportive community coalition. These are important considerations and need to be ensured in urban areas as well.

I am confident that given the learning from NRHM, states would be able to quickly put in place and expand the requisite institutional structures for community processes in urban areas and build the mechanisms for convergence, thus ensuring effective and functional community processes to lay the foundation for successful outcomes of the National Urban Health Mission.

Date : 17.01.2014

(Anuradha Gupta)





# CONTENTS

BACKGROUND:	1
<b>PART - I : URBAN ASHA</b>	<b>3</b>
I.1 Roles and Responsibilities for Urban ASHA	3
I.2 Selection of ASHAs	5
I.3 Programme Management and Supportive Mechanisms for ASHA Programme	8
I.4 Capacity Building of ASHAs	9
I.5 ASHA Drug Kit	11
I.6 Working Arrangements	12
I.7 Compensation to the ASHA	12
I.8 Setting up a Grievance Redressal Committee	13
I.9 Fund Flow Mechanism for the Community Processes Programme	14
I.10 Monitoring and Evaluation	15
<b>PART - II : MAHILA AROGYA SAMITIS ( MAS)</b>	<b>17</b>
II.1 Objectives and Goals of MAS	17
II.2 Process of formation of Mahila Arogya Samiti	17
II.3 Coverage of MAS	18
II.4 Composition of MAS	18
II.5 Characteristics of members of Mahilla Arogya Samiti	18
II.6 Office Bearers and their roles	19
II.7 MAS Bank Account	19
II.8 Capacity Building of MAS	19
II.9 Activities of Mahila Arogya Samiti	20
II.10 Monitoring of Mahila Arogya Samitis	21
II.11 Accounting for the Untied Fund for MAS	22
II.12 Role of NGOs in Community Processes in urban context	23
<b>Annexures</b>	<b>24</b>



# Background

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The last eight years of the National Rural Health Mission's Community Processes intervention have demonstrated that ASHA has a significant role to play in improving health outcomes. The Framework for Implementation of the National Urban Health Mission lays special emphasis on improving the reach of health care services to vulnerable groups among the urban poor. This involves the-homeless / pavement dwellers, beggars, street children, women working as commercial sex workers, construction workers, rag pickers, rickshaw pullers, elderly poor, disabled people and people with mental illness. Thus, the strategy for community health in urban areas involves facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor.

The strategy to strengthen Community Processes in urban areas relies on an ASHA in 1000-2500 population and a Mahila Arogya Samiti (MAS) (comprised of women living in a cluster of households within that particular slum area), at the level of 50-100 household viz population of 250-500. This implies that every ASHA will be responsible for two –five MAS. In addition the community processes may also leverage the existing community organizations and self – help groups developed through other initiatives to improve health access and awareness of people living in slums.

The Guidelines for Community Processes in Urban areas includes the following key aspects:

Part I deals with the

- Roles and Responsibilities of ASHA
- Selection of ASHA
- Supportive Structures and Management
- Capacity Building and Training of ASHA
- Working arrangements and compensation to ASHA
- Fund Flow Mechanism

Part II encompasses operational framework for Mahila Arogya Samitis.

The budgetary norms for the community processes programme in urban areas broadly follow those defined in the Guidelines for Community Processes in rural areas. Acknowledging the diversities in context of urban areas, it is envisaged that states will exercise flexibility and adapt these guidelines to local situations.



## I.1 Roles and Responsibilities for Urban ASHA:

The role of an ASHA is that of a community level care provider. This includes a mix of tasks: facilitating access to health care services, building awareness about health care entitlements especially amongst the poor and marginalized, promoting healthy behaviours and mobilizing for collective action for better health outcomes and meeting curative care needs as appropriate to the organization of service delivery in that area and compatible with her training and skills.

Her roles and responsibilities would be as follows:

- ▶ ASHA will take steps to create awareness on social determinants and entitlements related to health and other related public services. She would provide information to the community with special focus on the vulnerable groups, on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and facilities and the need for timely use of health services.
- ▶ She will counsel women, families and adolescents on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection and Sexually Transmitted Infection (RTIs/STIs), care of the young child, substance abuse, prevention of domestic violence and sexual violence.
- ▶ ASHA will provide community level curative care for ailments such as diarrhoea, fevers, care for the normal and sick newborn, childhood illnesses, nutrition counselling, and first aid. She will also measure blood pressure and blood and urine sugar. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme and will provide appropriate community level care for other communicable diseases like malaria, Japanese encephalitis, chikungunya, leprosy, etc. She will also act as a depot holder for essential health products like ORS-Zinc, Iron and Folic Acid Pills, chloroquine, condoms, oral contraceptives, sanitary napkins and others as appropriate to local community needs. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. These will be updated from time to time, States can add to the list as appropriate.
- ▶ The ASHA's role as a community level care provider can be enhanced based on state needs. States can explore the possibility of graded training to the ASHA to provide palliative care, screening for non-communicable diseases, childhood disability, mental health, geriatric care and others.
- ▶ ASHA will mobilize the community and facilitate people's access to health and health related services available at the AWC/ Primary Urban Health Centres/ urban secondary and tertiary health centres, for institutional delivery, Immunization, Ante Natal Check-up (ANC), Post Natal Check

up (PNC), ICDS, sanitation and other services being provided by the government.

- ▶ She will work with the Mahila Arogya Samiti to promote convergent action by the committee on social determinants of health and take action to increase access of vulnerable groups for various public services. In support with MAS, ASHAs will assist and mobilize the community for action on- gender based violence, alcohol –drug abuse, mental health issues, and education regarding irrational drug use and about exploitative practices of private health practitioners. Such collective action will be undertaken as the programme matures.
- ▶ She will arrange escort/accompany as required pregnant women & children requiring treatment/admission to the nearest pre- identified health facility i.e. Urban Primary Health Centre/Community Health Centre/First Referral Unit (CHC/FRU). In case the beneficiary belongs to homeless and marginalized community a more active escort by ASHA to the health care facility is recommended.
- ▶ The ASHA will provide information on the births and deaths in her area and any unusual health problems/disease outbreaks in the community to the Urban Primary Health Centre. She will work on issues of water and sanitation in coordination with Mahila Arogya Samitis and enable construction and use of household/community toilets and promote sanitation and hygiene in the community.

The ASHA will fulfill her role through five activities:

1. **Home Visits:** For up to two hours every day, for at least four or five days a week, the ASHA should visit the families living in her allotted area with first priority being accorded to vulnerable groups and marginalized families. Considering that an important focus of the National Urban Health Mission is on the vulnerable who do not live in 'homes', the ASHA will pay attention to ensuring that she reaches them wherever they are resident and can be accessed. Home visits are intended for health promotion and preventive care. They are important not only for the services that ASHA provides for reproductive, maternal, newborn and child health interventions, but also for non- communicable diseases, disability, and mental health. The ASHA should prioritize homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child. Home visits should take place at least once in a month. Where there is a new born in the house, a series of six visits or more becomes essential.
2. **Attending the Urban Health and Nutrition Day (UHND) and supporting outreach activities:** The ASHA should facilitate and promote attendance at the monthly Urban Health and Nutrition Day by those who need Aganwadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services. She would mobilize the beneficiaries belonging to vulnerable groups falling in the category of homeless / pavement dwellers, beggars, street children, women working as commercial sex workers, construction workers, rag pickers, rickshaw pullers elderly poor, disabled people and people with mental illness to attend the monthly outreach services delivered by ANM.
3. **Visits to the health facility:** This involves accompanying a pregnant woman, sick child, or some member of the community needing facility based care. Usually this is not a mandatory task but

often such assistance is needed for enabling access across different types of barriers particularly faced by the marginalized. ASHA is also expected to attend the monthly review meeting held at the Urban PHC

4. **Promotion of Mahila Arogya Samitis:** ASHA along with her ASHA Facilitator/Community organizer and ANM will help in the promotion of MAS. She will be the member secretary of the two-five Mahila Arogya Samitis, formed in her designated area and will help convene their monthly meeting and provide leadership and guidance to their functioning. These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.
5. **Maintain records:** Maintain records which help her in organizing her work and help her to plan better for the health of the people. She would maintain necessary information and records about births & deaths, immunization, antenatal services in her assigned locality as also about any unusual health problem or disease outbreak in the slum and share it with the ANM in charge of the area.

The first three activities relate to facilitation or provision of healthcare, the fourth is mobilizational and fifth is supportive of other roles.

## I.2: Selection of ASHAs

Prior to the selection of ASHA it is important that City/ District health Society undertakes mapping of the city/urban areas with vulnerability assessment of the people living in slums or slum like situations and identifies these “slum/vulnerable clusters” for selection of ASHA.

The general norm for selecting ASHA in urban area will be “One ASHA for every 1000-2500 population”. Since houses in urban context are generally located within a very small geographic area an ASHA can cover about 200-500 households depending upon the spatial consideration. When the population covered increases to more than 2500 another ASHA can be engaged.

In case of geographic dispersion or scattered settlements of socially and economically disadvantaged groups the “slum/vulnerable clusters” selection of ASHA can be done at a smaller population. In cases where a particular geographic area has the presence of more than one ethnic/vulnerable group, selecting more than one ASHA below the specified population norm will be desirable. In such a case one ASHA could be selected for and from a particular vulnerable group so that their specific needs are addressed through an appropriate understanding of the socio-cultural practices of that community.

The selected ASHAs will be preferably co-located at the Anganwadi Centre that are functional at the slum level, for delivery of services at the door step. In urban habitations with a population of 50,000 or less, ASHAs will be selected as in rural areas. The other community volunteers built under Jawahar Lal Nehru National Urban Renewal Mission (JnNURM), Swarna Jayanti Shahari Rozgar Yojna (SJSRY) etc. can also be utilized for this purpose

### Criteria for Selection

- ▶ ASHA must be a woman resident of the – “slum/vulnerable clusters” and belong to that particular vulnerable group which have been identified by City/District Health Society for selection of ASHA.

She should be preferably 'Married/Widow/Divorced/Separated' and preferably in the age group of 25 to 45 years.

- ▶ ASHA should have effective communication skills with language fluency of the area/population she is expected to cover, leadership qualities and be able to reach out to the community.
- ▶ She should be a literate woman with formal education of at least Tenth Class. If there are women with Class XII who are interested and willing they should be given preference since they could later gain admission to ANM/GNM schools as a career progression path.
- ▶ The educational and age criteria can be relaxed if no suitable woman with this qualification is available in the area and among that particular vulnerable group.
- ▶ A balance between representation of marginalized and education should be maintained.
- ▶ She should have family and social support to enable her to find the time to carry out her tasks.
- ▶ Adequate representation from disadvantaged population groups should be ensured to serve such groups better.
- ▶ Existing women Community workers under other schemes like-urban ASHAs or link workers under NRHM or RCH II, JnNURM, SJSRY etc. may be given preference provided they meet the residency, age and educational criteria mentioned above and are able to provide time for their activities.

### Selection Process

The designated nodal officer in the City Programme Management Unit/District Health Society/Urban Health Cell in District Programme Management Unit as the case may be is expected to oversee the process. This body should form an Urban ASHA Selection Committee comprising of members such as- CMHO/CDMO, DPO-ICDS, representative of Urban Local Body, and Programme Officers of JnNURM, District Urban Development Agency (DUDA), SJSRY as appropriate. This committee will be headed by the member of the Urban Local Body, particularly in the case of seven metros. The City Programme Management Unit/District Health Society/Urban Health Cell in District Programme Management Unit can also decide to induct more members from the NGO/Civil society based on the local context.

The City/District Level Urban ASHA Selection Committee would be responsible for Constitution of U-PHC/Unit level ASHA selection committees. The catchment area of the Urban-PHC (U-PHC) would form the unit for selection process. In cities where U-PHCs do not yet exist the appropriate unit for ASHA selection will be decided by the City/District urban ASHA selection Committee.

The selection committee would provide the guidelines for the selection of ASHA and will monitor and provide necessary support to carry out the ASHA selection process including approval of the list of selected ASHAs. The selection guidelines must adhere to the following principles:

- i. Selection process for ASHAs should involve consultation with existing local community based organization or other organizations representing the vulnerable sections.
- ii. Consultations with the existing self- help groups should also be organized.



- iii. Selection of a candidate as an ASHA should be done in consultation with Mahila Arogya Samitis, where such women's group exists. Otherwise there should be an effort to convene a meeting of local women's group. This meeting should aim to build awareness of the group about the programme and also undertake consultation for selecting a candidate as an ASHA. This women's group can potentially become the Mahila Arogya Samiti for the designated area.
- iv. For ensuring that the above process is followed the Unit-PHC level selection committee will form a team of five facilitators in each U-PHC catchment area through a consultative process, for facilitating the selection of the ASHA.
- v. The facilitators should preferably be from local NGOs; community based groups, or Civil Society Institutions. In case none of these is available in the area, the officers of other Departments at the slum level/local school teachers may be taken as facilitators.
- vi. These facilitators will work closely with the community and existing women's group in selecting the ASHA. The five facilitators should be oriented to the selection process and emphasis will be on the fact that it is rigorous community driven process.
- vii. The facilitators are required to raise awareness in the vulnerable clusters about the roles and responsibilities of the ASHA and the criteria on which she is to be selected. This is done through community interaction in the form of meetings, Focus Group Discussions (FGDs) and mobilizational events such as nukkad nataks etc. These processes would enthuse women to apply to become ASHA.
- viii. The facilitator will organize meeting of the households for which an ASHA is to be selected. In order to organize the meetings the facilitators should engage actively with councillors of urban local bodies, community groups, women's groups, existing self-Help groups, Mahila Arogya Samitis wherever formed, AWWs, ANMs other local Civil Society Institutions. In the meeting the facilitator will explain the roles and responsibilities of the ASHA and ask the community to select their ASHA from amongst the women interested in taking up this role.
- ix. This interaction should result in short listing of at least three names from each "slum/vulnerable cluster".
- x. The facilitators would enable recording of the names of shortlisted candidates with Unit-PHC level selection committee. The U-PHC level committee would propose the names of ASHAs to the City Level ASHA Selection Committee, which would approve the names of the ASHAs.

State Governments may modify the guidelines and the details of the selection process, based on their context except that no change may be made in the basic criteria of ASHA being a woman, a volunteer, with minimum education up to X class, (only to be relaxed in selected areas where no such candidate is available) and that she would be a resident of the "slum/vulnerable cluster". In case any of the selection guidelines or process is modified, these should be widely disseminated in local languages.

### ASHA Database

An ASHA database/ register will be maintained at U-PHC, City/District and State levels. The function of the register is to maintain updated information on the ASHA, population coverage, households

allocated, training inputs received, and performance, data on drop-outs and new appointments. Formats for the register at each level are at Annexure I. This should be updated as specified.

Database registers will be maintained at U-PHC and city/district levels by the nodal staff and updated as and when required. On an annual basis the data will be consolidated and sent to the state as an aggregate number as specified in the Annexure I. This would help in maintaining a comprehensive record of all the ASHAs working in the city/district as well as drop outs from the programme. The register will also record the number of areas without an ASHA.

### **Criteria for declaring an ASHA as a “drop out”**

ASHA is to be considered as drop out if

- ▶ She has submitted a letter of resignation to the City/District Urban ASHA Selection Committee and to the designated ASHA Facilitator/Community Organizer for her allocated area **OR**
- ▶ She has not attended the three consecutive UHNDs or outreach sessions **AND** not given reasons for the same **OR**
- ▶ She has not been active in most of the activities **AND** ASHA facilitator/Community Organizer has visited the slum cluster of the ASHA and ascertained through discussions with all MAS members that she is indeed not active.

If there is a genuine problem, she should be supported until it is overcome through the MAS or the ANM. If the problem persists and the community also agrees that ASHA should not continue, a signed letter stating this should be obtained from her and approved by the U-PHC Medical Officer. In case of her contesting her removal, it should be referred to the District Community Processes Team established under NRHM/NHM or other person appointed by the secretary of the City/district selection committee who would listen to her views, record them and then take a final view. It is desirable in case of all ‘dropouts’ whatever the reason to conduct and document an exit interview.

Vacancies howsoever they arise, should be filled in by the same selection process as laid down by state government, based on these guidelines.

### **I.3: Programme Management and Supportive Mechanisms for ASHA Programme**

The community processes programme in urban areas should also have a strong network of supportive structures woven around it, to facilitate ASHAs work, strengthen MAS and make ASHA more effective as a community health worker.

#### **Support Structure for Urban Community Processes:**

- (i) National Level: NUHM Division, Department of Health and Family Welfare, MOHFW. Technical support for the NUHM will be provided by the National Health Systems Resource Centre with support from the National ASHA Mentoring Group.
- (ii) State level: The State Community Processes Resource Centre as established under NRHM will be expanded with a team of members to support and supervise the urban community processes and would also act as the state nodal support for ASHAs and MAS in urban areas. In addition to this there will be a team of state trainers providing training support. The state AMG should be

expanded to involve experts familiar with urban health situations.

- (iii) District/City Level: The existing District Community Processes Team as established under NRHM will be used for supporting and coordinating activities of the urban community processes as well. In contexts where required this existing support structure could be expanded if needed. For large cities a City Programme Management Unit will be established.

*Support Structures at the state and city/district level will be supported through the programme management unit of National Health Mission at the state level*

- (iv) Unit level: There will be one ASHA Facilitator/Community Organizer for about every twenty ASHAs and her MAS. He/She will be a candidate with a bachelor's degree and two to three years' experience in working on social development and community organization. Preference should be given to women candidates.

He/She will provide direct support in a wide range of activities such as- selection and training of ASHAs, formation and capacity building of MAS, performance monitoring, supportive supervision and release of ASHA payments, regular supply distribution and replenishment ASHA Kits and training material. Each ASHA Facilitator/Community Organizer will provide- on the job mentoring, supervision and day to day mentoring support to a group of approximately ten ASHAs.

An Urban Primary Health Centre depending on the population covered will comprise of four to five ANMs for conducting outreach activities. The ANMs will conduct outreach sessions in their area every month in support with ASHAs and would organize once a week Medical/ Health Camps for slum/ vulnerable population coming under each ASHA in support with health professionals. The ASHA Facilitator will coordinate with ANM for reporting and validating information regarding ASHAs.

In addition the NUHM framework provides for a Community Mobilizer or Public Health Manager based within U-PHC.

**Monthly Review Meetings:** States will need to establish a mechanism of Monthly Review meetings at Urban PHC which will be attended by its Medical Officer, Community Mobilizer (Public Health Manager of U-PHC), ASHA Facilitator/Community Organizer and ANMs working in the U-PHC. These meetings will serve as a forum for -performance review, trouble shooting, problem solving, sharing and validating information related to payments, replenishment of drug kits and refresher trainings. State will ensure that similar mechanisms of periodic reviews are built for support structures for community level at the state and city/district level.

#### **I.4: Capacity Building of ASHAs**

Capacity building of ASHA is a continuous process. Building ASHAs knowledge base and skills is critical in enhancing her effectiveness to achieve the desired healthcare outcomes. ASHA needs more skills for her to be effective to fulfil her roles as described earlier.

The strategy for training urban ASHAs visualizes a thirty days of training for the first year for every newly inducted ASHA. Subsequently fifteen days of training every year will be conducted for every

ASHA.

The duration and skills specified above are the absolute minimum, which must be achieved for every ASHA. States can set their own upper limit on the number of days of training.

### **Training Strategy**

The training strategy includes:

#### **1. Induction Training**

All newly selected urban ASHAs will undergo an induction training to build her understanding and perspective on the health systems, rights based approach to health and its social determinants and on various health or non-health related entitlements. The first eight days of this training would be similar to the induction training of newly selected ASHA as in rural areas and would orient her to- her roles and responsibilities and build the skills of community rapport building, community engagement, leadership and negotiation to take action on health. In addition, ASHAs in urban areas will also be trained in an additional module spanning two days which will equip them with the skills to undertake health vulnerability assessment, household mapping and listing and health resource mapping. It will also strengthen her capacities to undertake promotion of Mahila Arogya Samitis and will orient her to issues related to safe drinking water, sanitation and safe housing and other social determinant of health such as alcohol/drug abuse, violence against women etc. at the community level.

#### **2. Skill based Training for key competencies in women and children's health and nutrition.**

The skill based training will be of twenty days and comprise of four rounds of five days each. It will be conducted two-three months after the induction training. This training will aim to develop competencies related to basic reproductive, maternal, newborn, and child health and nutrition and infectious diseases such as tuberculosis and malaria.

The induction training and the skill based training referred to above should be completed within one year of joining.

#### **3. Supplementary and Refresher Trainings:**

At least fifteen days of training annually should be planned in which new topics and skills can be added. These can also serve to reinforce existing skills in areas where the ASHAs need further inputs. The new skills would be specific to local needs.

The ASHA will also be provided skill based training for key competencies required in urban specific contexts. These competencies relate to- adolescent health in urban areas, addressing issues of drinking water, sanitation and hygiene, non-communicable diseases and in addition would equip her to address issues of drug/alcohol abuse, violence against women etc. in urban areas.

Skills in certain areas such as disability screening, mental health counselling, or other skills that the state would like to prioritize can be taught to selected ASHAs rather than all ASHAs in a particular area. She could then provide such services to larger set of slum cluster. The U-PHC

review meetings can be used as a forum for such training. States will develop modules with central assistance as needed for state specific issues as appropriate.

### **Training of trainers:**

Considering the U-PHC to be established at a normative population of 50,000, it will have about 25 ASHAs working under each unit. To train this group of ASHAs a team of three-four trainers would suffice and will have to spend at least the same number of days in acquiring the knowledge and skills as ASHAs. All U-PHC teams will form a group of trainers for the district and would be trained by the state trainer team (Or Master trainers), who in turn would be trained by the national training team. The current structure for training ASHA trainers in NRHM would be used for conducting training of trainers for urban ASHAs.

Thus there will be four levels of training:

**Level 1** ASHA and ASHA facilitators( Training of ASHA facilitators will take place before ASHAs so that they can provide support for ongoing ASHA trainings and provide on the job mentoring for ASHAs once they are trained)

**Level 2** To train the ASHAs and ANMs each U-PHC will select a group of trainers ensuring an appropriate mix of clinical as well as community mobilization skills. It follows that each U-PHC will constitute a training team comprising of three members such as- Staff Nurses, representatives from NGOs who have experience of training community health workers and have worked on community health issues at the district level.

If a district has a normative 15 U-PHCs it will have a group of 45 Trainers to train and will form a pool of District Trainers.

**Level 3** This group of trainers from each district/city will be trained by a team of state level trainers existing in the state and used for ASHA/Community trainings under NRHM. They would be trained at National Training Sites.

**Level 4** National Trainers to train state trainers from across the states.

The trainers would be paid compensation for the days they spend on acquiring or imparting training –both camp based training and on the job training. The similar guideline applies to the state level also where trainers would be drawn in from NGOs.

### **I.5 ASHA Drug Kit:**

Drugs have to be provided to all ASHAs to provide curative first contact care to provide symptomatic relief pending referral, and manage cases as per the protocols she has been trained in. The state must put in place a clear instruction detailing

- (a) How will the drugs be sourced?
- (b) How will it reach the ASHAs?
- (c) What documents and records need to be maintained and by whom to ensure timely and proper refills?

The contents of the drug kit are listed in Annexure ii.

The ASHA should have a stock card in which monthly refills should be recorded. ASHA Facilitator/Community Organizer should be in charge of refills. It is her responsibility to ensure that drugs have not expired and there are no stock outs. While refilling, she should put the drugs in the appropriate containers with familiar labels so that if there is any change in size, color or dose of the drug, ASHA does not get confused. ASHA Facilitator/Community Organizer will take drugs from the Urban PHC stores/ANM and distribute to ASHAs as per the need. The quantity of drugs collected and distributed by the ASHA Facilitator/Community Organizer should be available in their own records and also kept in the store. Provision of drugs for ASHA should be made from the U-PHC budget for drug procurement.

States can make appropriate addition to the list of drugs where additional tasks are allocated to ASHAs.

### **I.6: Working Arrangements:**

An ASHA should have a flexible work schedule and her workload should be limited to putting in only about three to four hours per day on about four days per week, except during some mobilization events and training programmes. This would mean that in most contexts she could do this work without adversely affecting her primary livelihood. During mobilization events, such as pulse polio, or while escorting a patient, she may be required to spend a full day on the programme in which case she must be compensated accordingly. Further such full day work cannot be made mandatory except for training programmes. Her immediate field level support will be provided by the ASHA Facilitator/Community Organizer. The ANM will build her skills for community level care and identification of illnesses. ASHA Facilitator/Community Organizer in coordination with MAS will support her in her activist role, in mobilization and in reaching the marginalized.

### **I.7: Compensation to the ASHA**

She is primarily an “honorary volunteer” but is compensated for her time in specific situations (such as training attendance, monthly reviews and other meetings). In addition she is eligible for incentives offered under various national health programmes. She would also have income from social marketing of certain healthcare products like condoms, contraceptive pills, sanitary napkins etc. Her work should be so designed that it is done without impinging on her main livelihood and adequate monetary compensation for the time she spends on these tasks- through performance based payments should be provided.

She is compensated for her time in the following situations:

- (a) For the duration of her training both in terms of TA and DA. (So that her loss of livelihood for those days is partly compensated)
- (b) For participating in the monthly meetings, other than for travel and refreshments at the meeting site. (For situations (a) and (b), payment should be made at the venue of the training when ASHAs come for regular training sessions and/or meetings)
- (c) For undertaking specific measurable tasks related to health or other social sector programmes.



## Other incentives

Social recognition also takes place at a group level. The state must invest in TV and Radio programmes, in hoardings and public displays, which project the ASHA as a person holding immense responsibility and an important community resource to overcoming barriers to accessing health care services. This in itself would be an incentive.

States may consider including other incentives such as:

- ▶ Group recognition/ awards
- ▶ Non-monetary incentive e.g. exposure visits, annual conventions etc.
- ▶ Sarees, ID cards etc.
- ▶ Supporting further education
- ▶ Career progression by making provision for admission to ANM/GNM training schools
- ▶ Social Security

The compensation package for ASHA for training and various services provided by her will be same as compensation package for ASHAs in rural areas unless specified otherwise and is enclosed at Annexure(iii). The states can add to the existing incentives but will need to revise the compensation package as further new incentives are added in the programme.

**Note:** Emoluments should be regular and should be undertaken through bank transfer right from the inception of the programme. States should negotiate with all banks not to charge penalty fees for small deposits and initiate opening of zero balance accounts, since these two factors deter ASHAs from opening bank accounts.

## ASHA Help Desk

ASHAs constitute an important link between the community and the health facility. They are regularly referring pregnant or sick mothers, children, and people with complications to the health facilities. An ASHA Help Desk should be established to ensure facilitation of proper service availability, to navigate the patients and help them during referrals at the health institutions. This particularly becomes important in urban CHCs or equivalent, district hospitals or tertiary health care facilities which have high caseloads and are crowded.

## I.8 Setting up a Grievance Redressal Committee - District Structure

- (i) Under NRHM a five member committee is notified by the District Health Society (DHS) (under the leadership of the Chief Medical Officer (CMO) and District Collector). The same committee can be expanded to seven members to address Grievances of urban ASHAs and the composition of the Committee will need to have representation from members of urban local bodies. Thus the composition will be as follows:
  - ▶ At least three members should be women in leadership positions or from within academic institutions.
  - ▶ Two of the seven members will be representatives from urban local bodies, two from

Non- Governmental agencies, or academic institution or individual women in leadership positions.

- ▶ Two would be government representatives from a non- health sector (WCD, ICDS, Education, Rural Development, PRI), and
  - ▶ One would be a nominee of the CMO
- (ii) The DHS will allocate to the ASHA Grievance Redressal Committee an office with a full time secretary and a functioning landline number and P.O. Box number both of which are to be widely publicized and displayed at PHC, CHC and District hospitals.
- (iii) The ASHAs should be made aware of the existence of the Grievance Redressal Committee and the processes by which their grievances can be communicated.
- (iv) The complaint may be initiated telephonically but should be submitted in writing and a signed receipt of the complaint should be provided to the ASHA.
- (v) The working hours of the office would be concomitant with those of the DHS. The secretary will maintain a register of grievances in a format which will include the name, date of receipt of grievance, and the specific complaint.
- (vi) The secretary will write to the concerned officer who is required to take action on the grievance. A reply has to be sent within 21 days to the complainant. A written documentation of the Action taken report will also be maintained and certified by the members of the committee. If the officer denies the substance of the complaint, that too has to be recorded.
- (vii) The committee will meet once a month to review the grievances and action taken. The committee will decide on the appropriate action for commonly recurring grievances.
- (viii) Where the complainant is not satisfied, she could appeal to the Chairperson of the District Health Society or the Mission Director, State Health Society.
- (ix) Similar arrangement will be put in place in the cities under the chairmanship of the Municipal Commissioner, where the NUHM is being implemented through the City Urban Health Mission.

### **I.9: Fund Flow Mechanism for the Community Processes Programme**

Funds for making the payments to ASHA and untied funds to MAS flow from NHM to State Health Society and from State Health Society to District Health Society and finally to U-PHC. As part of NUHM Flexipool, the fund allocation for ASHA programme is specifically earmarked.

The budget package for ASHA will cover cost heads related to training, Supervision and Support mechanism for ASHAs. The cost towards the provision of kits and other job aids would also be included. This illustrative cost for training and post training support and supervision of ASHAs in urban areas has been fixed to a ceiling amount of Rs.16000, similar to the costs for training and supporting ASHAs in rural areas. (See Annexure IV)



Incentives to ASHA under various programmes like JSY, immunization, disease control are much a part of those programs and are not shown under ASHA budgetary head.

From the State Health Society, the funds for U-PHCs and district level expenses flow to City/District Health Society <sup>1</sup>. The City/District Health Society will release funds to specific institutes or individual empowered to incur expenditure. Mostly the training funds would be released to a training institution or an officer made in charge of the training program. Funds for payment to ASHA Facilitator/ Community Organizers should be made directly from the district by bank transfer.

For the performance based incentives paid to ASHAs a revolving fund would be kept with the U-PHC ANM(in the PHC account) released with approval from U-PHC Medical Officers.Mechanism of payment should be single window for all the performance incentives earned and should be paid on a fixed day in a month from these sites.

- (a) ASHA would be entitled for TA / DA for attending training programmes. She would be given the amount at the venue itself.
- (b) For the compensation money under the various national programmes / Schemes, the programmes have in-built provisions for the payment of compensation. These compensations will be made in accordance with the programme guidelines.
- (c) The states should ensure that as far as possible the incentive payment to ASHA is made through e-transfer .

### **I.10 Monitoring and Evaluation:**

ANMs, ASHA Facilitator/Community Organizers with support from District Community Processes Team will monitor the functionality of ASHA on a set of indicators which will be based on the key tasks undertaken by her. Some of these indicators can include-

- ▶ Undertaking vulnerability assessment in coordination with MAS
- ▶ Preparing health resource map for her designated cluster with MAS
- ▶ Ensuring home visits to the marginalized and vulnerable households including low birth new borns and malnourished children
- ▶ Organizing monthly meetings of MAS and undertaking locale specific action.
- ▶ A Monitoring system will be developed to monitor the functionality as well as the outcomes of the ASHA programme at U-PHC, district and state level.

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<sup>1</sup>Mechanism for fund flow will vary for seven metropolitan cities where funds from state health society will be transferred to Municipal Corporations and state guidelines should elaborate these specific divergences to build further clarity.



# Part II Mahila Arogya Samitis (MAS)

Mahila Arogya Samiti (MAS) as the name suggest are local women's collective. They are expected to take collective action on issues related to Health, Nutrition, Water Sanitation and its social determinants at Slum/Ward level. They were particularly envisaged as being central to 'local community action', which would gradually develop to the process of decentralized health planning. Thus MASs are expected to act as a leadership platforms for woman's and focal community group in each slum area for improving awareness and access of community for health services, support the ASHA / Front line health worker/ ANM, to develop health plans specific to the local needs and serves as a mechanism to promote community action for health.

Main purpose of Mahila Arogya Samiti (MAS) includes, demand generation, ensuring optimal utilization of services, establishing referral linkages, increasing community ownership and sustainability and establishing a community based monitoring system.

## II.1 Objectives and Goals of MAS

1. To provide an institutional mechanism for the community to be informed of health and other government initiatives and to participate in the planning and implementation of these programmes, leading to better outcomes.
2. Organize or facilitate community level services and referral linkages for health services for Maternal, New born, Child health and Nutrition (MNCHN) and other related services for water sanitation and hygiene (WASH), adolescent health issues and non-communicable diseases for increased access of the community for these services.
3. To provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
4. To provide mechanism for the community to voice health needs, experiences and issues with access to health services, such that the institutions of local government and public health service providers can take a note and respond appropriately
5. Generate community awareness on MNCHN, WASH and locally relevant health issues and to promote the acceptance of best practise in health by the community members.
6. To focus on preventive and promotive health care and management of untied fund.
7. Provide support and facilitate the work of community health workers like ASHA and other frontline health care providers who form a crucial interface between the community and health institutions.

## II.2 Process of formation of Mahila Arogya Samiti:

- a. Selection of an ASHA for a designated "slum/vulnerable cluster" will be done by women's group which can later potentially serve as Mahila Arogya Samitis in that area.

- b. Constitution of a team at slum level: The ASHA, ASHA facilitator/Community organizer with support of NGO field functionary(if any), AWW and ANM will constitute a team for selecting the MAS members. As far as possible the community women's group involved in the selection of ASHA should be part of MAS. Each ASHA will supervise the formation of two-five MAS.
- c. Meetings with slum women: The team (ASHA and others) conduct a series of meetings with women from the slum to understand the health conditions and to sensitize the women to work towards improving the health of the men, women and children in the slum. It is generally observed that the initial meetings have a large number of slum women attending mainly due to curiosity or with expectations to get some benefits (monetary).
- d. Identification of active and committed women: At least a gap of 1-2 weeks is given between women to reflect, discuss with others and determine their commitment to serve their slum community. Generally towards the 3rd or 4th meeting, the numbers of women attending falls and only interested women come for the meeting. Active, interested and committed women will be identified and over a period of time, encouraged to work collectively on community issues to form the base of the Mahila Arogya Samiti. It may be borne in mind that each community responds differently and takes its own time to crystallize, and interventions would have to be designed, keeping in alignment with the community. Social acceptance should be ensured by talking to family members.

### II.3 Coverage of MAS

The MAS is to be formed at Slum level, will approximately covers approximately 50-100 house holds. However, this can be modified based on the ground realities in each slum area, e.g. small slum of less than 50 families or presence of disparate groups within each slum. In case of existing Anganwadi Centres in the slum, the coverage of each MAS should be aligned with the coverage area of the Anganwadi Centre and has to cover all pockets of the slum.

### II. 4 Composition of MAS

Mahila Arogya Samithi should have 10 -12 members, depending on the size of the slum, but the group should not be less than 8 members and not more than 20 members. In case of MAS formed in a slum with different social groups, representation should be ensured from all groups and from all pockets of the slum.

### II.5 Characteristics of members of Mahila Arogya Samiti

The membership in the group would be a natural process, guided by ASHA and others. Therefore the following parameters not be seen as eligibility criteria but it can be used for preferential inclusion of members

1. Woman with a desire to contribute to 'well-being of the community' and with a sense of social commitment and leadership skills.
2. Woman's age is not being kept as a barrier as the role of the woman in the house and the community is either as a target beneficiary or as an influencing force.

3. If a group is being formed over a number of pockets of different communities, membership from all such pockets shall be ensured.
4. If the slum has a presence or history of collective efforts (as a self-help group, Development of Women and Children in Urban Areas (DWCUA) group, Neighbourhood Group under SJSRY, thrift and credit group), women involved in these efforts should be encouraged to be part of MAS
5. Service users like pregnant women, lactating mothers, Mothers with children of up to 3 years of age and patients with chronic diseases who are using the public services should also find place in the MAS
6. ASHA will be the Member secretary of MAS

## II.6 Office Bearers and their roles

Chairperson: MAS members will elect the chairperson of the group. The chairperson will lead the meeting and ensure smooth coordination among members for effective decision making. She is accountable for ensuring that meetings are held monthly. Planning awareness generation activities and other advocacy events and helping member secretary in maintenance and updating group record and registers are her other functions.

A coordination mechanism of MAS needs to be built with the urban local bodies. One way to do this could be to form a federation of a group of MAS at the ward level which will be chaired by an elected women member of the urban local body.

Member Secretary: ASHA will be the member secretary and will fix the schedule and venue for monthly meetings of the samiti and ensure that meetings are conducted regularly with participation of all members. She will draw attention of the samiti on specific constraints and achievements related to health status of the community and enable appropriate planning and maintaining records and registers and arrangements for the Urban health and Nutrition days.

## II.7 MAS Bank Account

Every MAS should have a bank account opened in the nearest bank, to which the untied fund of Rs 5000 per year to each MAS shall be credited. The chairperson & Member secretary(ASHA) are the joint signatories of MAS account.

## II.8 Capacity Building of MAS:

- ▶ Capacity building of MAS is a continuous process. The knowledge base of the members needs to be strengthened for clear understanding of the objectives, functioning and roles and activities of MAS.
- ▶ The training of MAS will be conducted through quarterly workshops of two days and will aim to develop their capacities in the following aspects:
- ▶ Community participation and need for MAS
- ▶ Objectives of NUHM

- ▶ Health and its determinants viz nutrition, safe drinking water, sanitation and hygiene.
- ▶ Concept of inequity, vulnerability, socio-economic marginalization and its impact on health
- ▶ Objectives, roles and activities of MAS
- ▶ Identification and mapping of vulnerable groups all aspects of community mobilization, management of untied funds, monitoring of public services and undertaking local level planning for improving access of the community to health and other services like safe water and improved sanitation facilities.
- ▶ All ASHAs, ANMs and ASHA Facilitator/community organizers/district level support structures will be given prior training to build their capacity for formation, supporting and facilitating the MAS and also do the supportive supervision role. These trainings will be conducted at the U-PHC level as a part of induction training for ASHAs, following which they will support the training of MAS members.
- ▶ For each urban PHC there will be on an average 160 MAS. If average members in one MAS are ten there will be approximately 1600 members to be trained for every U-PHC. Thus 40 batches of MAS members will need to be formed for the purpose of training. In order to complete one cycle of quarterly training for members in a month, a minimum of three sites would suffice. For each site there will be a need to place three to five MAS trainers.
- ▶ MAS trainers from each district will be trained by a group of state trainers identified by the state.
- ▶ State and District Community Processes Team will identify local NGOs for training the members of MAS. Suitable staff from the ICDS department, teachers and water and sanitation programme and other urban programmes such as JnNURM, SJSRY working in that area can also be taken as trainers. The members will be trained every quarter for two days by this identified pool of trainers.

## II.9 Activities of Mahila Arogya Samiti:

1. Mapping and listing of slum households; also preparation of resource map in the communities for identifying vulnerable and socio-economically disadvantaged group.
2. Monitoring and facilitating access to essential public services: ensuring that all the people in the community or geographical area of MAS, particularly marginalised, vulnerable groups and disabled are receiving the services related to health, water, sanitation nutrition and education
3. Organising local collective action for Preventive and Promotive Health activities: MAS serves as an inspiring organization and bring the community together for collective action on health. This could be done by motivating for community mobilisation and utilising support for organizing cleaning drives, improving sanitation.

It will promote convergent and community action in partnership with all other urban area initiatives for Vector control, environmental health, water, sanitation, housing.

#### 4. Facilitating service delivery and service providers in the community:

##### **This will be by:**

- ▶ Supporting ANM, AWW and ASHA in organising the Urban Health Nutrition Day and immunization sessions.
  - ▶ Mobilizing pregnant women and children, particularly from marginalized families, and coordinate with ASHA and ANM in organising outreach sessions(both routine and special) activities in the community.
  - ▶ Allowing outreach workers and community service providers to articulate their problems in the meetings. The meeting should identify who the ANM, Anganwadi worker and the ASHA are unable to reach and help these providers to reach these sections.
5. Community health planning is a continuous process and is to be done in each monthly meeting.
6. Maintain records of births and deaths in the slum cluster.
7. Monthly Meetings: Meetings of MAS should be atleast once every month. It is suggested that there be one regular date-like 10th of every month or second Saturday of every month-when the meeting is held to ensure that members can plan on ensuring attendance. A regular venue fixed at a convenient place like AWC, School etc. a minutes register and meeting attendance register would also facilitate proper functioning. In a 15 member Samiti,7 members represent a minimum quorum, but with a large samiti whose composition is intended for social inclusion and mobilization, the meeting quorum could be even 33% .monthly meeting reviews work done, plans future activities and decides on how the untied funds are to be spent.
8. Management of untied funds:An untied fund for Rs.5,000 is given annually to MAS: MAS can use these funds for any purpose aimed at improving health of the community. It is to be utilized as per decision of the MAS. Nutrition, education, sanitation, environmental protection, public health measures, emergency transport are the key areas where this fund could be utilised. Decision for utilisation of funds should be taken during the meetings.The fund shall only be used for community activities that involve benefit to more than one household. Exceptions to this are in case of a destitute women or very poor household, where the untied grants could be used for health care needs of the poor household especially for enabling access to care.MAS fund should preferably be not used for works or activities for which an allocation of funds is available through urban local bodies or other departments. The MAS is encouraged to contribute additional funds to its account. Decisions taken on expenditure should be documented in the minutes. It is preferably adopted as a written resolution that is read out and then incorporated into the minutes in a meeting where there was adequate quorum.

## **II.10 Monitoring of MahilaArogyaSamitis**

Every ASHA Facilitator/Community Organizer would assist City/District PMU in maintaining a detailed data base on MAS.

The data base should have information on:



- a. No. of slums under each U-PHC
- b. No of MAS formed
- c. Composition of the Samiti
- d. Monthly meetings held
- e. No. of MAS with Bank Accounts opened
- f. Dates of release of the un-tied fund to each
- g. Total Fund spent by each MAS – as per UCs received.

Other than this, the district community processes team reviews all aspects of MAS once a month, if possible conducts a monthly meeting of the ASHA facilitator/community organizers who similarly conduct once a month meeting with the ANMs and ASHAs. In these meetings, the information regarding functionality is received and the ASHA facilitators/community organizers and ASHAs are trained to provide assistance in solving the problems they face. All supervisory staff must make a sample visit to MAS meetings and ANMs and ASHA facilitator/Community organizers must try and attend MAS meetings, at least once in 2 months.

- a. % of MAS having regular monthly meeting
- b. % of MAS who have submitted UCs
- c. % of MAS who have submitted UCs with over 90% of their funds spent
- d. % of UHND held as compared to UHNDs planned

## **II.11 Accounting for the Untied MAS Fund**

- a. MAS has to present an account of its activities and expenditures in the bi- annual meetings of ULBs in which the plan and budget of these bodies is discussed.
- b. The annual Statement of Expenditure and UCs prepared by MAS, will be forwarded by the ASHA Facilitator to the U-PHC to City/District PMU.
- c. All vouchers related to expenditures will be maintained for upto three years, by the MAS and should be made available to ULB, or audit or inspection team appointed by district authorities. After that the Statement of Expenditure (SOE) should be maintained for 10 years.
- d. At the state level disbursements done by the district/city PMU will be treated as advances, and these advances will be treated as expenditures after the SOE for these advances has been received.
- e. District will conduct financial audit of MAS account on a test sample basis annually as a part of auditing district accounts.
- f. Utilisation Certificate (UC) should be based on the format given in Annexures
- g. In case of delayed fund receipts MAS need to be given a six month period to spend funds beyond financial year end. When final accounts are presented, unspent funds are to be regarded as unsettled



advances. District should top-up MAS funds on the unsettled advances.

### **Records**

- a. Record of Meetings – with attendance signatures.
- b. Record of approvals. given by members for expenditure/withdrawal
- c. Cash book
- d. Public Services Monitoring Register
- e. Birth Register
- f. Death Register

### **II.12 Role of NGOs in Community Processes in urban context:**

NGOs play an important role in supporting community processes component. The City/District Health Society should harness their skills as additional technical capacity in training and supporting the ASHA and MAS. Experience from the NRHM demonstrate that where ASHA training and supportive supervision was undertaken by NGOs the outputs in terms of competencies gained and community ownership are higher. In areas where support systems are slow in being established specific zones can be given to NGOs for selection, training and support of ASHA and MAS. However the selection of NGOs should be done through a rigorous and transparent process and they should have well- defined terms of reference. Effort should be made to ensure that such NGO led intervention are well integrated with the urban health system.

# Annexures

## Annexure - I ASHA Database Register

### Frequency – Annual

- At U-PHC Level :** At U-PHC level, ASHA Facilitator/community organizer would maintain an ASHA database register for every ASHA in the PHC area.

ASHA Base register format for ASHA Facilitator/ Community Organizer Date of filling the register-																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18		
ASHA Name	U-PHC Name	Mobile Number	Name of ANM in charge	Age	Education level	Caste – SC/ ST/ OBC/ other	Marital status (M- Married) (S- Married but currently single) (U – Unmarried)	Other sources of income	Date of selection ASHA	Date of filling the register	Letter from Urban Local Body Y/N	ID card issued Y/N	Certificate for any skill, if issued. Date of issue of certificate. (Fill as N if None)	AADHAR/ UID number	Bank account number No... (Fill as N if no bank account)	Date of cessation from ASHA work	Reasons for dropout <sup>2</sup>		
1																			
2																			

### ASHA Facilitator/Community Organizer will also provide data on:-

- Number of “slum/vulnerable cluster” without an ASHA in the U-PHC area
  - Number of ASHA who cover a population greater than 2500 in the U-PHC area
- At City / District Level.** At the City/District level, the district community processes team will maintain the register in the following format. This will be maintained on a yearly basis but in case of any drop out the state officials should be notified of the change of status.

District ASHA data base register Date of filling the register-							
U-PHC Name	Name of Vulnerable cluster	Population of cluster	ANM in charge	ASHA Name	Date of selection of ASHA	Date of cessation from ASHA work	Reasons for dropout
1.	1.						
	2.						

<sup>2</sup> Any ASHA is to be considered as drop out if –

- She has submitted a letter of resignation OR
- She has not attended the three consecutive UHNDs AND not given reasons for the same
- AND She has not been active in most of the activities
- AND ASHA Facilitator/Community Organizer visited the area of the ASHA and ascertained that she is indeed not active.

If there is a genuine problem, she should be supported until it is overcome through the MAS. If she cannot continue, a written and signed declaration should be obtained from her and approved by U-PHC Medical Officer. District/City Selection committee has the authority to remove her name from the data base register. Arrangements should then be made to fill in the vacancy.

District Community Processes team consolidates data from all U-PHCs on –

- (i) Number of vulnerable clusters without an ASHA in the district/city
  - (ii) Number of ASHA who cover a population greater than 2500 in the district/city
3. At State level– Based on the data collected above in formats above at block and district levels the following information will be compiled by State consultant for all districts of state-
- (i) Total number of urban ASHAs in the state
  - (ii) Number of drop outs in the state in last year
  - (iii) Number of urban ASHA joined in the past fiscal year
  - (iv) Number of U-PHC without an ASHA in the state
  - (v) Number of urban ASHA who cover a population greater than 2500 in the state

### **Annexure II CONTENTS OF ASHA DRUG KIT**

1. DDK for Clean deliveries at home
2. Tab. Paracetamol
3. Paracetamol syrup
4. Tab. Iron Folic Acid (L)
5. Tab PunarvaduMandur (ISM Preparation of Iron)
6. Tab. Dicyclomine
7. Tetracycline ointment
8. Zinc tablets
9. Povidine Ointment Tube
10. G.V. Paint
11. Cotrimoxazole syrup
12. Paediatric Cotrimoxazole tablets
13. ORS Packets
14. Condoms
15. Oral pills (In cycles)
16. Spirit
17. Soap
18. Sterilized Cotton
19. Bandages, 4cm X 4 meters
20. Nischay Kit
21. Rapid diagnostic kit
22. Slides for Malaria & Lancets
23. Emergency Contraceptive Pill
24. Sanitary napkins (to promote Menstrual Hygiene amongst adolescent girls)
25. Chlorine tablets

### **STATE SPECIFIC DRUGS**

1. Paediatric Iron Syrup
2. Tab. Chloroquine

### Annexure III: ASHA INCENTIVES UNDER VARIOUS NATIONAL PROGRAMMES

Serial Num.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Linkages	Documented in
<b>I</b>	<b>Maternal Health</b>			
	JSY financial package			
a)	For ensuring antenatal care for the woman	200 for Urban areas	Maternal Health-NRHM-RCH Flexi pool	MOHFW Order No. Z 14018/1/2012/-JSY  JSY -section  Ministry of Health and Family Welfare  -6th. Feb 2013
b)	For facilitating institutional delivery	200 for Urban areas		
	Reporting Death of women(15-49 years age group) by ASHA to U-PHC Medical Officer .	200 for reporting within 24 hours of occurrence of death by phone	U-PHC Un-tied Fund	MOHFW-  OM -120151/148/2011/MCH; Maternal Health Division; 14th Feb 2013
<b>II</b>	<b>Child Health</b>			
1	Undertaking six ( in case of institutional deliveries)and seven( for home deliveries) home- visits for the care of the new born and post-partum mother <sup>1</sup>	250	Child Health-NRHM-RCH Flexi pool	HBNC Guidelines –August 2011
2	For follow up visits to a child discharged from facility or community SAM management centre	150 only after MUAC is equal to nor more than 125mm		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
3	Ensuring monthly follow up of low birth weight babies and new borns discharged after treatment from Specialized New born Care Units	50		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
<b>III</b>	<b>Immunization</b>			
1	Complete immunization for a child under one year	100.00	Routine Immunization Pool	Order on Revised Financial Norms under UIP-T.13011i01/2077-CC-May 2012
2	Full immunization per child upto two years age( all vaccination received between 1st and second year age after completing full immunization after one year	Rs 50		
3	Mobilizing children for OPV immunization under Pulse polio Programme	100/day	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

<sup>3</sup>This incentive is provided only on completion of 45 days after birth of the child and should meet the following criteria-birth registration, weight-record in the MCP Card, immunization with BCG, first dose of OPV and DPT complete with due entries in the MCP card and both mother and new born are safe until 42nd of delivery.

IV Family Planning				
1	Ensuring spacing of 2 years after marriage	500	Family planning Compensation Funds	Minutes Mission Steering Group meeting- April- 2012
2	Ensuring spacing of 3 years after birth of 1 <sup>st</sup> child	500		
3	Ensuring a couple to opt for permanent limiting method after 2 children	1000		
4	Counselling, motivating and follow up of the cases for Tubectomy	150	Family Planning Sterilization compensation funds	Revised Compensation package for Family Planning- September 2007-No-N 11019/2/2006-TO-Ply
5	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	200		
6	Social marketing of contraceptives- as home delivery through ASHAs	1 for a pack of three condoms	Family planning Fund	Detailed Guidelines on home delivery of contraceptives by ASHAs-Aug-2011-N 11012/3/2012-FP
		1 for a cycle of OCP		
	2 for a pack of ECPs			
7	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	150/case	Family planning Fund	- Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
V Adolescent Health				
1	Distributing sanitary napkins to adolescent girls	Re 1/ pack of 6 sanitary napkins	Menstrual hygiene- ARSH	Operational guidelines on Scheme for Promotion of Menstrual Hygiene Aug 2010
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	50/meeting	VHSNC Funds	
VIII Revised National Tuberculosis Control Programme				
	Honorarium and counselling charges for being a DOTS provider		RNTCP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
a)	For Category I of TB patients (New cases of Tuberculosis)	1000 for 42 contacts over six or seven months of treatment		
b)	For Category II of TB patients( previously treated TB cases)	1500 for 57 contacts over eight to nine months of treatment including 24-36 injections in intensive phase		
c)	For treatment and support to drug resistant TB patients	5000 for completed course of treatment( 2000 should be given at the end on intensive phase and 3000 at the end of consolidation phase		

<b>IX National Leprosy Eradication Programme</b>				
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	250( for facilitating diagnosis of leprosy case)+ 400(for follow up on completion of treatment)	NLEP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	250(for facilitating diagnosis of leprosy case)+ 600((for follow up on completion of treatment)		
<b>X National Vector Borne Disease Control Programme</b>				
<b>A) Malaria and Kala Azar</b>				
1	Preparing blood slides	15/slide	NVDCP Funds for Malaria control	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2	Providing complete treatment for RDT positive Pf cases	75		
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen			
4	For referring a case and ensuring complete treatment for Kala Azar	300		
<b>B) Lymphatic Filariasis</b>				
5	For one time line listing of lymphoedema and hydrocele cases in all areas of non-endemic and endemic districts	200	NVBDCP funds for control of Lymphatic Filariasis	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
6	For annual Mass Drug Administration for cases of Lymphatic Filariasis	200/day for maximum three days to cover 50 houses and 250 persons		
<b>C) Acute Encephalitis Syndrome/Japanese Encephalitis</b>				
7	Referral of AES/JE cases to the nearest CHC/DH/Medical College	300 per case	NVBDCP funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

XI	Incentive for Routine Recurrent Activities			
	Mobilizing and attending outreach sessions or Urban Health and Nutrition Days	200 per session	NUHM Flexi Pool	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
	Convening and guiding monthly meeting of MAS	150		
	Attending monthly meeting at U-PHC	150		
	a) Line listing of households done at beginning of the year and updated every six months b) Maintaining records as per the desired norms like Household Registers, Meeting Minutes, Outreach Camps registers c) Preparation of due list of children to be immunized updated on monthly basis d) Preparation of due list of ANC beneficiaries to be updated on monthly basis e) Preparation of list of eligible couples updated on monthly basis	500		

#### Annexure IV: ASHA training and post training support and supervisory costs for one block in rural areas (STATE LED)

The budget package for a normative block for financing training and supervision would include fund for 180 ASHA, nine facilitators, and three trainers.

A 15 day training programme every year (considering that over the last few years the majority of the ASHAs would have received training upto Module 7. Since this is complete, they will undergo about 12- 15 days of training every year (new and refresher). All new ASHAs will undergo an eight day induction training, and subsequently 20 days in module 6 and 7. This will be completed within the first two years of her entering the programme. Thus each ASHA (new or old) will get 12-15 days of training per year. This budget is based on the 15 day costing.

1. A visit by the ASHA facilitator once a month to every ASHA for post training and support, mentoring, and supervision. Cost of cluster meeting in the facilitators areas is also part of this.
2. One meeting of ASHA and facilitators at PHC every month
3. One review meeting of all nine facilitators with the Block coordinator (whose expenses are part of Support Structure Guidelines)

No	Item of Expenditure	Unit Rate in Rs	Quantity	Days	Total Amount
I	<b>Training for 15 days</b>				
1	ASHA- wage compensation for training day	150	180	15	4,05,000
2	ASHA- food, accommodation, venue	200	192	15	5,76,000
3	ASHA and facilitator travel (6 trips)- TA to training site three times (three rounds of training)	100	189	6	1,13,400
4	Trainers fees (3 trainers*6 batches*3 rounds)	600	18	15	1,62,000
5	ASHA Refresher Training in preparation for certification (includes food, accommodation, and venue: Rs.200, wage compensation for ASHA (Rs. 150), training to be led by ASHA facilitators	350	189	4	2,64,600
6	3 Trainers travel (6 trips):	200	3	6	3,600
	<b>Sub-total</b>				<b>15,24,600</b>
II	<b>Supervision/Support Costs for training</b>				
1	Supervision costs by ASHA facilitators(12 months) (@Rs.200/day honorarium and Rs. 50/day travel), including for PHC review meeting	250	9	240	5,40,000
2	PHC Review meeting day plus social mobilization- cost of travel of ASHA	150	180	12	3,24,000
3	Monthly Review meeting of facilitators with BCM at block level-cost of travel and meeting expenses	125	10	12	15,000
	<b>Sub-total</b>				<b>8,79,000</b>
III	<b>Cost of Job aids; Tools and Kits for ASHA</b>				
	Cost per ASHA for module, (Rs. 125), Drug kit (Rs.1000), Equipment kit (Rs. 150)- since most ASHA will requires refurbishing of some parts of the kit, and only new ASHA will need entire kit), communication material (Rs. 75/head); ASHA Diary and register etc. Rs. 150)	1500	180	1	2,70,000
IV	<b>Other Non-Monetary Incentives for ASHA</b>				



a)Cost of - sammelans; either Block or District level Rs450/ASHA); b) Uniforms for ASHA- renewal or fresh provision(-450 per ASHA c) CUG membership; SIM Provision-(150/ ASHA)	1050	180	1	1,89,000
<b>Total cost per year</b>				<b>28,62,600</b>
<b>Cost/ASHA</b>				<b>15903</b>
1-Should the block level implementation be entrusted to an NGO, an additional amount of 10% of total budget should be provided for institutional overheads= 17493				
2-In addition, States should also make provisions for cost of ASHA Awards as- Rs 5000 per block and Rs 10,000 per district.				
3-Provision of exposure visits for ASHAs could also be made by states @ Rs10,000 per ASHA for a team of 10 ASHAs of each district from the state				







**NATIONAL HEALTH MISSION**  
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