

# **GUIDELINES : ACCREDITED SOCIAL HEALTH ACTIVITIST (ASHA)**

## **Background of ASHA Concept, Role & Responsibilities of ASHA, Selection Criteria for ASHA, Removal Criteria for ASHA and Institutional Arrangements for ASHA**

---

### **1. Background of ASHA Concept:**

The Government of India launched National Rural Health Mission (NRHM) in 2005 to address the health needs of rural population, especially the vulnerable sections of society. The Sub Centre (SC) is the most peripheral level of contact with the community under the public health infrastructure. This caters to a population norm of 5000, but is effectively serving much larger population at the SC level.

Thus, provision for new band of community based functionaries, named as Accredited Social Health Activist (ASHA) was made to fill this void. ASHA is the first port of call for any health related demands of the rural population, especially women and children, who find it difficult to access health services. The role, responsibilities, profile, selection procedure, training modality and compensation package for ASHA is given below. It has been envisaged that States have flexibility to adapt the Govt of India guidelines keeping their local situations in view.

ASHA is volunteer health activists in the communities, who is creating awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing public health services. She is a promoter of good health practices.

ASHA will be entitled for Performance Based Incentives fixed by the NRHM State HQ for prefixed activities only. The performance based incentives required to be given on monthly basis to ASHA. There will be no provision of fixed honorarium/incentive/salary.

**2. Roles & Responsibilities of ASHA:** The roles and responsibilities of an ASHA include the functions of a healthcare facilitator, a service provider and a health activist. Broadly, her functions involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization

of health services; participation in health campaigns and enabling people to claim health entitlements. She is also providing a minimum package of curative care as appropriate and feasible for that level and making timely referrals for further treatment. Her roles and responsibilities are as follows:

- ASHA have to take steps to create awareness and provide information to the community on determinants of health such as proper diet and nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services at doorsteps.
- ASHA have to conduct home visits of the pregnant women/mother/newborn under Home Based Post Natal Care (HBPNPNC), and they are supposed to counsel pregnant women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA have to mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center and other public health facilities, such as Routine Immunization (RI), Ante Natal Check-ups (ANCs), Post Natal Check-ups (PNCs), sanitation and other services being provided by the Government.
- ASHA have to work with the Village Health Sanitation Nutrition Committee/Village Level Committee (VHSNC/VLC) of the Gram Panchayat to facilitate a comprehensive village health plan with ANM, AWWs and PRI members.
- ASHA have to mobilize targeted community once in a month for the celebration of Village Health Nutrition Days (VHND) at their Aanganwadi Centre. The ANM, AWW, Members of VHSNC and community people are expected to participate in the celebration of VHND.
- ASHA have to arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre- identified health facility i.e. Primary Health Centre/Community Health Centre/ First Referral Unit (PHC/CHC /FRU).
- ASHA have to provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. ASHA are also acting as Dot Providers of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme (RNTCP).
- ASHA are also acting as a Depot Holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Contraceptives (Condoms, Oral Pills, Emergency Pills), etc. Provision of Drug Kit and HBPNPNC Kit has

been made for ASHA. Contents of the Drug/HBPNC Kits are based on the recommendations of the expert/technical advisory group set up by the Govt of India.

- ASHAs' role as a service provider is being enhanced subsequently. State makes provision of graded training to ASHA for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- ASHA are expected to provide first information about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the SC/PHC/CHC or directly to the District Authorities or even to the State HQ at the NRHM Help Line.
- Fulfillment of all these roles by ASHA are envisaged through continuous training and up-gradation of their skills over the years.

### **2.1 ASHA is expected to fulfill her role through 5 major activities in the community:**

- i. 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 marginalized families. 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 to these households 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.
- ii. Attending Village Health and Nutrition Day (VHND):** The ASHA should promote attendance at the monthly Village 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.
- iii. Visits to the health facility:** This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility based care. The ASHA is expected to attend the monthly review meeting held at the PHC.
- iv. Holding village level meeting:** As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), the ASHA is expected to help convene the monthly meeting of the VHSNC and provide leadership and guidance to its functioning. These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.
- v. Maintain records:** Maintaining records which help her in organizing her work and help her to plan better for the health of the people. The first three activities relate to facilitation or provision of healthcare, the fourth is mobilization and fifth is supportive of other roles.

**3. Selection of ASHA:** The general norm are of 'One ASHA for every '000 rural population'. In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc.

**3.1 Selection Criteria for ASHA:**

- ASHA must be primarily a woman resident of the village - 'Married/Widow/ Divorced/Separated' and preferably in the age group of 25 to 45 yrs.
- ASHA should have effective communication skills, leadership qualities and be able to reach out to the community.
- ASHA should be a literate woman with formal education up to 8<sup>th</sup> Class. Educational qualification may be relaxed only, if no suitable person with this qualification is available.
- Adequate representation from disadvantaged population/marginalized groups should be ensured to serve such population/groups better.
- ASHA should have family and social support to enable her to find the time to carry out her tasks in the community on regular basis.

**3.2 Selection Process of ASHA:**

- The selection of ASHAs would have to be done carefully. The District Health & Family Welfare Society envisaged under NRHM would oversee the process.
- The Society would designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved. S/he would also act as a link with the community and with other departments.
- The Society would designate Block Nodal Officers, preferably Block Medical Officers, to facilitate the selection process of ASHA as per the guidelines.
  - i. The Block Nodal Officer is supposed to constitute a Committee comprising 4-5 members of the local VHSNC/VLC (i.e. Chairperson of the Committee (Woman Panch/Sarpanch), Convener of the VHSNC/VLC (Aanganwadi Worker), ANM(s), School Teacher, existing ASHA (if any) and local ASHA Facilitators alongwith the District ASHA Coordinator (DAC), local Block ASHA Coordinator (BAC).
  - ii. Committee is required to make public announcement in the local community/village for requirement of ASHA in a particular area of the village with prior information to the Gram Panchayat.
  - iii. Interested women as enrolment of ASHA are required to submit formal/informal application with any of the committee members. Committee Members would call a joint meeting and scrutinize the application/candidates for selection as ASHA.
  - iv. Committee members would be required to interact with all interested women by way of conducting Focused Group Discussions in presence of the Gram Panchayat and local community, for whom ASHA is to be selected. This should lead to awareness of roles and responsibilities of ASHA and acceptance of ASHA as a concept in the community. This interaction should result in short listing of at least three names from each village/area concerned.

- v. Subsequently, a meeting of the Gram Sabha would be convened to select one out of the three shortlisted names. The minutes of the approval process in Gram Sabha shall be recorded. The VHSNC/VLC would enter into an agreement with the women as ASHA. The name will be forwarded by the Gram Panchayat to the Block Nodal Officer for record, with a copy to District Nodal Officer for information.
- vi. The Block Nodal Officer, finally send the finalized name of the women to the Executive Secretary of District Health & Family Welfare Society (i.e. Civil Surgeon) for her enrolment as a ASHA in the District.

As per the operational guidelines of Government of India, the State Governments may modify guidelines except that no change may be done in the basic criteria of ASHA being a woman volunteer with minimum education up to VIII class and that she would be a resident of the village. In case any of the selection criteria or guidelines is modified, these should be widely disseminated in local languages.

#### **4. Removal of ASHA:**

Following is criteria for declaring any ASHA as an Inactive/Dormant ASHA, Drop Out, if:

- She has submitted a letter of resignation to the VHSNC/VLC and her Facilitator  
OR
- She has not attended the three consecutive VHNDs; without giving any information/ reason for the same  
OR
- She has not attended the three consecutive Monthly Meetings at PHC; without giving any information/reason for the same  
OR
- She has not been active in most of the RMNCH+A activities and like mobilization of pregnant women/mother/newborn for routine immunization services, home visits for HBPNC and population stabilization services etc. in her Area.  
OR
- DAC, BAC, AF visited the village of ASHA and ascertained through discussions with all VHSNC/VLC members that she is indeed not active.

If there is a genuine problem, she should be supported until it is overcome through the VHSNC or village SHG. 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 BAC/CM after due validation from Gram Sabha/Panchayat.

In case of her contesting her removal, it should be referred to the DAC or other person appointed by the Executive Secretary of the District Health & Family Welfare Society, 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 Govt, based on these guidelines.

## 5. Institutional Arrangements

The success of ASHA scheme will depend on how well the scheme is implemented and monitored. It will also depend crucially on the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme. It is therefore necessary that well defined and yet flexible and participatory institutional structures are put into place at all levels from state level to village level. ASHA will be a central component of the National Rural Health Mission (NRHM) and its institutional structure would reflect this.

- i. District Health Society under the chairmanship of the District Magistrate/President Zila Parishad will oversee the selection process. Society will have representation from all related departments and civil society and the Panchayati Raj Institutions (PRIs). The Society will designate a District Nodal Officer and a Block Nodal Officer preferably a senior health person. The job of the Nodal Officers at the District and Block will be to facilitate the selection process by involving the Gram Sabha.
- ii. At village level it is recognized that ASHA cannot function without adequate institutional support. The women's committees (like self help groups or women's health committees), Village Health Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and AWWs, and the trainers of ASHA and in-service periodic training would be major source of support to ASHA at PHC.
- iii. At Block level, ASHA scheme will have a Block Co-ordination Committee with the Block Nodal Officer/Block Panchayat President as Chairperson. This committee will ensure involvement of PRIs and civil society and support of all related departments at the Block. Actual arrangements would vary depending on availability of a suitable NGO and of relative strengths and merits of different participants. If a suitable NGO is available at Block, the NGO would also be a member of Coordination Committee.
- iv. The Gram Panchayat would lead the ASHA initiative in three ways:
  - Gram Sabha undertakes (through the process outlined earlier) the selection of ASHA.
  - It is involved in supporting the ASHA in their work and itself undertaking many health related tasks through its statutory health committee. All ASHA will be involved in this Village Health Sanitation Committee of the Panchayat either as members or as special invitees (depending on the state laws).
  - It develops the Village Health Plan in coordination with ASHA.
  - A part of the incentive may be provided by/routed through Panchayat.
- v. In such situations where an NGO with good track record is available in the Block or a good NGO is willing to take up the responsibility, the entire selection, facilitation and training process can be given to the NGO. This will, however, not reduce the role of the Block Co-ordination Committee and Gram Panchayat in overseeing the processes.

- vi. State NRHM committee would have to monitor and support the District Health and Family Welfare Societies and District Nodal Officers through a network of coordinators/support NGOs.
- vii. ASHA strategy would be reflected in the State Action Plan, for which funds shall be released under the overall allocations under NRHM /RCH-II.

### **5.1 Role and Integration with *Aanganwadi***

*Aanganwadi* Worker (AWW) will Guide ASHA in performing following activities:

- Organizing Health Day once/twice a month. On health day, the women, adolescent girls and children from the village will be mobilized for orientation on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailment and importance of immunization etc. AWWs will inform ANM to participate & guide organizing the Health Days at *Aanganwadi* Centre (AWC).
- AWWs and ANMs will act as resource persons for the training of ASHA.
- IEC activity through display of posters, folk dances etc. on these days can be undertaken to sensitize the beneficiaries on health related issues.
- AWWs will be depot holder for drug kits and will be issuing it to ASHA. The replacement of the consumed drugs can also be done through AWW.
- AWW will update the list of eligible couples and also the children less than one year of age in the village with the help of ASHA.
- ASHA will support the AWW in mobilizing pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific days of immunization, health checkups/health days etc. to AWCs.

### **5.2 Role and Integration with ANM**

Auxiliary Nurse Midwife (ANM) will guide ASHA in performing following activities:

- She will hold weekly / fortnightly meeting with ASHA and discuss the activities undertaken during the week / fortnight. She will guide her in case ASHA had encountered any problem during the performance of her activity.
- AWWs and ANMs will act as a resource person for the training of ASHA.
- ANMs will inform ASHA regarding date and time of the outreach session and will also guide her for bringing the beneficiary to the outreach session.
- ANM will participate & guide in organizing the Health Days at AWC.
- She will take help of ASHA in updating eligible couple register of the village concerned.
- She will utilize ASHA in motivating the pregnant women for coming to sub centre for initial checkups. She will also help ANMs in bringing married couples to sub centres for adopting family planning.
- ANM will guide ASHA in motivating pregnant women for taking full course of IFA Tablets and TT Injections etc.

- ANMs will orient ASHA on the dose schedule and side effects of oral pills.
- ANMs will educate ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.
- ANMs will inform ASHA on date, time and place for initial and periodic training schedule. She will also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.

#### **6. Working Arrangements of ASHA:**

ASHA will have her work organized in following manner. She will have a flexible work schedule and her work load would be limited to putting in only about two-three hours per day, on about four days per week, except during some mobilization events and training programmes.

- A. At the AWC:** She will be attending the AWC on the day when Immunization/ANC sessions are being organized. At least once or twice a week, she would organize health days for health IEC, rudimentary health checkup and advice including medicine and contraceptive dispensation.
- B. At the Home:** She will be available at her home so as to work as depot holder for distribution of supplies to needy people or for any assistance required in terms of accompanying a woman to delivery care centre/FRU or RCH camp.
- C. In the Community:** she will organize/attend meetings of village women/health committees and other group meetings and attend Panchayat health committees. She will counsel and provide services to the families as per her defined role and responsibility.

#### **7. Provision of Modular Training for ASHA**

Capacity building of ASHA is critical in enhancing her effectiveness. It has been envisaged that training will help to equip her with necessary knowledge and skills resulting in achievement of scheme's objectives. Capacity building of ASHA has been seen as a continuous process.

- **Induction training:** After selection, ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. Considering range of functions and tasks to be performed, induction training may be completed in 23 days spread over a period of 12 months. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days to complete induction training
- **Training materials:** would be prepared according to the roles and responsibilities that the ASHA would need to perform. Her envisaged functions and tasks will be expanded into a listing of competencies and the training material would be prepared accordingly. The training materials produced at the national level would

be in the form of a general prototype which states may modify and adapt as per local needs. The training material will include facilitator's guide, training aids and resource material for ASHAs

- **Periodic trainings:** After the induction training, periodic re-training will be held for about two days, once in every alternate month at appropriate level for all ASHAs. During this training, interactive sessions will be held to help refresh and upgrade their knowledge and skills, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest. The opportunity will also be used for replenishments of supplies and payment of performance linked incentives. ASHAs will be compensated for attending these meetings.
- **On-the-job training:** ASHAs needs to have on the job support after training both during the initial training phase and during the later periodic training phase it is needed to provide on the job training to ASHAs in the field, so that they can get individual attention and support that is essential to begin and continue her work. ANMs while conducting outreach sessions in the villages will contact ASHA of the village and use the opportunity for continuing education. NGOs can also be invited to take up the selection; training and post training follow up. Similarly block facilitators identified earlier for selection of ASHAs can also be engaged for regular field support.
- **Training of trainers:** A cascade model of training is proposed. At most peripheral level, Block trainers (who are the members of identified block training teams) would have to spend at least the same number of days in acquiring the knowledge and skills as ASHAs. These ToTs will also have to be similarly phased. These trainers should be largely women and chosen by block nodal officer. The block teams would be trained by a district trainer's team. (Or Master trainers) who are in turn trained by the state training team. The duration of ToTs for District Training Teams (DTT) and State Training Teams (STT) will be finalized by the states depending on the profile of the members to be selected as DTT and STT.
- **Constitution of Training teams:** It follows that each state, district and block would have a training team comprising of three-four members. Existing NGOs especially those working on community health issues at the district / block level may also be entrusted with the responsibility for identifying trainers and conducting of TOTs. 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 district level also where trainers would be drawn in from Programme Managers and NGOs. The State Institutes of Health and Family Welfare along with reputed and experienced NGOs would form training teams at the state level. State level training structures to be used for trainings under various National Health and Family Welfare Programmes Trainings may be adhered wherever feasible.

- **Continuing Education and skill up-gradation:** A resource agency in the district of state (preferably an NGO) will be identified by the State. The resource agency in collaboration with open schools and other appropriate community health distance education schemes will develop relevant illustrated material to be mailed to ASHAs periodically for those who would opt for an eventual certification.
- **Venue of training :** The principle of choice of venue shall be that the venue should be close to their habitation that the training group should not be more than 25 to 30. In most situations this could be the PHC or alternatively Panchayat Bhavan or other facilities that are available.
- **National level:** At the national level the NIHFWS would in coordination with the National Rural Health Mission & its technical support teams and the Training Division of the Ministry will coordinate and organize periodic evaluation of the training programmes. The findings of these concurrent evaluations should be shared with State Governments.
- **State level:** At the State level, the State Institute of Health and Family Welfare (SIHFWS) in coordination with the State Training Cell of Directorate of Family Welfare will oversee the process of training, monitor and organize concurrent evaluation of training programme.

#### **8. Compensation/Performance Based Incentives to ASHA:**

ASHA would be an honorary volunteer and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood. However ASHA could be compensated with performance based incentives 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/bi- monthly training, as the case may be.  
*(For situations (a) and (b), payment will be made at the venue of the training when ASHA come for regular training sessions and meetings).*
- c) Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks should be assigned to ASHAs on priority (i.e. before it is offered to other village volunteers) wherever they are in position. *(For situation (c) disbursement of compensation to ASHAs will be made as per the specific payment mechanism built into individual programmes).*
- d) Other than the above specific programmes, a number of key health related activities and service outcomes are aimed within a village (For example all eligible children immunized, all newborns weighed, all pregnant women attended an antenatal clinic etc). The Un-tied Fund of Rs.10,000/- at the SC (to be jointly operated by the

ANM and the *Sarpanch*) could be used as monetary compensation to ASHA for achieving these key processes.

e. The exact package of processes that form the package would be determined at the State level depending on the supply-side constraints and what is feasible to achieve within the specified time period. *(For situation (d) the payment to ASHAs will be made at Panchayats).*

- Group recognition/ awards may also be considered.
- Non-monetary incentive e.g. exposure visits, annual conventions etc can be considered.
- A drug kit containing basic drugs should be given.

*A suggestive/indicative compensation package for ASHA for training and various services provided by her is enclosed at Annexure-I. This would be finalized subsequently in consultation with the States and various other stakeholders in due course.*

\*\*\*\*\*