



स्वास्थ्य एवं
परिवार कल्याण मंत्रालय
MINISTRY OF
HEALTH AND
FAMILY WELFARE



INTEGRATED TRAINING MODULE FOR ASHA

2026

PART - A





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PART A : Being an ASHA

INTEGRATED TRAINING MODULE FOR ASHAs AND ASHA FACILITATOR'S GUIDES

DISCLAIMER

The Integrated Training Strategy for the Primary Healthcare Team at AAM is a new initiative to consolidate and align existing training related to Comprehensive Primary Health Care (CPHC). The ASHA Facilitator Guide and Training Modules have been developed incorporating programme-specific technical content, guidance, and resources provided by the respective Programme Divisions.

The respective Programme Divisions retain ownership of their programme-specific content. The modules have been finalised based on the inputs and technical guidance received from the concerned Programme Divisions and duly vetted prior to dissemination. As this is a new and evolving initiative, the modules may be reviewed and updated from time to time in accordance with programme requirements, emerging evidence, policy changes, and stakeholder feedback.



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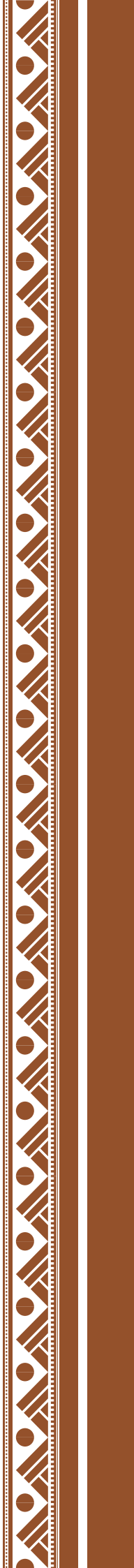
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KEY ABBREVIATIONS

AAM	Ayushman Arogya Mandirs
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BMO	Block Medical Officer
BP	Blood Pressure
CBAC	Community-Based Assessment Checklist
CDR	Child Death Review
CHO	Community Health Officer
CPHC	Comprehensive Primary Health Care
COPD	Chronic Obstructive Pulmonary Disease
DEIC	District Early Intervention Centre
ENT	Ear, Nose and Throat
FAQ	Frequently Asked Questions
GERD	Gastroesophageal Reflux Disease
Hb	Haemoglobin
HBNC	Home-Based Newborn Care
HBYC	Home-Based Young Child Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IHIP	Integrated Health Information Platform
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control
IUCD	Intra-Uterine Contraceptive Device

JAS	Jan Arogya Samiti
KMC	Kangaroo Mother Care
LASA	Look-Alike Sound-Alike
LBW	Low Birth Weight
LLINs	Long-Lasting Insecticidal Nets
MAM	Moderate Acute Malnutrition
MAS	Mahila Arogya Samiti
MCP Card	Mother and Child Protection Card
MO	Medical Officer
MOIC	Medical Officer In Charge
MNS	Mental, Neurological and Substance Use
MPA	Medroxyprogesterone Acetate
MPW	Multipurpose Worker
MR	Measles-Rubella
MUAC	Mid-Upper Arm Circumference
NBSU	Newborn Stabilisation Unit
NCD	Non-Communicable Disease
NDPS	Narcotic Drugs and Psychotropic Substances
NMR	Neonatal Mortality Rate
NRC	Nutrition Rehabilitation Centre
NQAS	National Quality Assurance Standards
ORS	Oral Rehydration Solution
PHC	Primary Health Centre
PHQ	Patient Health Questionnaire
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PNC	Postnatal Care
POC	Point of Care
PPE	Personal Protective Equipment
PPH	Postpartum Haemorrhage
PRI	Panchayati Raj Institution
RBSK	Rashtriya Bal Swasthya Karyakram

RCH	Reproductive and Child Health
RDT	Rapid Diagnostic Test
RKSK	Rashtriya Kishore Swasthya Karyakram
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition
RR	Respiratory Rate
SAM	Severe Acute Malnutrition
SBCC	Social and Behaviour Change Communication
SHC	Sub Health Centre
SHG	Self-Help Group
SNCU	Special Newborn Care Unit
SpO ₂	Peripheral Oxygen Saturation
SRS	Sample Registration System
SSBSK	Samagra Shishu Bal Swasthya Karyakram
STI/RTI	Sexually Transmitted Infection / Reproductive Tract Infection
SVR	Sustained Virological Response
TB	Tuberculosis
UACS	Upper Airway Cough Syndrome
UPHC	Urban Primary Health Centre
UPT	Urine Pregnancy Test
VHSNC plus	Village Health, Sanitation and Nutrition Committee plus
VHSND	Village Health, Sanitation and Nutrition Day
Vit A	Vitamin A
WHO	World Health Organization
WIFS	Weekly Iron and Folic Acid Supplementation
WRA	Women of Reproductive Age



A1

Being an ASHA



PART A

A1 Being an ASHA

By the end of the section, will learn:

- Who is an ASHA?
- Roles, responsibilities, and tasks of an ASHA.
- Values, Attitude, Soft Skills and Technical skills required by the ASHA to perform her role as community mobiliser, service provider and, health educator/ activist.
- The art of communication, counseling and negotiation for successful engagement with the community.

A.1.1 WHO IS AN ASHA?

An Accredited Social Health Activist (ASHA) is a woman selected by her community, based in her community, and serves as a resource to her community as well as the health system.

What are the Main Roles of the ASHA?

ASHAs have a three-fold role:

To be a community mobilizer to bring community members together to address health-related issues and facilitate them in accessing health and health-related services available in public health system like Ayushman Arogya Mandir (AAM).

To be a service provider of community-level healthcare services.

To act as a health activist, who advocates for better healthcare services and access to health entitlements within their community, particularly for the marginalized. Also, who works with the community to find solutions and facilitates access to appropriate healthcare facilities, with enhanced focus on vulnerable groups.



An ASHA

22 year old Ms. B had come to the Urban Primary Health Care (AAM-UPHC) for her first antenatal checkup. As the MO placed her stethoscope on Ms. B's chest, she found that the heart sound was abnormal and suspected that she might have a heart problem. She was therefore identified as needing further assessment and follow-up. She was labelled as high risk and the same was highlighted on her ANC card. Despite the early diagnosis and her contact with the health system, Ms. B died at home during the later part of her pregnancy. The busy UPHC and the busy ANM could not keep track of her and failed to reach her when she stopped coming. **Now this should not happen because you as an ASHA can help identify women who need closer follow-up, encourage them to continue care, facilitate referral and help them reach appropriate health services by planning their delivery at optimal level of health facility (Birth Mirco Planning)**

With continuous training and support, ASHAs mature in their roles and responsibilities, gain confidence of the people, make them aware of their health rights and responsibilities, and gradually are able to involve the community in local health planning and convince community towards better health seeking behaviour.



ASHA creating awareness in society



Table 1: An overview of the activities under various roles of ASHA:

Community mobilizer	Service provider	Activist
• Support community to access all the 12 package of services available at the level of AAM-SHC, AAM-PHC, AAM-UPHC, AAM-USHC, CHC, DH such as: • Institutional delivery • Immunization, • Antenatal Check-ups (ANCs) • Postnatal Check-ups (PNCs) • IUCD insertion/ other family planning services • Adolescent health services • Services related to management of NCDs and communicable diseases • Mental health ailments • Eye problems, ENT problems • Elderly, palliative and emergency care services provided at AAMs. • Accompany pregnant women & children/patients requiring treatment/ admission to the nearest pre-identified health facility i.e., AAMs and Community Health Centres /First Referral Unit/ Nutritional Rehabilitation Centers (as per the need). • Mobilise the community towards adopting wellness measures. • Cases that are line listed for higher management to be mobilized for VHSND and AAM Shivar under the guidance of ANM/CHO/MO	• Perform population enumeration, empanelment of individuals with AAM, Complete the CBAC for all population and above to assess their risk for various diseases and identify those who need screening or referral. • Counsel women and families on: ✓ Birth preparedness and complication readiness, ✓ Importance of safe delivery ✓ Care of 'At risk' newborn, infant and child ✓ Exclusive breastfeeding and complementary feeding ✓ Immunization ✓ Safety and security of children at home and surrounding environment ✓ Contraception/ birth spacing ✓ Prevention of common infections including Reproductive Tract Infection/ Sexually Transmitted Infection (RTIs/STIs) ✓ Mental health issues and substance abuse ✓ Prevention of violence (domestic, and sexual etc.) ✓ Digital exposure, and obesity in child ✓ Teenage pregnancy ✓ Prevention and management of NCDs. ✓ Self Breast Examination (SBE), Regular screening for cervical cancer ✓ Oral examination ✓ Obesity prevention and management among all age groups ✓ Elderly care	• Leveraging VHSNC plus/ MAS/ JAS and working with them to formulate comprehensive annual health plan for the village, influencing determinants of health. • Assist VHSNC plus/ MAS, mobilize and ensure community action on gender-based violence, alcohol. • Work on issues related to social determinants including water and sanitation in coordination with VHSNC plus/ MAS enable construction and use of household / community toilets and promote sanitation and hygiene in the community. • In case the beneficiary is from a vulnerable family you as an ASHA may need to make more effort to ensure care for that family by accompanying her to the health care facility.

Community mobilizer	Service provider	Activist
	• Assist in community-level curative care for minor ailments such as: ✓ Diarrhoea ✓ Fever ✓ Postnatal mothers ✓ Care for the normal and sick newborn ✓ Care of 'At-risk' children and childhood illnesses/ danger signs. ✓ Nutrition counselling ✓ Directly Observed Treatment under National Tuberculosis Elimination Program ✓ Care and support for elderly ✓ Home-based palliative care • Provide community-level care for other communicable diseases like Malaria, Dengue, Japanese Encephalitis, Chikungunya and, Leprosy, • Community level emergency care and referral etc. • Act as a depot holder for essential health products like: ✓ ORS ✓ Zinc ✓ Iron and Folic Acid ✓ Chloroquine ✓ Condoms ✓ Oral Contraceptives ✓ Sanitary Napkins	• Create awareness and provide information to the community on: ✓ Determinants of health such as nutrition, water sanitation and hygiene (WASH) practices ✓ Healthy living and working conditions ✓ Information on all services available at AAMs ✓ Importance of seeking timely health care services ✓ Benefits available from various government schemes for financial risk protection • Undertake the health promotion and wellness activities by counselling individuals and families on: ✓ Lifestyle modifications such cessation of tobacco, arecanut and alcohol/ substance use ✓ Healthy diet ✓ Regular exercise
	• Provide information about births and deaths in her area and any unusual health problems / disease outbreaks in the community to the AAM-SHC/ PHC/ UPHC/ USHC level.	



A.1.2 KEY ACTIVITIES OF AN ASHA

The outcome of the work of ASHA in her community relies on teamwork; she will achieve far more when she teams up closely with Auxiliary Nurse Midwife (ANM Didi), and the Anganwadi Worker (AWW) of the Anganwadi centre in her area. This will improve the coordination, efficiency, and effectiveness of her work. The Community Health Officer (CHO) designated at the AAM-SHC and Medical Officer (MO) at AAM-USHC may be approached for any kind of guidance and facilitation as and when needed. ASHA, ANM and AWW as AAA platform work together at community level, each according to her own role, to support health, nutrition and early childhood development.

Below are the major five activities, which you as an ASHA shall be performing in your area:

- 1. Home visits:** You as an ASHA is responsible for conducting home visits for two to three hours daily, at least four to five days a week, focusing on health promotion, surveys for identifying the high risk and timely referral for treatment at AAM/VHSND and follow-ups. You have to build community trust through active listening and open discussion, making sure to prioritize households with pregnant women, newborns, sick individuals, elderly patients, or persons with disabilities.
- 2. Planning and active participation in the Village/ Urban Health, Sanitation and Nutrition Day (VHSND/ UHSND)/ Outreach Immunization sessions/ Special outreach camps:** You as an ASHA should mobilize people to attend the monthly VHSND/UHSND and other scheduled outreach services. You should also support mobilization for the monthly Ayushman Arogya Shivar at the AAM, as scheduled.
- 3. Visits to the health facility (Care Companion):** You as an ASHA have to accompany the beneficiary/ sick individual or others who ask for your help to a healthcare facility. You also have to visit the nearest designated AAM to attend a training session or meeting to discuss and review healthcare matters. The number of such visits varies from month to month.
- 4. Holding/ attending community-level meetings:** You as an ASHA would be organizing/ attending meetings of women's groups, and the Village Health Sanitation and Nutrition



Home visit by ASHA



ASHA as Care Companion



ASHA facilitating health care access



ASHA conducting community level meeting

Committee plus (VHSNC plus)/ Mahila Arogya Samiti (MAS), to share data with ANM and CHO from CBAC, which in turn will help identify vulnerable individuals/ families, used to increase health awareness and support village health planning.

5. **Maintain records:** This will help you as an ASHA to organize and plan work, review your performance, set the priorities for the community you are serving and submit the incentive claim at the end of the month.

Essential tasks for an ASHA

1. Know the population and health needs

- Different age groups/ vulnerable groups/ at risk groups etc.
- Families in your area and each member of the family.
- Line listing of beneficiaries for different healthcare services.

2. Identify health needs and risks

- Household enumeration and maintenance of family health records.
- Community-Based Assessment Checklist (CBAC) for risk screening, vulnerability screening and enlisting pregnant women, newborn, children, adolescent, elderly, and specially - abled for provisioning adequate services.
- Screening for common communicable diseases (TB, leprosy, malaria, etc.) and referral.
- Identification of high-risk pregnancies, infants and vulnerable individuals (TB, addictions, etc.).
- Detection of malnutrition and developmental concerns among children.
- Identification of mental health issues, substance abuse, and psychosocial concerns.
- Identification of people with common non communicable diseases including hypertension, diabetes and cancers.
- Maintaining line list of people with chronic diseases in the population and ensuring their follow up
- Assessment of environmental and social determinants affecting health.

3. Mobilize for preventive services

- Generate awareness on role of social determinants of health (WASH, etc).
- Collaborate with – Anganwadi (ICDS), School (Education) for effective delivery of services.
- Prepare a list of all available health facility (AAM-SHC/ USHC, AAM-PHC/ UPHC, CHC, SDH and DH) where the patients/beneficiaries can be referred without delay in care.
- Collaborate at the level of community-based structures – VHSNC plus, MAS, JAS.

4. Raise community awareness for :

- Available healthcare services for their needs and how to access them.
- Various entitlement schemes of the Government and how they can avail them, including their enrolment under the Ayushman Bharat scheme.
- Healthy lifestyle, health promotion activities, self-help activities.



5. Inform supervisors:

- Specific needs of population to aid focused interventions.
- Any sudden change in disease pattern, especially for communicable diseases.
- Information on morbidity/ disease burden, if so required, through specific surveys.

6. Referral and facilitate access to health services:

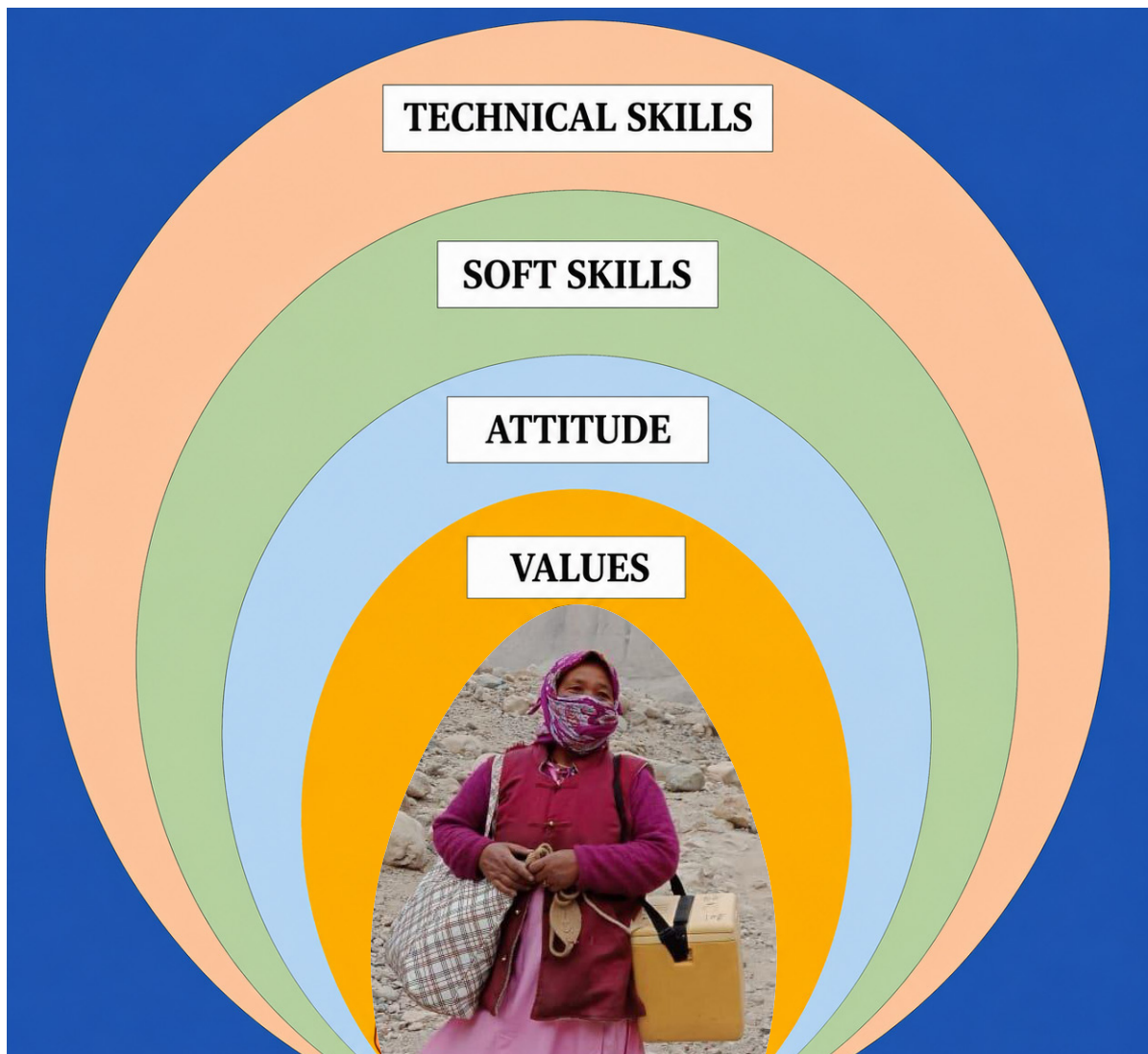
- Accompanying the beneficiary to the facility when so required.
- Mobilizing beneficiaries to the VHSNDs, UHSNDs/ outreach camps for getting services.
- Follow up with beneficiaries, remind and support them to attend required visits, complete investigations and take treatment as advised, and report problems to the health team with special focus on vulnerable/ those at risk.
- Provide appropriate first aid, seek help and arrange prompt referral to the appropriate health facility in an emergency.
- Acting as depot holder and providing certain items like Iron Folic Acid (IFA)/ Oral Rehydration Solution (ORS)/ Oral Contraceptive (OC) pills etc.



7. Provide Community based care.

- Provide first aid for injuries (like open wound, insect bite, etc) and community-based care for common illnesses.
- Provide care for the postnatal women, newborns and young children for health promotion, identification of danger signs and prompt referral when required as per Samagra Shishu Bal Swasthya Karyakram (SSBSK) scheduled home visits from birth to 36 months, with intensified and joint ANM/CHO visits for at-risk newborns and children, along with follow-up through VHSND and Shishu Shivir.
- Mobilize any individual requiring medical assistance to the AAMs/referral facility.
- Equipping the parents with the required information of their child, tracking the growth and development, and raising red flags to ANM/ CHO in case it is faltering.
- Support delivery of palliative care services by identifying beneficiaries in need facilitated services provided by CHO/ANM.

A.1.3 VALUES, ATTITUDE AND SKILLS OF AN ASHA



You as an ASHA should not only have technical knowledge and skills, besides core values, attitude and soft skills that build trust, credibility, and sustained productive community engagement.



Ethical Values: Fundamental to ASHA's role

These values can be grouped into core ethical, interpersonal and professional values for simplicity of discussion:

Table 2: Core ethics and values in an ASHA

S.No.	Core Value	Description
1	Honesty and Integrity	Give correct information, keep records properly, and do not give special treatment to family or relatives.
2	Commitment and Accountability	Do your work regularly, take responsibility, and complete the work given to you.
3	Respect, Empathy and Compassion	Speak politely, listen to people, understand their problems, and help them with care.
4	Equity and Inclusiveness	Treat everyone equally, whatever their caste, religion, gender, age, disability, or financial condition. Give extra support to those who need it.
5	Confidentiality and Trust	Keep people's personal and health information private and maintain their trust.
6	Professionalism and Continuous Learning	Be punctual, regular and responsible. Follow instructions and keep learning new things.
7	Teamwork and Community Ownership	Work together with ANM, AWW, other health workers and the community to improve people's health.

Skills can be learnt, but values must be practiced. An ASHA who lives by these values becomes a pillar of her community.

Pillar of Strength – There are four pregnant women in Ms. S's catchment area at the moment, all in different phases of pregnancy. Two are educated and relatively well-off; their husbands are supportive, and they are fairly regular with their check-ups. One is careless, and her family is not supportive, but she lives near Ms. S's house, so she calls her and reminds her when her visit is due. The fourth woman, Ms. M lives on the outskirts of the village. Her husband drinks and is shunned by the villagers. She is the sole breadwinner and misses her ANC visits. Ms. S is comfortable thinking that 3 out of 4 women are coming for ANC, and that is good enough, so she does not make the extra effort required for Ms. M. **Is she right in her thought and work? What are the values she needs to practice?**



Key Message: Equality and Equity

Treat everyone equally irrespective of class, caste, sex, and religion. As health activists, her concern is the well-being of all individuals not just those she know well or who come to her or who are the better off and powerful. There are extremely poor families, inaccessible areas, distant parts of our villages, have only women in their households, and are disabled or handicapped and are unable to access health care services.

Treating everyone with equity also means spending more time and effort on those who need more.



Ms. V is visiting households, counselling on hygiene and sanitation, and distributing ORS packets before the arrival of the rainy season when the incidence of diarrhoea rises. In one household, a grandmother dismisses the ORS packet, saying that she already knows how to prevent dehydration or “paani ki kami” using home-based fluids. Ms. V listens to her patiently and agrees wholeheartedly, praises her wisdom and reiterates the use of home-based fluids like rice water, and coconut water for treating a child with diarrhea along with the use of ORS. Besides she also talks about danger signs & dehydration in children and inform them about the health care services

Which values are highlighted by this incident? Can you as an ASHA label and name them and think of other examples like this?

A.1.4. SOFT SKILLS OF AN ASHA

These are briefly described below:

1. Leadership at grass root level: You should mobilize people and resources toward achieving the common goal of health for all. ASHA will often have to play the role of a mobilizer as a leader. Hence it is important to understand the meaning of leadership qualities, which will help you to become an effective leader.



ASHA counselling on healthy practices

What does leadership mean:

- Being responsible and updated with knowledge that can help people prevent, control and treat the diseases.
- Setting an example for other people to follow.
- Inspiring people by providing optimism and showing confidence for their willingness to initiate change.
- Being non-judgmental and transparent in your actions
- Being confident, assertive, enthusiastic, passionate, and accountable.
- Motivating and enabling people to cooperate for getting things done.



Table 3: Two common styles of leadership are:

Leadership Style	Description
Authoritarian Leadership	Leaders exercise strong control and make decisions independently, expecting strict adherence to instructions. They are less open to others' opinions and prefer work to be done in their way.
Participatory Leadership	Leaders encourage collaboration and involve team members in decision-making, valuing diverse ideas and shared responsibility. This approach promotes teamwork and inclusiveness.

For participatory leadership, an ASHA needs to:

- Encourage community members to share views and concerns during meetings and home visits.
- Involve women, families, and local groups in planning health activities.
- Work collaboratively with ANMs, AWWs, VHSNC plus/ MAS members, JAS members and other front line workers.
- Promote group discussions instead of one-way communication.
- Respect and value local knowledge and community suggestions.
- Support collective decision-making for health actions, care seeking and problem-solving.

2. Communication Skills Communication skills refer to the ability of the ASHA to listen attentively and convey health-related information clearly, accurately, and respectfully to individuals, families, and community groups, using language and methods appropriate to the local context. Communication is the exchange or two-way flow of information and ideas between two or more persons. Good communication is an essential element of leadership, coordination, and teamwork. Communication skills will enable you to counsel women and families on health promotion, adopting healthier practices, and mobilizing them to avail services at health institutions besides establishing rapport with the community and other stakeholders, such as health functionaries. There are three different forms of communication – verbal, non-verbal, and written. Each of these is useful for you as an ASHA.



ASHA counselling on newborn practices with the beneficiaries

- **Verbal communication:**
 1. Explain health messages in local language and simple terms that should guide community towards decision making for suitable care.
 2. To convey the message correctly and ensure that the beneficiaries are able to understand the message and ensure it through proper feedback.
 3. Avoid interruption by phone calls while you are communicating to the client, if it is urgent please do seek permission from the person speaking with.
- **Non-Verbal Communication:** Besides words, your hand movement, body posture &

eye contact also make an impact while you talk to people. For example, when communicating with children, it is important to get down to their eye level, listen to them attentively, and speak when appropriate. Similarly, when interacting with a bedridden person, you should sit beside them and offer any assistance they may need.

- **Eye contact:** Maintaining eye contact with the person while talking indicates the sincerity and confidence.
- **Body posture:** Facing the person, standing, or sitting appropriately close, and holding the head erect gives value or weight to messages.
- **Facial expressions:** Effective communication requires supporting facial expressions therefore expressing appropriate feelings on the face. A smile always helps.
- **Gestures:** The use of hand gestures to describe and emphasize adds value but it should not be overdone in excitement or anxiety.
- **Written Communication:** As an ASHA, you might need to write applications and letters to the authorities to improve access to health care services. You also need to document the processes and decisions taken during meetings. You should remember the following important points while drafting such letters:
 - Address it to the appropriate person
 - Check that the letter has a date and subject
 - Keep sentences short and avoid unnecessary words
 - Use simple and familiar words instead of complex and unfamiliar ones
 - Explain facts through evidence and examples



ASHA encouraging the beneficiary for treatment compliance



ASHA taking written complaint on drinking water quality from the beneficiary

Active listening is the crucial part of communication:

Show interest & pay attention while talking to the beneficiaries to make them feel heard and respected. This will allow you as an ASHA to understand others, solve problems, share interests, see how the other person feels, or even show support. It also helps identify hidden problems (like domestic violence, depression, substance use etc.) that the beneficiary may not show out is otherwise critical to their health needs.

- Hearing happens naturally, but listening means paying attention and understanding what the person says.
- Active listening makes people feel heard, respected, and supported.
- Listen carefully, avoid distractions, observe body language, and repeat the main points to check understanding.
- Do not judge or criticize. Listen with care to build trust and understand any problems the person may have.



Table 4: Points to remember while communicating with stakeholders

Communicating with stakeholders:	Points to take care of while communicating:
Keep in mind the following points while talking to stakeholders and health functionaries- ✓ Give due respect to all the stakeholders, whether they are from the community or from the health care system. ✓ Prepare necessary evidence and data before sharing it with the stakeholders. ✓ Be very specific about the information, example – ‘eat good food’ is not helpful. Help family choose their best food basket from the best they can afford and what is healthy for them ✓ Be calm while communicating. Do not show anxiety and do not use a blaming and judging tone.	✓ When you visits families, greet the individuals and explain the reason for your visit. ✓ Maintain eye contact with the person to whom you are talking to, be confident but speak in a gentle tone that is loud enough to be heard and always be respectful. ✓ Stick to the point so that you do not end up using too much time and use simple words in the local language. ✓ Do not use technical words or jargon. The pronunciation should be clear and relatable to the local context. ✓ Be specific, sincere, honest, and direct while communicating. ✓ Be empathetic and try to share the feelings of individuals. ✓ Be open-minded and non-judgemental. This will help you in understanding the other person’s point of view better.

3. Counselling Skills: Counselling skills refer to the ability to engage in structured, empathetic, and supportive dialogue that helps individuals and families understand health issues, explore concerns, make informed choices, and adopt healthy behaviors, within the defined scope of your role. Good communication skills are required for good counselling.

Table 5: What is the difference between communication and counselling?

Communication Skills:	Counselling Skills
The ability to listen and convey health information clearly. • Active listening • Clear verbal communication • Use of local language • Non-verbal communication • Asking open-ended questions	The ability to support individuals and families to make informed health decisions through empathetic dialogue. • Establishing rapport and trust • Demonstrating empathy and non-judgment • Exploring beliefs, concerns and barriers • Providing clear options with explanations • Supporting informed decision-making • Reinforcing behaviour change through follow-up • Knowing limits and referral

Table 6: Counselling involves problem-solving and not merely preaching to adopt correct practices.

GATHER Approach for Counselling of Beneficiaries	
G GREET	Greet –To make the client feel welcomed ➤ Be polite, friendly and respectful: introduce yourself, and offer a seat ➤ Explain the purpose of the interaction, maintain privacy ➤ Assure the beneficiary that all information discussed will be confidential
A ASK	Ask –to understand client's situation and needs for a service/ healthy behavior ➤ Asking simple brief questions to assess what the client already knows ➤ Listen actively to what the client says to understand their current situation ➤ Identify information gaps or misconceptions that need to be corrected ➤ Help the client express his/her feelings, needs, doubts, concerns or questions
T TELL	Tell To provide correct information about the healthy behaviour /services needed ➤ Use counseling job aids effectively to give relevant and specific information ➤ Tailor information to the client's needs ➤ Put risks into perspective
H HELP	Help the client in decision making and availing services. ➤ Ask if the client wants to learn more /answer his/ her concerns and questions ➤ Help beneficiary understand what the shared information means to him/her ➤ Help the beneficiary to decide to adopt the healthy behaviour/ avail services
E EXPLAIN	Explain healthy behavior/service in detail & remove any doubts he/she may have. ➤ Dispel myths misconceptions to help overcome barriers in adopting the healthy behaviors/ availing services. ➤ Tell how, when, and where the services will be provided ➤ Ask him/ her to repeat instructions to make sure that they have understood ➤ Thank the beneficiary/Tell him that you are there to answer any other
R RETURN	Return/ referral –to fix the next visit / ensure appropriate referral, if required ➤ Schedule return visit by the client for availing/ follow up of services provided ➤ Refer to service provider/ appropriate place for further services



Table 7: Let us understand by examples:

Situation	Which skill is required	
	Communication skill	Counselling skill
Telling a pregnant woman about her next ANC visit date	Giving information	x
Explaining family planning options	Active listening and explaining	✓
Discussing options for birth microplanning (institutional delivery)	Active listening and explaining	✓
Conveying details of next VHSND/ UHSND	Giving information	x
Explaining to a scared Mr. V who has been bitten by a dog, the advantages of Rabies vaccine	Explaining	✓
Mr. P has been put on Anti-Tubercular Treatment. Telling him the importance of compliance and completing of drug treatment.	Explaining	✓

4. Decision-Making Skills: Each decision has a consequence and even a small decision can change many things. You as an ASHA can recall decisions taken personally by you or by others which have left an important impact. You will often be required to take decisions that will affect the community at large. You should learn the skill of enabling participatory decision making by involving the community at all levels. If the decision is taken together, the ensuing actions are owned and supported by the community wholeheartedly.

Case study:

Ms. R worked as an ASHA in a slum where a public toilet complex had been built by the civic authorities. However, nobody would go there as it was frequented by some locals who played cards and drank in its waiting area. They had started locking the gate when nobody was there. Nobody had the courage to tackle them. The matter was raised in the JAS meeting. ASHA suggested that they go to the local councillor, who might be of help. They collectively went to the area councillor. He got the local authorities to intervene, got the complex cleaned and also assured that water tank would be filled regularly. The families have decided to pool in small amount every month and hired an individual for keeping the toilet clean.

Case Study:

Ms. M found in her survey that many elderly had impaired vision possibly due to cataract. Some youngsters also complained of low vision. In the VHSNC plus meeting, she highlighted this and suggested that they should have an eye screening in Ayushman Arogya Mandir next month. Everyone agreed and also volunteered to participate in making necessary arrangements. The team from nearby SDH agreed to come at the request of MO. People from the area provided the required space, furniture and also snacks for the visiting team. As a result of her prompt decision making initiative, four cataract surgeries were undertaken at SDH and twenty-six individuals received spectacles.

Decision-making skills are sharpened through experience and practice. However, one needs to be confident and prepared to take responsibility if the decision fails. In case of any problem, you as an ASHA may seek guidance from the ANM and CHO for correct decision support. A good working relation between ASHA, ANM & CHO can significantly impact the health of the community ASHA serves.

Define the problem	Gather information	Think of possible solutions	Choose solution by consensus	Put decision to action
Examine the situation carefully and analyze it from all perspectives to find out the actual problem.	Collect all the necessary information, seek advice from the appropriate authority, and involve the community to help them become part of the solution.	Work with VHSNC and Gram Sabha to identify solutions. This shows that people accept and understand the problem and are interested in identifying solutions.	To gain consensus and approval, discuss in VHSNC plus meetings. Before selecting the right alternative, assess all available options.	During this process, keep checking if it is moving towards the expected solution and if there is something else that needs to be addressed. It should not set up a conflict of a debilitating nature among groups.

Steps of Decision making

5. Negotiation Skills: The ability of an ASHA to reach a mutually acceptable health decision when there is resistance or disagreement is called negotiation skills. Negotiation is listening, adjusting, and protecting health interest at the same time. You might have to constantly negotiate with people and situations to be able to fulfil our responsibility. It is important to realize that it is quite a challenge to negotiate with people in authority but with enough preparation and practice you as an ASHA can deal effectively.



Table 8: The Steps of Successful Negotiation

Communication and Listening skills:	Use nonverbal methods like eye contact, gesture, posture, etc. for communication. Listening is necessary for negotiator to understand meanings in depth and able to concentrate on what is being communicated.
Ask for the other person's perspective:	Use questions to find out what the other person's concerns and needs might be. Examples of likely questions are: What do you need from me on this? What are your concerns about what I am suggesting/asking?
State your needs:	It is important to state not only what you need but also why you need it.
Prepare options beforehand:	Before entering a negotiation, prepare some options that you can suggest if your preferred solution is not acceptable. Anticipate why the other person may resist your suggestion and be prepared to counter the same with an alternative.
Do not argue:	Negotiating is about arriving at solutions. Arguing is about trying to prove the other person wrong. If you disagree with something state your disagreement in a gentle, but assertive, way. Do not demean the other person or get into a power struggle.
Consider timing:	There are good times to negotiate and bad times. Bad times include those situations where there is a high degree of anger on either side, a preoccupation with something else, a high level of stress or tiredness on one side or the other.

Case Study

Ms. N is a pregnant woman in her 8th month. The ASHA has advised **institutional delivery**, but Ms. N's mother-in-law insists on **home delivery**, saying, "All our children were born at home. Hospitals are unnecessary and costly".

How would you as an ASHA ensure that women gets access to institutional delivery respecting the mother-in-law opinion?



ASHA counselling the beneficiary for institutional delivery

Table 9: ASHA's Negotiation Approach

Step		ASHA's response	Value shown / Skill used
Step 1:	Acknowledge the Other Person's View (Respect)	"Amma, I understand that earlier deliveries in the family happened safely at home."	Value shown: Respect, relationship preservation
Step 2:	State the Health Need Clearly (ASHA's Position)	"Today, we know that even normal deliveries can suddenly become risky."	Skill shown: Clear communication
Step 3:	Identify Common Ground (Shared Goal)	"We all want both the mother and baby to remain safe."	Skill shown: Interest-based negotiation

Step		ASHA's response	Value shown / Skill used
Step 4:	Address the Key Concern (Cost / Fear)	"Delivery in the government hospital is free. You or me can stay with her, and transport facility is available."	Skill shown: Problem-solving
Step 5:	Offer a Practical Compromise (Win - Win)	"Let us go to the hospital. If everything is normal, she can deliver safely and come back home within 24 hrs. If there is any problem, help is already there."	Skill shown: Flexibility
Step 6:	Leave the Decision with the Family (Autonomy)	"You can think about it. I will come again tomorrow."	Skill shown: Non-coercive influence
Outcome The family agrees to institutional delivery without feeling forced or disrespected			

6. Coordination Skills: ASHA is a link between health care services and community thus you as an ASHA are expected to regularly coordinate with various stakeholders and the community. To achieve the goal of a healthy community, you will need to work in coordination with different departments/stakeholders. These include:

- Health Department
- Education Department
- Urban Local Bodies (ULBs)
- Community platforms -VHSNC plus, JAS, etc
- Women and Child Development
- Local NGOs
- Panchayati Raj Department
- Youth Groups
- AYUSH Department
- Tribal Health
- Self Help Groups (SHGs)
- Water and Sanitation etc.



Inter-sectoral coordination meeting with other departments

ASHA need to coordinate with various healthcare and other field functionaries for:

- ✓ Obtaining and updating services and scheme information on decisions taken at the PHC or at the Integrated Child Development Officer's (ICDS) level on schemes and programs related to health service provision.
- ✓ Sharing concerns regarding access to health care and nutrition services at the village level.
- ✓ Planning health activities to get optimum outcomes, such as a Ayushman Arogya Shivar at the AAM/village/slum level or organizing VHSNDs/ UHSNDs.

- ✓ Ensuring timely referrals for pregnant women, sick children or adults when needed.
- ✓ Apprising CHO/ ANM of the beneficiaries requiring the home visits & ensuring these visits are conducted.
- ✓ Identifying and reporting families who need to be linked to Anganwadi for services.
- ✓ Organizing outreach immunization sessions at Anganwadi.
- ✓ Sharing details of malnourished children. Getting the follow-up data of malnourished children from Anganwadi.

How to be an effective coordinator of a meeting?

ASHA should be prepared adequately before the meeting. It's essential to meet with participants in advance and convey the agenda, ensuring everyone is aware of what will be discussed and be aware of the complexity of the issues.

- During the discussion, keen observation and active listening are important, as changes in expressions can convey significant information.
- Be ready with clear explanations, anticipate the need for on-the-spot decisions and articulating outcomes effectively.
- Allocate ample time for each participant to express their views and avoid simultaneous discussions.
- At the meeting's conclusion, summarize the decisions and action plan, specifying responsible individuals, support, and deadlines.
- Ensure prompt implementation of decisions in the following days and maintain thorough documentation.
- In coordinating efforts, staying in touch with all stakeholders is key, and don't hesitate to seek assistance when necessary, ensuring confidence in the person providing support.



ASHA as a coordinator for community meetings

Key Messages:

- ASHA is a bridge between the community and the health system, helping people access health information, services and care.
- The three important roles of ASHA are community mobilizer, service provider and health activist.
- The main focus is to identify health needs, support timely care, facilitate referrals and ensure follow-up, especially for those needing extra attention.
- Every person matters—including vulnerable, poor, marginalised and hard-to-reach families; no family should be left behind.
- Respect, empathy, equality, confidentiality, teamwork and accountability are important values, supported by good communication, counselling, negotiation and problem-solving skills.



A2

Knowing the Health System



PART A

A2 Knowing the Health System

By the end of the session, You as an ASHA will learn about:

- The basic structure, functions, and services of all levels of the health system
- The two way referral linkages
- The teams available at different levels
- Continuum of care

A.2.1 DIFFERENT LEVELS OF CARE

The healthcare system consists of primary, secondary, and tertiary healthcare.

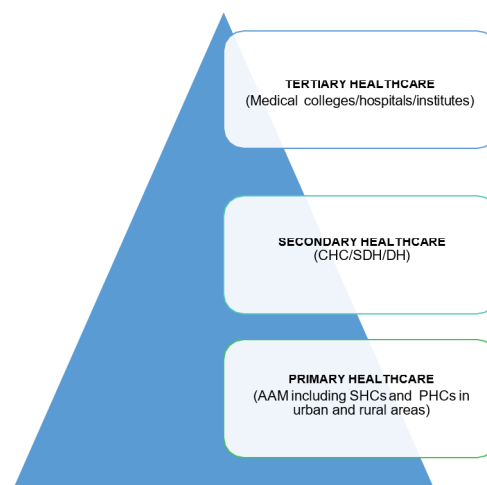
Primary Level Care:

Primary care services include health promotion through education and counseling, disease prevention, diagnosis and treatment of acute and chronic illnesses.

The primary level care is provided through Ayushman Arogya Mandir - Sub Health Centres (AAM-SHC) and Ayushman Arogya Mandir – Urban/ Primary Health Centres (AAM-UPHC/PHC).

The Government of India launched the Ayushman Bharat program in 2018. At the primary care level, Ayushman Bharat strengthened sub-health centres and primary health centres to Ayushman Arogya Mandir. The Ayushman Arogya Mandir deliver Comprehensive Primary Health Care (CPHC) by bringing healthcare closer to the homes of people, with time to access care being 30 minutes for all segments of society. Key focus of the program is to bring quality care closer to the people. These primary healthcare facilities have adequate availability of essential medicines and diagnostics close to the community.

- **Ayushman Arogya Mandir - Sub Health Centres (AAM-SHC)** in rural areas and **AAM-USHC** in urban areas: It is the most peripheral and first contact point between the



Levels of healthcare facilities

health-care system and the community. The AAM-SHCs is equipped and staffed by an appropriately trained Primary Health Care team led by a Community Health Officer (CHO) and comprising of Multi-Purpose Workers (male & female) and ASHAs, whereas AAM-USHC team is led by a Medical Officer.

The AAM-SHCs/ USHCs team work closely with communities to enable empowerment of individuals, families and communities with knowledge and skills to take responsibility for their own health. The AAM also focuses on improving health literacy through interpersonal communication, and media including social media, for promotion of healthy lifestyles – diet, yoga, exercise, tobacco cessation, and self-care for those with chronic disease conditions.

- **Ayushman Arogya Mandir - Primary Health Centres in rural areas:** It is the first contact point between the community and the health facility where a medical officer is available. Each AAM- PHC/UPHC is linked to its allotted cluster of AAM-SHCs/ USHCs in its jurisdiction and serves as the first point of referral for many disease conditions for its linked AAM. The Medical Officer at the AAM-PHC/ UPHC is responsible for ensuring that CPHC services are delivered through all AAM-SHCs/ USHCs in her/his area and through the AAM- PHC/UPHC itself. The rural PHC and urban PHC has a larger team which includes staff nurses, a pharmacist and a lab technician, along with other staff.

The AAM provides **Teleconsultation** services through e-Sanjeevani, where CHO can connect the patient to a Medical Officer/Specialist depending on their need. The Medical officer/specialist can provide consultation to the patients, thus reducing the need for physical travel and out of pocket expenditure.



CHO conducting Teleconsultation

Secondary Healthcare Level

Secondary healthcare refers to a second tier of health system, where more complex problems are dealt with. Patients from primary health care are referred to specialists in Community Health Centres (CHC), First Referral Unit (FRU), Sub District Hospitals (SDH) or District hospitals for treatment. This level serves as the second referral level in the health system.

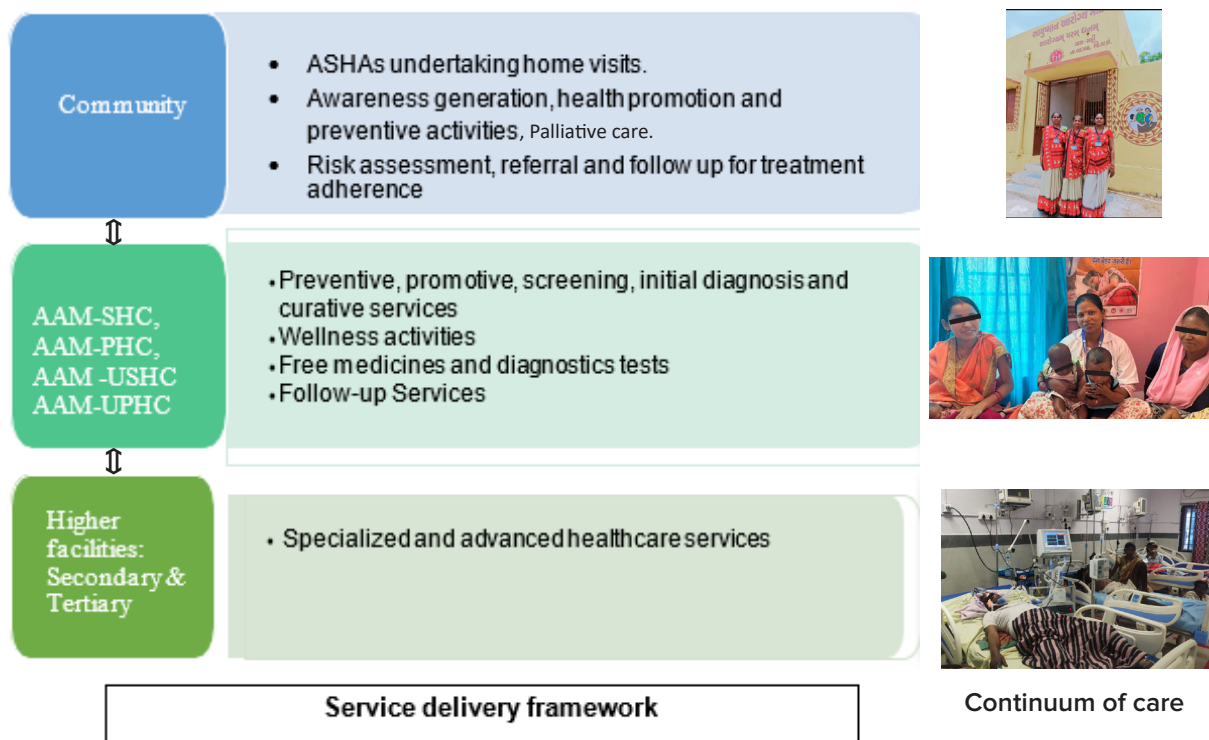
Tertiary Healthcare Level

Tertiary Health care refers to a third level of health system, in which super-specialized care is provided usually on referral from primary and secondary care. In India, under the public health system, tertiary care service is provided by medical colleges and advanced medical research institutes.

The second component of Ayushman Bharat program comprises Pradhan Mantri Jan Arogya Yojana (PMJAY) which aims to provide financial protection for secondary and tertiary care to socially vulnerable and low-income households. We will learn more about PMJAY and your role as an ASHA to support PMJAY in the subsequent chapters.



A.2.2. CONTINUUM OF CARE



By now the levels of healthcare system in India would be clear. For more clarity, please see the example given below:

Mr. R had acute chest pain. The ASHA recognises that this may be an emergency and helps the family seek urgent medical care. They approached village AAM-SHC. CHO checked his B.P and pulse and had a tele consultation with medical officer at AAM-PHC. Medical officer advised some medicine and advised referral to the District hospitals.

He went to District Hospital. An ECG was done. Doctor diagnosed heart attack and after administering a medicine shifted him to the nearby Medical College hospital for surgery



This is Primary healthcare facility: they provide preventive, promotive, basic curative, referral and rehabilitative healthcare services.



This is Secondary healthcare facility- they provide specialist care and additional facilities like ECG, X-ray etc.



This is Tertiary healthcare facility- they provide advanced and highly specialized medical care.

A.2.3. SERVICES AVAILABLE AT DIFFERENT LEVELS OF HEALTH SYSTEM

Table 10A: Levels of Health Systems - rural areas

Service delivery level/centre	Population Coverage	Providers	Available Services
Village Health Sanitation and Nutrition Day organized at Anganwadi centre	At Village level	One ANM One ASHA One Anganwadi Worker* One Anganwadi Sahayika*, CHO*	• Registration and health checkups for pregnant women and lactating mothers, immunization and elderly care. • Immunization of children / adolescents. • Growth monitoring and nutritional counselling. • Counselling/provision of condoms and oral contraceptives. Counselling of adolescents • Distribution of the take home ration for pregnant, lactating mothers, malnourished children, and adolescents by Anganwadi worker • Counselling and screening of services related to expanded package of services at AAM
Sub Health Centre – Ayushman Arogya Mandir (SHC-AAM)	3000 population in tribal hilly areas and up to 5000 population in plain areas	• One Community Health Officer (CHO) • One ANM / MPW Female • One MPW (Male) • All ASHAs of the SHC's	The following services are available at SHC-AAM: • Basic diagnostic services: 14 at AAM-SHC • RMNCHA+ • Prevention, screening, and referral for patients with non-communicable diseases such as cancer, diabetes, hypertension, kidney disease, etc. • Palliative care • Health care for the old people (geriatric care) • Screening and referral of the people with mental health issues. • Screening people for eye disorders, ear, nose, and throat-related illnesses. • Screening and referral of oral health problems • Referral in case of emergency in trauma and burns.

* WCD works under ICDS

* To provide care for expanded package of service



Service delivery level/centre	Population Coverage	Providers	Available Services
Primary Health Centre (PHC)/ PHC-AAM: 4-6 bedded and acts as a referral unit for 6 Sub-Centres/ AAM-SHC	20,000 in hilly, tribal, or difficult areas and 30,000 population in plain areas	• One or two MBBS Medical Officer • One AYUSH Doctor • One Staff nurse • One Sanitary Staff (Many PHCs have two Medical Officers)	In addition to services provided by SHC-AAM, PHC-AAM provides the following: • Basic diagnostic services: 63 at PHC • 24 Hours institutional delivery services both normal and assisted (if designated as 24X7 PHC) • Out-patient care for all common ailments • Essential Newborn Care (with the provision of Newborn Care Corner (NBCC) in labour room) • Abortion services only with trained personnel and facility • Health check-ups and treatment of school children. • Adolescent Friendly Health Clinic for 2 hours once a week on a fixed day addressing adolescent health concerns • Screening of general health, assessment of anaemia/nutritional status, eyes testing, hearing problems, dental check-up, common skin conditions, heart defects, physical disabilities, learning disorders, behaviour problems, etc.
Community Health Centre: 30-50 bedded hospital and acts as a referral for 4-6 PHCs	80,000 in tribal/ hilly/ desert areas & 1,20,000 In plain areas.	5-6 doctors including specialists for different types of health care. Nurses and Paramedical staff more than PHC.	In addition to services at PHC-AAM: • Diagnosis and treatment of major non-communicable diseases e.g. diabetes, hypertension, cancer , Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease etc. • Basic specialist services for newborn, dental ailments, childhood illnesses, orthopedics • Treatment of mental illness, trauma, and burns patients • Caesarean Section Delivery.
Tertiary Care (Medical College)			• Advanced specialist and highly specialised care, usually available at medical colleges and other higher-level institutions.

Remember: A person may move from one level to another depending on the health problem. After treatment at a higher facility, the person may return to the lower-level health team for follow-up. This is called continuity of care.

Service delivery level/centre	Population Coverage	Providers	Available Services
Sub-District / District Hospital- 100 to 500 beds depending on the size, terrain & population of the district.	One per district	Specialist for different types of health care with an adequate number of nurses and paramedic staff.	Generally, provides all basic specialty services and also certain kinds of highly specialized services • Specialized Newborn Care Unit for sick and high-risk newborns, blood bank, specialized labs, and provides services for cesarean sections, post-partum care, safe abortion, and all kinds of family planning procedures. • Provides surgical services according to available specialists, infrastructure and designated services. Treat accident and emergency patients. • Specialist services for non-communicable diseases like cancer, diabetes and hypertension, and other problems.

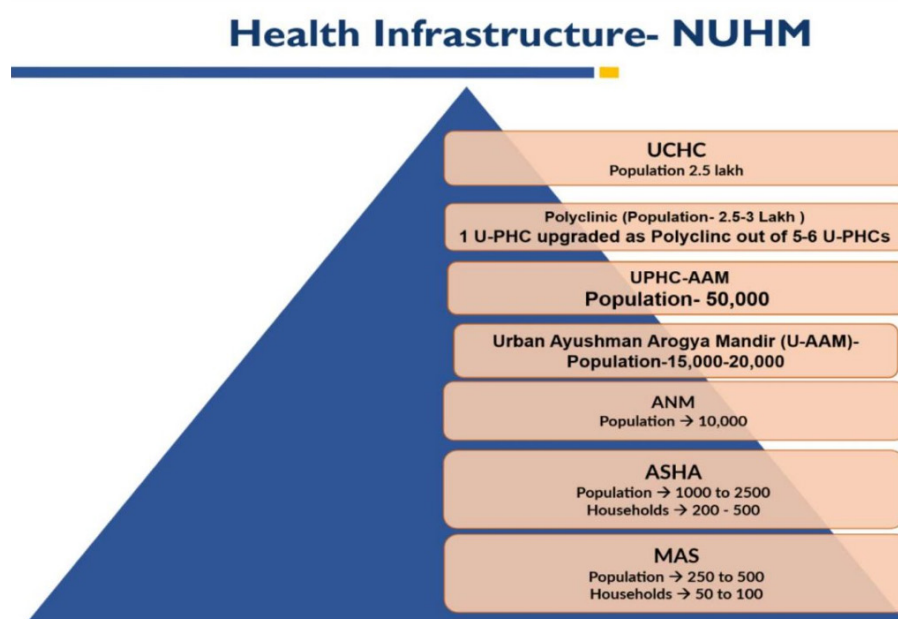
Table 10B: Levels of Health Systems - urban areas

Service delivery level / centre	Population Coverage	Providers	Available Services
Ayushman Arogya Mandir – Urban Sub Health Centre	15,000 to 20,000 population	MO, a staff Nurse/ Pharmacist, MPW	The following services are available at AAM USHC and UPHC: • RMNCHA+ services • Prevention, screening, diagnosis, basic management and referral for patients with ▪ Non-communicable diseases such as cancer, diabetes, hypertension, kidney disease, etc. ▪ Palliative care ▪ Health care for the elderly (geriatric care) ▪ Mental health issues. ▪ Eye disorders, ear, nose, and throat-related illnesses. ▪ Oral health problems ▪ First aid and Referral in case of emergency in trauma and burns. • Basic diagnostic services: 14 at AAM USHC and 63 at UPHC • 24X7 UPHCs provide Labor and Delivery services as well as basic in-patient services.
Ayushman Arogya Mandir – Urban Primary Health Centre / 24X7 UPHC 2 to 6 beds	30,000 to 50,000 population	MO, staff Nurse, LT, Pharmacist	
Polyclinic 2-4 day care beds	2.5 lakh population	Visiting specialists, MO, staff Nurse, LT, Pharmacist	• In addition to services provided by the AAM UPHC, the polyclinics have Specialists available for outpatient specialist consultations.



Service delivery level / centre	Population Coverage	Providers	Available Services
			Rotational Specialist clinic (6 core specialties at Polyclinics- Medicine, obstetrics & gynaecology, Paediatrics, Ophthalmology, Dermatology, Psychiatry/ Psychosocial care)
Urban Community Health Centre/ FRU 50 to 100 beds	2.5 to 5 lakh population	Full time specialists and inpatient Care staff	In addition to services at UPHC-AAM: - Diagnosis and treatment of major non-communicable diseases e.g. diabetes, hypertension, cancer, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease etc. - Basic specialist services for newborn, dental ailments, childhood illnesses, orthopedics etc. - Treatment of mental illness, trauma, and burns patients - Caesarean Delivery.

The figure below describes the health infrastructure in urban areas as per the National Urban Health Mission



Key Messages:

- Ayushman Arogya Mandirs and other primary-level facilities are important points of care for the community.
- Health problems needing higher-level care are managed through CHC, District Hospital and other referral facilities, as required.
- Timely referral and continued follow-up help people receive the right care at the right place.
- ASHA connects families with the health system and helps them reach, use and continue appropriate health services.



A3

Knowing the body



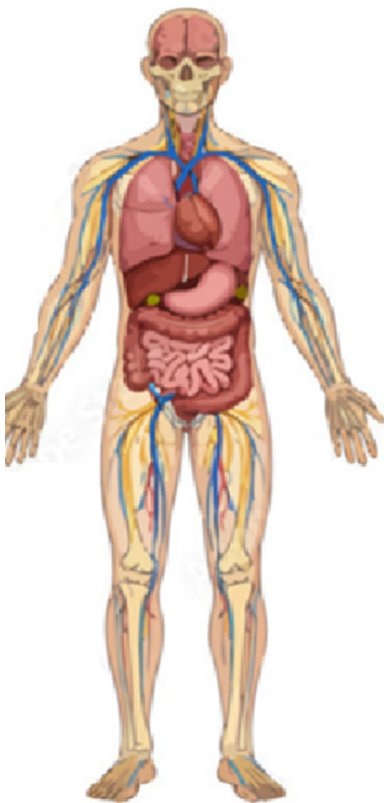
PART A

A3 Knowing the body

By the end of this session, ASHA will be able to:

- Understand the basic structure and functions of major body systems
- Apply basic knowledge of the human body to promote healthy practices and provide appropriate health education within the community.

A.3.1. Our body is made of many organ systems. It is important to know some basic facts about our body. This will help in understanding and then imparting this information to our beneficiaries to allay their fears, instill caution about our delicate organs and dispel myths and misconceptions.



Organs of the human body



Bony skeleton



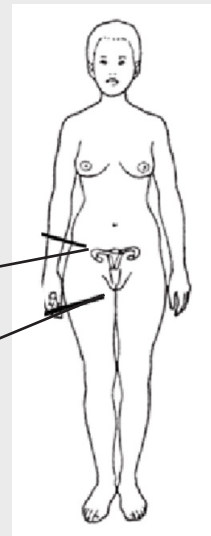
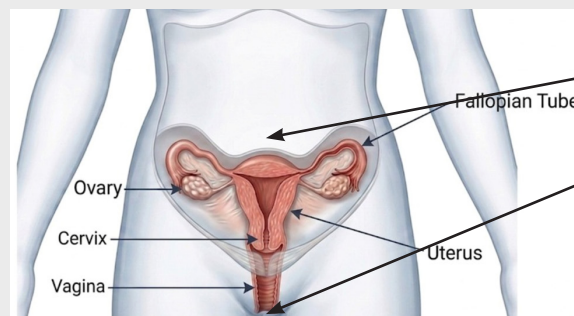
Muscles of the body

Human body is made of different organs which help us to perform different functions. These organs are protected and held together by a bony structure covered by muscles. Bones covered by muscle and the skin give the shape to our body and help us to move. Bones are made of calcium and minerals and therefore to have strong bones we must have enough calcium and minerals in our food. Similarly muscles are made of proteins and therefore for a strong body we must consume adequate amount of proteins in our diet.

The organ systems include our –

- **Nervous system:** Helps us think, feel, sense, and control different parts of the body.
- **Circulatory system:** The heart pumps blood to carry oxygen to all parts of the body.
- **Respiratory system:** Helps us breathe in oxygen and breathe out carbon dioxide.
- **Digestive system:** Helps digest food and absorb nutrients needed by the body.
- **Urinary system:** Removes waste from the blood and passes it out as urine.
- **Female reproductive system:** Helps in reproduction and includes the ovaries, uterus and other reproductive organs.
- **Male reproductive system:** Produces and carries sperms and produces male hormones.

Female reproductive system - Comprises the two ovaries with tubes to carry egg, uterus, cervix and vagina. Ovaries and uterus are placed deep in the lower part of the body and communicate with the outside through vagina. These are dealt with in more detail in section on family planning.

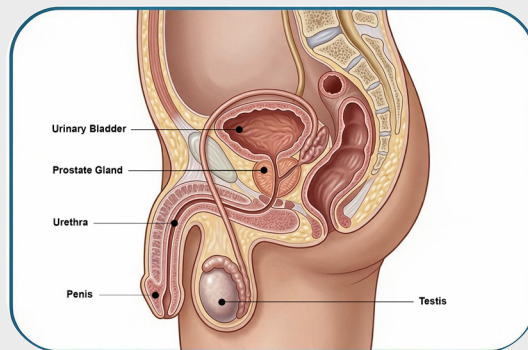


Female reproductive system



Male reproductive system - comprises the two testes and the tubes carrying the sperms to the storage bags (seminal vesicles) from where they are released into urethra which communicates with the outside. The testes lie in the scrotal sac on both sides of the penis. Penis is the external male reproductive organ.

Testes produce sperms which are released into the tubes and carried away to the storage site till they are released. Testes also produce male hormones which are released directly into the blood.



Male reproductive system

Key Messages:

- Basic knowledge of the human body and its major organs and systems helps in understanding common health problems.
- The major body systems perform different functions and work together to keep the body healthy.
- Understanding the body makes it easier to explain health conditions and healthy practices in simple language.
- Correct basic knowledge helps in addressing doubts, reducing fear and correcting common misconceptions.



A4

**Knowing the other partners in
community / social determinants
of health**



PART A

A4 Knowing the other partners in community / social determinants of health

In this session, ASHA will learn about:

- The structure and functioning of key community platforms (VHSNC plus, JAS, MAS) and the role within these committees.
- How to work with the community and Anganwadi worker to improve health and nutrition
- Identifying and addressing social determinants of health through community action.

A.4.1 SOCIAL DETERMINANTS OF HEALTH

Look at the following pictures. Do these conditions influence the health of the people in your area.

What can you do as an ASHA to improve these conditions?



Unsafe drinking water



Poor sanitation and unclean surroundings



Alcohol addiction



Malnutrition



Lack of skilled care during pregnancy / childbirth



High burden of infectious disease

You as an ASHA will learn about the available platforms and have the opportunity to help your community in changing some of these condition through collective community action.

Things that affect our health, including food, water, sanitation, housing, income, education, family support and access to health services. These work together and can either protect health or cause illness. Below are the most common conditions and factors that influence the health of individuals, families and community:



How determinants interact with each other

Determinants do not work alone, they are interconnected with each other.

For example:

- A poor family (social determinant) living in unhygienic surroundings (environmental) may face frequent diarrhoea/sickness, reducing child nutrition (biological) and school attendance (social).
- A woman unable to take decisions (social) may not seek ANC (health services), putting mother and baby at risk.



Key Messages:

- Health does not mean only being free from disease. It means feeling well and healthy in all aspects of life. Health includes physical, mental, emotional, and social well-being.
- There are other social determinants like water, sanitation, environment, etc which directly or indirectly impact health
- You as an ASHA will help families and the community to adopt healthy practices and use health services when needed.
- You as an ASHA will get an opportunity for motivating collective health seeking actions amongst your community members and for improving social determinants of health.

A.4.2. HOW COMMUNITY PLATFORMS CAN BE USED FOR HEALTH PROMOTION?

Community platforms are regular community/ facility-level gatherings or groups where people come together to discuss and act on issues related to health, nutrition, sanitation, women's empowerment, and child development. The key community and facility-based platforms where the ASHA plays an important and active role in supporting health services:

1. Village Health Sanitation and Nutrition Committee plus (VHSNC plus)
2. Mahila Arogya Samiti (MAS) in urban areas
3. Jan Arogya Samiti (JAS)



ASHA attending JAS meeting

Why are Community Platforms important for ASHA?

1. **Community Mobilization and Awareness:** Community platforms allow to share key health messages with a larger group or representatives of the community. This saves

time, ensures that everyone receives the same information and helps reinforce messages across the community.

2. **Local Level Planning and Monitoring:** Community platforms serve as forums for public participation where you can gather information on local health needs, report births and deaths, plan interventions (like Village Health Plans), and monitor the quality and availability of health services, thereby ensuring accountability of the local health system.
3. **Build Trust and Recognition:** Regular participation in community platforms increases your visibility and acceptance as an ASHA. Over time, people begin to recognize you as a trusted health resource. This strengthens your credibility and supports your leadership role in promoting health and nutrition practices.
4. **Strengthen Behaviour Change:** Community meetings provide opportunities for demonstrations, discussions, and peer learning. When families learn together and see others adopting healthy behaviours. They are more likely to follow practices such as hand washing, IFA consumption, breastfeeding, toilet use, and safe water management. Group settings make health messages easier to understand and adopt.
5. **Grievance Redressal and Inclusivity:** These platforms provide an opportunity for community members to raise problems about health and nutrition services and ensure that vulnerable groups are included in discussions.
6. **Action on Social Determinants:** By working within community platforms, you can address broader social determinants of health beyond medical care, such as water and sanitation issues, gender and equity concerns, and local living conditions.



ASHA as a community mobilizer to the AAM



ASHA conducting community meeting for local level planning



ASHA building trust of the community

1. Village Health Sanitation and Nutrition Committee plus (VHSNC plus)

The Village Health Sanitation and Nutrition Committee (VHSNC plus) is a sub-committee or a standing committee of the Gram Panchayat. The VHSNC plus is formed at the level of revenue village and functions under the ambit of Panchayati Raj Institutions (PRI). In states where there are several revenue villages and thus a number of VHSNC plus within a Gram Panchayat, a coordination mechanism is desirable. The VHSNC plus acts as a sub-Committee of the Gram Panchayat and act under the latter's oversight.

Objectives of the VHSNC plus:

1. Create institutional mechanism for community engagement and mobilization, leading to better health outcomes. Improving awareness and access to health and health-related social entitlements for vulnerable groups.
2. Bringing different people and departments together to solve problems that affect health, such as water, sanitation, nutrition and access to services.



3. Serving as safe spaces for the community, especially vulnerable groups, women, tribal communities to voice their needs, experiences and issues related to health access, social issues like domestic violence, and other services, such as nutrition, education, clean drinking water, and sanitation.
4. Empowering panchayats with the understanding of their role in collaborative governance for health and other public services.
5. Providing support to ASHAs, primary healthcare providers, and frontline staff from other departments to engage communities and ensure universal reach and coverage of government programmes.

A VHSNC plus will consist of a total of 20-30 members, ensuring adequate representation of different sections of the community, all genders, marginalized and vulnerable populations, Community Based and Civil Society Organizations (CBOs and CSOs), as well as government departments, leading to meaningful consultations across the spectrum of stakeholders for convergent action. About **50% of members will be women and SC/ST sections and minorities.*** Every VHSNC plus is entitled to an annual untied grant of Rs. 10,000 from the NHM. Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures are key areas where these funds could be utilized. The fund shall only be used for community activities that involve benefit to more than one household.

The Chairperson of the VHSNC plus is a woman elected member of the gram panchayat (panch) preferably from among the SC/ST communities, who is a resident of that village. If there is no woman panch from that village, then preference should be given to any panch from the SC/ST. **ASHA is the Member-Secretary and Convenor of VHSNC plus.**

Guidelines for Village Health, Sanitation & Nutrition Committee Plus



ABOUT THE COMMITTEE

- The Village Health Sanitation and Nutrition Committee Plus receives Rs. 10,000 as Untied fund every year from the government for local health planning and action
- The committee constitutes the members of Gram Panchayat, ASHA, ANM, Anganwadi worker and other community members.
- ASHA is the member Secretary of VHSNC Plus



MAIN ACTIVITIES OF THE COMMITTEE



Facilitate easy access to public services



Promote hygiene and cleanliness



Monitor services on Village Health Sanitation and Nutrition Day



Organise monthly meeting



Develop village health plan



Utilise the untied fund



2. Mahila Arogya Samiti (MAS)

As the name suggests, Mahila Arogya Samitis (MAS) are local women's collectives. 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 lead to process of decentralized health planning. Thus, MAS provides a platform for women to discuss local health problems, improve awareness and access to health services, support frontline workers such as ASHA and ANM, and take collective action for health.



ASHA and MAS leading a community awareness rally

The main purpose of MAS includes, demand generation, ensuring optimal utilization of services, optimal utilization of referral linkages, increasing community ownership to sustain collective action for health and establishing a community-based monitoring system.

Objectives of MAS:

1. Provide an institutional mechanism for community to be informed of health and other government initiatives and to participate in the planning and implementation of these programs, leading to better outcomes.
2. Organize or facilitate community level services and referral linkages for health services for Maternal, Newborn, Child health and Nutrition (MNCHN) and other related services for water sanitation and hygiene (WASH), adolescent health issues and non-communicable diseases enabling increased access of the community for these services.
3. Provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
4. Provide a 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 health, WASH and locally relevant health issues and promote the acceptance of best practice in health by the community members.
6. 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, MPW and other frontline health care providers who form a crucial interface between the community and health institutions.

Mahila Arogya Samiti 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. Every MAS must have a bank account opened in the nearest bank, to which the untied fund of Rs 5,000 per year shall be credited. The chairperson and member secretary (ASHA) are the joint signatories of MAS account.

3. Jan Arogya Samiti (JAS)

Jan Arogya Samiti operates at the level of Ayushman Arogya Mandir. Jan Arogya Samitis are multi-stakeholder platform comprising elected representatives of local government of the area, health care providers, representative of civil society groups and facility users and has an oversight role on the facility, engages in community-based health promotion and acts as grievance redressal forum for the community. JAS plays a crucial role in fostering trust among the public in the healthcare system. It also contributes to increased utilization of services and promotes ownership of Ayushman Arogya Mandir.

Objectives of JAS:

1. Serve as institutional platform of SHC/PHC/UPHC level AAM (similar to RKS at CHC/ SDH / DH), for community participation in its management, governance and ensuring accountability, with respect to the provision of healthcare services and amenities.
2. Support AAM team in working with VHSNC plus, for health promotion and action on social and environmental determinants of health, in community-level activities of National Health Programs and other community interventions.
3. Serve as an umbrella for VHSNC plus, providing mentorship and supporting them in management of untied funds and coordination with the health system.
4. Engage the VHSNC plus of its area, in community level interventions of AAM, particularly, in the facilitation of screening for various age-groups, promoting follow-up and treatment adherence (including support to patient support groups).
5. Leverage existing organized volunteers like; NSS, NCC, Red cross, Scouts and Guide, youth groups for patient follow up, counselling, community mobilization, conducting surveys and other related action.
6. Support and facilitate the conduct of activities pertaining to social accountability at AAM in coordination with VHSNC plus.
7. Act as Grievance Redressal platform for families who access healthcare services at AAMs, ensuring availability and accountability for quality services.
8. Co-ordinate with Community Health Officers (CHOs) at SHC/Medical Officers (MO) at PHC to manage and be accountable for the use of untied funds at AAM.
9. Mobilize resources (both monetary and non-monetary) from rural and urban local bodies, other Government schemes and programs, Corporate Social Responsibility (CSR) funds, and philanthropy and charity organizations, and ensure their use for improving quality of services and undertaking health promotion activities at AAMs.
10. Facilitate and support Gram Panchayats of the area in undertaking health planning.
 - **For AAM-SHC** - The Sarpanch of the Gram Panchayat (GP) falling under the SHC-AAM area shall be designated Chairperson, the Medical Officer of the concerned PHC of the AAM area shall be the Co-Chairperson and the Community Health Officer



JAS meeting

(CHO) of the AAM is Member Secretary. ASHAs are members of JAS AAM-SHC.

- **For AAM-PHC/UPHC** - Zila Panchayat Member/Janpad Panchayat member/ Ward Member of ULB of the corresponding area, Block Medical Officer / Taluka Health Officer are co-chair and the Medical Officer in-charge of AAM-PHC/UPHC will be Member Secretary

Who leads the JAS?

- AAM-SHC (Rural): The Chairperson is the Sarpanch of the Gram Panchayat covering the AAM area, or a similar elected village representative where applicable.
- AAM-PHC (Rural): The Chairperson is a Zila Panchayat or Janpad Panchayat member of the area, or a similar elected local representative.
- AAM-USHC/UPHC (Urban): The Chairperson is the Ward Member/Councillor representing the AAM area.
- If an elected representative is not available, an appropriate administrative, development or public health officer may be designated as Chairperson, as per the local context.

Other important members

- Health staff and Medical Officers linked to the AAM are part of JAS.
- ASHAs, ANMs/MPWs and other frontline health workers are included.
- Representatives from women's groups, schools, youth groups and civil society may be included.
- Other departments working on health-related issues may also be represented.
- Special invitees may include TB champions/survivors, cancer survivors and youth representatives.

JAS Meetings

- JAS meetings will be held once every three months (quarterly).
- The meeting calendar can be planned at the beginning of each quarter.
- Quarterly meetings are expected to make it easier for members to attend regularly and help ensure that decisions are followed up with action.

Important principle for forming JAS

- Priority should be given to elected representatives of the concerned area.
- If an elected representative is not available, the decision should be taken at the lowest appropriate local level, as close as possible to where services are provided.
- If this is also not possible, a person with local administrative or financial authority may be included, provided their role, decision-making power and accountability are clearly defined.

A.4.3 ANGANWADI WORKER - AN IMPORTANT PARTNER

Anganwadi worker is also a local resident and is in charge of the Anganwadi Centre, which provides following services:

- **Supplementary nutrition:** For children under six years, and for pregnant and lactating mothers. This could be a cooked meal, or in the form of take-home rations. Malnourished children are given additional food supplements. Adolescent girls (10 years to 19 years) are also given weekly Iron and Folic Acid Supplement and tablets for de-worming bi-annually.
- **Growth monitoring:** Involves weighing of all children below 5 years of age, and growth monitoring through growth charts especially for those under 3 years of age, tracking malnourished children and referral for children who are severely malnourished.
- **Early Childhood Care and Development:** Includes activities for playful learning and providing a stimulating environment, with inputs for growth and development especially for children between three to six years of age.

Coordination and role integration with Anganwadi worker

ASHA should work closely with Anganwadi worker for following activities:

- **Organizing VHSND/ UHSND:** On VHSND/ UHSND, the women, adolescent girls and children from the village be mobilized for service delivery & 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.
- **Nutritional surveillance and growth monitoring** is an important activity of Anganwadi workers and also critical for care of children as per the SSBSK. The Anganwadi also provides nutrition for infants, young children and pregnant women. Close coordination with the AWW will multiply the outcomes of the field work. AWW will also share their beneficiary list so that no beneficiary is missed out. IEC activity through display of posters, folk dances etc. on these days can be undertaken to sensitize the beneficiaries on health-related issues.
- The ASHA along with the AWW will be 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 check-ups / health days etc. to Anganwadi Centres.

The other stakeholders engaged in looking after her population.

While ASHA looks after them in their households and during outreach sessions (VHSNDs/ UHSNDs), they also receive services from the Anganwadi, schools, and health facilities through respective health centre team – CHO and ANM at the AAM-SHC, Medical Officer at AAM-PHC/UPHC/USHC and Specialists at CHC / SDH / DH. Community members in



VHSNC plus/ JAS / MAS are also involved in activities which directly or indirectly impact the health and wellbeing of the community.

The figure below describes the various stakeholders at different levels that the ASHA needs to provide services to or collaborate with.

Households	VHSNDs/UHSNDs	Anganwadis & Schools	Health Facilities & Community Platforms
• Eligible couples • Pregnant and breastfeeding mothers • Newborns and infants • Children 1–13 years • Adolescents • People with chronic diseases • Elderly people • People with disabilities • Vulnerable and marginalized groups • People needing palliative care	• Pregnant and breastfeeding mothers • Newborns and infants • Children 1–10 years • Adolescents 10–19 years • People with chronic diseases • Elderly people	Anganwadi • Children below 6 years • Pregnant and breastfeeding mothers School • School-going children • School Health and Wellness Ambassadors	• AAM-SHC team – CHO, ANM/MPW and field supervisors • Medical Officer at PHC/UPHC • CHC/SDH • District Hospital/ Medical College • VHSNC members in rural areas • MAS members in urban areas • JAS members at health facilities

Key Messages:

- Health is influenced not only by illness but also by food, water, sanitation, housing, education, income, family support and access to services.
- Community health improves when people and different community groups work together on local health problems.
- VHSNC plus, MAS and JAS are important platforms for community participation, health planning and collective action.
- The Anganwadi team and other community partners have an important role in improving health, nutrition and child development.
- Community action can address issues such as nutrition, sanitation, gender concerns, substance use and access to health services.



A5

Knowing the Population, Community, Families and Individuals



PART A

A5 Knowing the Population, Community, Families and Individuals

During this session, You as an ASHA will learn about:

- The importance of knowing the households and population groups in the area.
- Calculate estimated number of beneficiaries / individuals requiring follow-up and extra care - pregnant women especially high risk women, newborns, malnourished children, specially abled children and adults, elderly persons with comorbidities etc
- Identification and prioritisation of vulnerable and marginalized families in the area.
- Maintenance of updated household information, registers, and resource mapping for effective service delivery.
- Effective planning of your daily and monthly activities based on the health needs of your community.

A.5.1 KNOWING THE POPULATION

Introduction: Different groups within the community, including children, adolescents, women, men, and the elderly, have distinct health needs. You as an ASHA is expected to know and understand the health needs of every family within your area, to enable you to plan you work efficiently, ensure timely services, detect risks early and prevent complications and mortality. You will also be able to ensure that no family or individual who needs care is left behind.

Knowing the area population includes identification and prioritization of vulnerable individuals and households e.g. pregnant women especially the high-risk pregnancies, mothers and newborns, individuals with disability, elderly with restricted mobility, migrant or seasonal worker families, poor and marginalized households, homeless. By knowing your community closely, you build trust, improve health-seeking behavior, and make sure that every person receives the benefits and services they are entitled to.

In order to know your beneficiaries and the families, you have to know the extent of your population - both the numbers and the geographic spread of the area assigned to you.



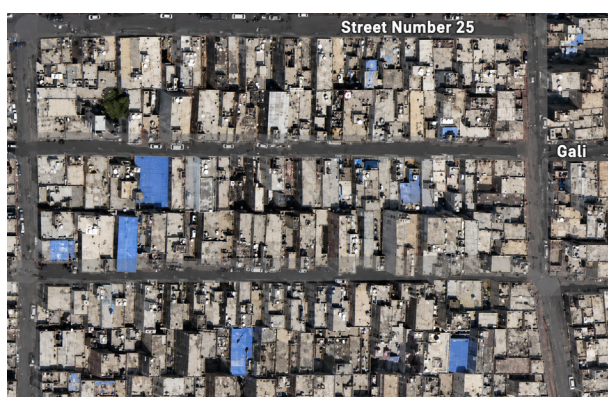
ASHA meeting with the beneficiaries in her catchment area

On an average an ASHA in rural areas covers a population of around 1000 whereas in the urban areas an ASHA's area has an average population of around 2500. In hilly and tribal areas, one ASHA may be present for a hamlet, owing to the geographical spread of hamlets.

1. Population Allocation to ASHA

Population	Approx. Households
1,000 (Rural)	200 - 250 households
1,000 - 2,500 (Urban)	200 - 500 households

The population may vary from ASHA to ASHA and in certain areas may also change due to migration, marriages, festivals, or seasonal labour movement etc., so records must be updated regularly based on the actual population.



Urban area slum aerial view



Village aerial view



Why is it important for an ASHA to know all the households in the area?

2. What you should know about people living in you area of work ?

As an ASHA, you are more than a messenger and a service provider; you are a bridge between the health system and community. To build this bridge, you must have two skills: Mapping (knowing who and where), Listening (understanding the community needs) and information on health system.

Your population will comprise of newborns and mothers, children, adolescents, adults, senior citizens. Though majority of them would be healthy, some individuals in each group would be needing your extra attention. While some of your actions are for the entire community to further improve their well-being, many of your activities will be for the sick / vulnerable members of your population.



ASHA knowing her population



A.5.2 ESTIMATING THE BENEFICIARIES

To be able to do your work, you will have to know the expected number of beneficiaries in each group. At any time how many pregnant women would you expect to be in your care.

To know approximate numbers of **who makes up your population**, one can use the population distributions pattern of Government of India (Census 2011). Your district team can give a more accurate data after doing certain calculations. The table gives approximate planning estimates based on Census 2011. These are not actual figures for every community and should not replace the household survey.

Table 11: Guide to calculate the population of different age group in the assigned area

Age Groups	Percentage (number of individuals in 100 population)	Formula for calculating number in 1000 population	Total population in catchment of 1000	Total population in catchment of 2500
0-1 years of age	3	$3/100 \times 1000$	30	75
1-5 years of age	11.2	$11.2 /100 \times 1000$	112	280
5-9 years of age	9.2	$9.2 /100 \times 1000$	92	230
10-19 years of age	18.4	$18.4 /100 \times 1000$	184	460
15-49 years women of reproductive age group	24	$24 /100 \times 1000$	240	600
30 years & above	37	$37/100 \times 1000$	370	925
60 years & above	8	$8 /100 \times 1000$	80	200

(This table suggests population distribution for a population of 1,000, please calculate the beneficiaries as per population 10-19 yrs & 15 -49 Yrs - These groups overlap and should not be added together. Each percentage is used separately for planning the relevant beneficiary group. The 60+ group is included within the 30+ group; do not add these percentages.)



An ASHA has a population of 1200. Her AAM-SHC is planning a camp for population above 30 years of age. How many adults above 30 years of age are there in her area?

Ans: 444



There is a new ASHA. Survey data of previous ASHA (catchment area of 2000) was handed to her. It shows data of 100 elderly. Is this the complete data? How many elderly are expected in the area?

Ans: 160

Similarly, You will need the numbers of infants in your area to plan and assess your performance on immunization activities.

Activity to be done by all ASHAs:

Population of the area: _____

An ASHA must know the expected number of following groups in he area:

S.No	Category	Calculated estimation	Number as per actual household survey
1.	Infants		
2.	Children under five		
3.	Children 5-9 yrs		
4.	Adolescents		
5.	Adults 19-29 yrs of age		
6.	Adults more than 30 yrs of age		
7.	Elderly more than 60 yrs of age		
Why is there a difference in the two values?			

While these numbers came from the census population profile, you will also need to calculate the expected number of other key beneficiaries in order to improve coverage of comprehensive health services. Eg Pregnant women, women with high-risk pregnancies, newborns and eligible couples etc.

Table 12: Calculate them as per the data pertaining to State using the method described below:

a. Estimated Number of Pregnant women - How many pregnant women in my area?
(Using SRS 2023-based estimates (CBR: 18.4/1,000))

Birth rate = 18.4 (no. of children born over 1000 population in an year)

Population under ASHA = 1000

expected number of live births = $(18.4 \times 1000)/1000 = 18.4$ births

Correction factor = 10-15% for pregnancy losses (abortions/stillbirths)

= $(10/100) \times 18.4 = 1.84$

Therefore, the total number of expected new Pregnancies in a year under one ASHA in 1000 population = $18.4 + 1.84 = 20.24$ (20 – 21) per year
at any point in time 10 - 12 pregnancies

b. Estimated Number of Newborn - How many newborns in my area?

Birth rate = 18.4

Population under ASHA = 1000

Therefore, expected number of live births = $(18.4 \times 1000)/1000 = 18.4$ births annually

Hence number of newborns expected per month = $18.4/12 = 1.5$ (1-2) month.



c. Eligible couples (couples where wife is between 15-45 years of age & may need contraception): 17% of total population - ASHA will generally have a total number of 170 eligible couples/1000 in your area.

d. Pregnant women with complications -

Estimated Maternal Complications is approximately 15%.

You will generally have a total number of 21 expected new pregnant women in a year. And out of these, about 3-4 pregnant women out of these will be with complications.

e. Estimation of beneficiaries for common Non- Communicable Diseases (NCDs)-

Estimated Population under ASHA = 1000

Population 30 years and above is 37% of the total population = 370

No. of men 30 years and above (51% of the total 30 years and above) = 188

No. of women 30 years and above - 49% of the total 30 years and above = 182

Screening targets for hypertension and diabetes cases, annually = 370

Screening targets for oral cancer (for men and women annually) = 370

Screening targets for Breast cancer & cervical cancer (for women) annually = 182

Please Note:

Data Requirements for Calculation of Beneficiaries: District-level, State-level, National*-level figures can be used (If local not available). Use the latest census report to know the exact population of the area under your jurisdiction. You may seek the help of the ASHA Facilitator, Block Coordinator, District Coordinator or Trainers in calculation

* there can be a variation in numbers if referral figures are being used

Ms. R is an ASHA worker in Rebar village of Uttar Pradesh. She serves a population of 1,120. About 24 babies are expected to be born each year for every 1,000 people.

Based on this information, calculate:

1. The estimated number of live births expected in Ms. R's village in one year.
2. The estimated total number of pregnancies expected in one year, assuming that 10% additional pregnancies are included to account for pregnancies ending in miscarriage, abortion, or stillbirth.

Ms. B has an urban population of 2500. Calculate the number of beneficiaries in all age groups.

- Eligible couples:
- Pregnant women with complications :
- Estimated Number of Pregnant women :
- Estimated Number of Newborn :
- Estimation of beneficiaries for common Non- Communicable Diseases (NCDs):

VILLAGE RESOURCE MAPPING

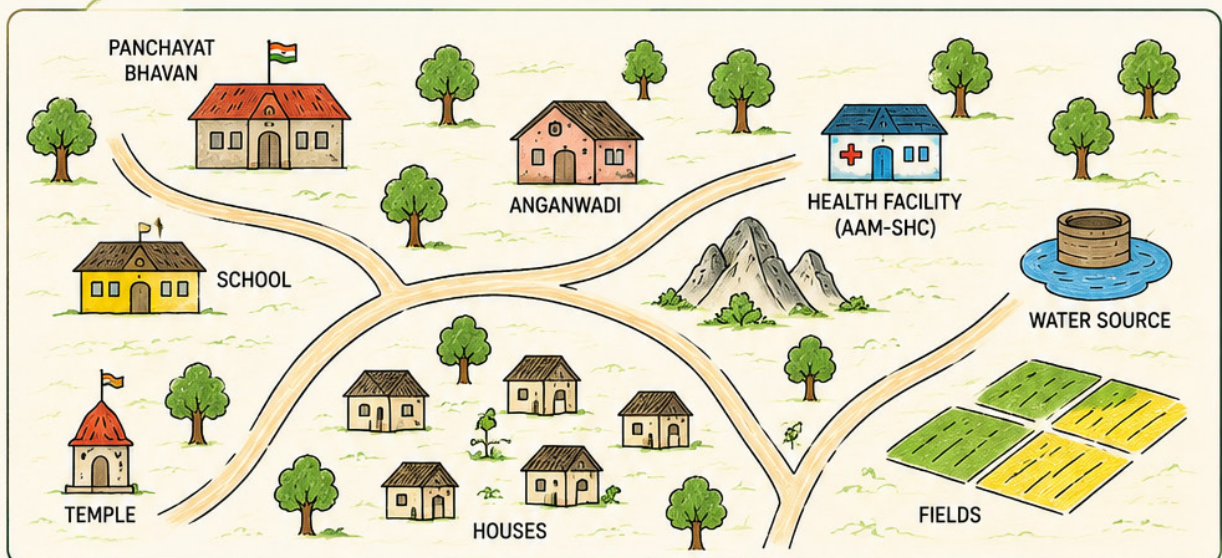
Understanding our village,
Identifying our resources, Planning for a healthier community



People and Community Institutions



Households and Vulnerable Groups



Health Facilities and Services

KEY RESOURCES IN OUR VILLAGE

-  Houses
-  Panchayat Bhavan
-  School
-  Anganwadi
-  Health Facility (AAM-SHC)
-  Water Source
-  Fields/Roads



Together we map, together we plan,
together we build a healthy village!





Which key groups need extra attention from ASHA and should be tracked by her?

A.5.3 VILLAGE AND URBAN RESOURCE MAPPING

Why village or urban resource mapping is important for ASHAs?

Resource mapping of a village or an urban catchment area means knowing about the key resources like health centres, anganwadis, schools, water sources, women's groups, and local support groups / influential people. These along with the landmarks, can also be drawn and represented pictorially with inclusion of the houses, families, and important places. It helps to easily identify pregnant women, newborns, vulnerable individuals / families. Mapping helps to plan visits and work together with the community to find solutions and improve health services in areas that need more attention. This helps in planning outreach activities and VHSNDs, due list preparation, conducting health surveys, delivering behavior change communication, and make follow-up visits. Mapping is a dynamic tool that must be updated every quarter to track changes and improve service delivery.

A.5.4 IDENTIFYING BARRIERS TO ACCESSING HEALTHCARE

You as an ASHA must identify the barriers in your community. For example, when a pregnant mother misses a scheduled ANC visit or a TB/HT/DM patient stops his/her medicine, you must look for the barrier. Use this checklist to understand the barriers in the village, this may help you to take action against the barrier:

Table 13: Checklist to identify the barriers and action required from ASHA

Barrier Type	What to look for	ASHA's Action
Physical	Is there a river or hilly terrain making travel difficult?	Organize group transport or request the ANM for campsite near their cluster.
Financial	Are daily wage workers afraid to lose a day's pay for a checkup?	Organize outreach – early morning / evening or on a holiday. Sensitize CHO so that they are seen on priority when they go to the health centre.
Social	Are certain families excluded due to caste or religion?	Visit their homes personally; ensure they feel welcome at the health facility / Anganwadi.
Information	Do they believe "the vaccine causes fever"?	Share the problems that can happen if the disease they are protecting from, was to occur. Tell them that small percentage of children have fever which can be managed easily and use IEC/ flip charts to explain benefits.
Behavioural	Is there a fear of how doctors/ ANM treat them at the AAM – SHC/ PHC?	Accompany them to the facility to act as their advocate and support.

Who are Marginalized?

Marginalized families are those people in an area who are often left out, unseen, or unable to use health services due to poverty, social barriers, or difficult living conditions. These families face more challenges in reaching the health system and therefore need extra attention and support from ASHAs.

Examples of Marginalized Families may include:

- Very poor families who struggle for daily needs.
- Single women-headed households (widows, deserted or separated women).
- Families from socially disadvantaged groups who may face discrimination.
- Households living in slums, remote, far outskirts of the hamlet or hamlet areas distant from the health centre.
- Migrant workers or seasonal migrants who keep shifting and miss services.
- Families without ration cards or identity documents, making it hard to access schemes.
- People with disability or chronic illnesses who cannot travel easily.
- Elderly people living alone without regular support.
- Pregnant women or newborns in vulnerable households where no one is there to guide or assist them.

A.5.5. REACHING THE UNREACHED

Reaching the unreached means making sure that every family in your area receives health information and services, especially those who live in remote corners, belong to vulnerable groups, or are often missed out during routine visits. You as an ASHA can play a very important role in identifying these families and supporting them to access timely care. Knowledge of the barriers and the village mapping are the best tools to identify these unreached beneficiaries. Reaching the unreached is not just a task, it is a way of working. When you make regular visits, build trust, coordinate with Anganwadi, ANM, and community leaders, every family gets the care they deserve.

Eight-Steps path for reaching the unreached

The Eight-Steps path is important because it helps you to reach every family, especially those who are usually left out. Many families do not come forward for health services due to distance, fear, traditions, or lack of awareness. This method gives a step-by-step way to understand these families and reach out to them:

1. Mapping (Household Mapping)

List all households & vulnerable families in the area.

2. Prioritising (Prioritise the Vulnerable)

Focus on pregnant women, children, elderly, specially abled those with chronic illness and families with barriers to care.



3. Communicating (Contact & Communication)

Visit homes, talk kindly, share simple health messages.

4. Understanding (Understand Needs)

Listen to families' concerns and reasons for not using services.

5. Counselling & Trust Building

Support them patiently and build their confidence in health services. Also ask senior colleagues like ANM/CHO and MO to visit the family.

6. Persisting (Repeated Follow-Up)

Visit again to create ABHA, take VHSNC plus members along and offer any support if needed, ask other members of the family to visit VHSND sessions, until the family accepts services.

7. Co-ordinating (Link with Community Groups)

Involve MAS, VHSNC plus, SHGs, ANM, CHO, Anganwadi and local leaders.

8. Community Mobilisation

Conduct meetings, events, and group actions to support health behaviours.



Community Mobilisation facilitated by ASHA



Case Study: Geographical and Cultural Barriers

Ms. M is a 21-year-old girl who lives in a small hamlet on the outskirts of the village where only six families reside. This hamlet is about two kilometres away from the main village where ASHA lives. In these families, there has been a long-standing tradition that women give birth at home with the help of a traditional birth attendant assisted by the elderly women in the household.

An ASHA comes to know that Ms. M is pregnant. ASHA asks her family member to take her there on a bicycle so that she can talk to her and explain why delivering at the health centre is important for her and her baby and also tell about the Janani Suraksha Yojana (JSY). She counsels her for a long time, but the elderly women in the family still do not agree to a facility-based delivery. This takes a lot of her energy and time.

In the part of the village where ASHA live, there are three other pregnant women. She has already convinced them to deliver at the AAM-PHC, and they have all agreed. They have also promised to call her if they need help in going to the hospital. Believing that Ms. M's family will not agree, she decide not to visit that hamlet again.

As an ASHA, what else could she have done in this situation?



A.5.6 POPULATION ENUMERATION

Household Survey: As a part of ASHA's duties, you routinely carries out a household survey and capture details of the households / families living in your area with the help of CBAC form. The information includes the identification details of the head of the household, the address and the contact details, enumeration of the social determinants and basic amenities. In addition to this information, the household survey provides you with the list of the family members, their ages, gender, their educational status, marital status, employment status.

Thus the household survey has been providing the entire age wise listing of the population eg. total population, total infants, under fives, women in reproductive age group, eligible couples, adolescents and elderly etc. This survey is updated SOS/annually.

The periodic household surveys have been a source for identifying the beneficiaries like newly wed couples pregnant women, children due for immunizations, eligible couples, elderly people with cataract, people with communicable diseases Tuberculosis (TB), leprosy, people with non-communicable diseases (diabetes, hypertension & cancers), people with hearing and/or visual impairment and mental health problems, people who are specially abled, elderly and those who have special needs for life support at home.

From Community to Family to Individuals – knowing each beneficiary by using Community Based Assessment Checklist (CBAC)

ASHAs have also been carrying out the assessment of entire thirty plus population for non-communicable diseases using the Community Based Assessment Checklist or CBAC.

An integrated revised CBAC form has been developed which aims to collect details of individuals of all age groups to assess the risk factors for age specific health issues.

Now the CBAC form include and covers all age groups with age appropriate questions. The current CBAC has also been digitized and ASHA can enroll the family, the individual and fill the CBAC form through mobile application. Due to logistical difficulties in many states / areas the form is still being filled in hard copies.

The CBAC assessment helps in identifying all those who are at a higher risk of having a particular problem by questioning them assessing them for the risk factors / symptoms of the diseases/ conditions being covered in the current CBAC - hypertension, diabetes, cancer, TB, leprosy, visual / hearing impairment, mental health issues, elderly issues etc. Those already diagnosed are segregated for ensuring treatment / followup. Those suspected to be having a problem are referred immediately to AAM-SHC/PHC for further evaluation. Those found at high risk are immediately referred/accompanied to higher centre and ANM and CHO informed.

The Family Household Details are filled in General form of the CBAC: You as an ASHA must maintain a record of all the population in your catchment area in the format given below.

Key points to remember

- The form is self explanatory
- To be updated every year (annually)

Vulnerability should be identified in the family folder as per the given criteria for prioritizing the families.

COMMUNITY BASED ASSESSMENT CHECKLIST (CBAC)

Section -1: General Information

Date: DD/MM/YYYY

Details of ASHA	
1) Name of ASHA:	5) Name of Village/ Slum/ Ward/Temporary accommodation (Rain Basera/ Construction sites/ Nomad tents/ any other):
2) Name of Block:	6) Name of District/State:
3) Name of AAM-SHC/ AAM-USHC:	7) Name of AAM-PHC/ UPHC:
4) Name of VHSNC plus/MAS (if urban):	

Section 1- Household Details	
1) Household Number/ID:	
2) Address:	
3) Name of Head of the family:	4) Telephone number of Head:
5) Occupation of Head of the Family:	
6) Family Size (total number of members staying for more than 6 months in household):	
7) Any Health Insurance card issued: Yes ☐ No ☐ n-process, since when _____ Public ☐ Private ☐ No. of family members covered- All ☐ Specify _____ ☐ Don't want to disclose	
8) Type of house: Kuccha** Yes ☐ No ☐ Semi Pucca*** Yes ☐ No ☐ Pucca**** Yes ☐ No ☐	
9) Availability of power for more than 8 hours regularly: Yes ☐ No ☐ If yes, Regular electricity Through Solar Panel ☐ Generator ☐ Any other ☐ None ☐ All ☐	
10) Toilet available: Yes ☐ No ☐ with water pipe/ tap connection: Yes ☐ No ☐	
11) Source of drinking water (multiple answer applicable):	Yes ☐ No ☐
• Tap water/ hand pump within house	Yes ☐ No ☐
• Tap water (Outside the house)	Yes ☐ No ☐
• Hand pump outside of house	Yes ☐ No ☐
• Well/ tank	Yes ☐ No ☐
• River/ pond	Yes ☐ No ☐
• Piped water collected and stored	Yes ☐ No ☐
• Any other specify	Yes ☐ No ☐
12) Type of fuel (multiple answer applicable):	Yes ☐ No ☐
• Firewood/ crop residue/ cow dung cake	Yes ☐ No ☐
• Coal/ kerosene	Yes ☐ No ☐
• LPG/ Piped	Yes ☐ No ☐
• Any other specify	Yes ☐ No ☐
13) Motorized Vehicle available: Yes ☐ No ☐	
(If yes, specify e.g. Motor bike/ Car/ Tractor/ or any other specify)	
14) Family Vulnerability: (Automatically filled based on the criteria and questions response*)	Yes ☐ No ☐
15) a. Any recent birth in last one year in the family:	Yes ☐ No ☐ If Yes, Registered Yes ☐ No ☐
b. Any recent death in last one year in the family:	Yes ☐ No ☐ If Yes, Registered Yes ☐ No ☐
c. Has any infant or baby less than 28 days died in your family in last 6 month?	Yes ☐ No ☐
If yes, do you know the cause?	Yes ☐ No ☐



Note*: Mark Vulnerable if any two of the following is present from Section 1 (Household Details) entries:

- ☐ Kuccha house = Yes
- ☐ Electricity available = No
- ☐ Toilet available = No
- ☐ Toilet with Water pipe/ Tap connection = No
- ☐ Tap water (Outside the house)/ Hand pump outside of house/ Well/ tank/ River/ pond/ Piped water collected and stored = Yes
- ☐ Type of fuel - Firewood / crop residue / cow dung/ Coal / kerosene = Yes
- ☐ Motorized vehicle available = No
- ☐ Migrant status = Yes
- ☐ Residence is slum / temporary accommodation = Yes
- ☐ Occupation is daily wage / informal / unemployed= Yes

**** Kuccha House:** The walls and/or roof of which are made of material other than those mentioned above, such as unburnt bricks, bamboos, mud, grass, reeds, thatch, loosely packed stones, etc. Are treated as kutchha house.

*****Semi -Pucca house:** A house that has fixed walls made up of pucca material but roof is made up of the material other than those used for pucca house.

****** Pucca House:** A pucca house is one, which has walls and roof made of the following material. Wall material: Burnt bricks, stones (packed with lime or cement), cement concrete, timber, ekra etc

Family Members' Detail

Sr. No.	Name of individual	ABHA ID	Age	Sex M/F/ Others	Marital Status	Literate (can read or write) (Yes/No)	Currently residing at Native or Birthplace (Yes/No) If no, migrated to another place temporarily (Yes/No)	Current health condition (Any diseases diagnosed) (Yes/ No)	Disease Code (refer to Annexure 1)	Remarks (such as Disease code (anything which is not captured), any other/special remark)

Annexure 1- Disease codes (Person diagnosed with/ on treatment for any of the below diseases)

1. Diabetes
2. Hypertension
3. Cardiovascular or heart disease
4. Respiratory disease
5. Cancer



6. Kidney disease/ Chronic Kidney Disease/ Dialysis
7. Mental ailment
8. Vision defect
9. Hearing defect
10. Physical disability
11. Neurodevelopmental disability
12. Any other concern, like birth defect visible to naked eye (specify)
13. Anemia
14. Malnutrition
15. TB
16. Leprosy
17. HIV/AIDS
18. Hepatitis
19. Vector borne diseases (Chikungunya, Malaria, Dengue, Japanese Encephalitis, Kala Azar, Filariasis)
20. Acute Flaccid Paralysis (Polio)
21. Rubella
22. Diphtheria
23. Pertussis
24. Neonatal Tetanus
25. Chickenpox/Measles etc.
26. Any other (specify)- State specific issues like Sickle Cell Disease

A.5.7 COMPLETION OF COMMUNITY-BASED ASSESSMENT CHECKLIST (CBAC)

Why CBAC is important for ASHAs?

Community Based Assessment Checklist (CBAC) is a very important tool for you as an ASHAs. It helps you to identify vulnerable population, health risks early, refer people on time, and prevent illness and untimely/premature death.

The new CBAC has been redesigned to:

Cover all age groups – from newborns to elderly

Focus on early detection of diseases

Strengthen preventive, promotive, and referral services

Increase optimal utilization of AAM services



ASHA discussing CBAC form with CHO

Remember:

CBAC is not just a form. It is a Bird's-eye view, and data-powered decision tool.

Age specific informant for CBAC filling

Age Group	Who Gives Information
0–5 years	Mother/ Caregiver
>5–10 years	Mother/Caregiver
>10–19 years	Adolescent (with family support)
20–59 years	Individual
Pregnant / Lactating women	Woman herself
60+ years	Elderly person / caregiver



ASHA measuring waist circumference for waist to hip ratio

CBAC is filled during:

- House-to-house visits
- VHSND / UHSND



CBAC consists of two sections, and second section has two more parts:



Individual details & anthropometry

Before starting questions, ASHA records:

- Age
- Weight
- Height
- BMI (auto-calculated)
- Waist to Hip Ratio

Why all these parameters matter?

- Identifies malnutrition, overweight, obesity
- Helps in anemia, NCD, child nutrition tracking

Part A: Risk assessment (Age-wise)

A. Newborns & Young Children (0–6 weeks & 0–5 years)

ASHA checks for 'At-risk' children, such as:

- Low birth weight (<2.5 kg)
- Preterm birth
- Discharged from SNCU/NBSU
- Breastfeeding not started
- <6 months → mixed feeding
- Congenital defects
- Delayed milestone development
- Poor weight gain

ASHA's Action

- Ensure scheduled home visits
- Refer to FRU / SDH / DH, when required
- Support for exclusive breastfeeding upto 6 months

- Track immunization and NRC follow-ups
- Link to Anganwadi Centre (AWC)

B. Children (5–10 years)

Key focus areas:

- Immunization status
- Anganwadi / school attendance
- Deworming and Vitamin-A
- Anemia Mukh Bharat (IFA syrup)
- Screen time and physical activity
- 4D's: Defects, Deficiencies, Diseases, Developmental delay

ASHA's Role

- Counsel parents
- Link child to AWC / school
- Ensure IFA, Albendazole and Vit-A
- Refer if any developmental delay is seen

C. Adolescents (10–19 years)

Important questions include:

- School/college attendance or dropout
- Weekly IFA (Blue tablets)
- Screen time
- Anthropometry (NCD Screening)
- Deworming
- Physical activity
- Tobacco, smoking, substance use
- Menstrual history (for girls)
- Menstrual hygiene practices
- Early pregnancy history

Special Focus: Adolescent Girls

- Age of menarche
- Type of menstrual products used
- Changing frequency
- Disposal practices
- History of pregnancy



ASHA conducting awareness session based on CBAC



ASHA's Action

- Promote RKSK and WIFS, deworming, menstrual hygiene
- Counsel on nutrition, hygiene, substance use, violence and injuries, mental health, teenage pregnancies etc.
- Refer school dropouts to appropriate services

D. Adults (20–59 years)

Risk assessment includes:

- Weight category (under/overweight)
- Tobacco, alcohol, substance use
- Physical activity (150 min/week)
- Screening for:
 - Blood Pressure
 - Blood Sugar
 - Haemoglobin
- Weekly IFA for Women of Reproductive Age

ASHA's Role

- Preconception care risk assessment
- Motivate for regular screening
- Counsel on lifestyle modification
- Link with CHO/MO at AAM

E. Pregnant & Postnatal Women

ASHA records:

- Last Menstrual Period (LMP) and Expected Date of Delivery (EDD)
- Antenatal Care (ANC) and Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) visits
- Iron, calcium, BP, diabetes medicines
- Type of delivery
- Pregnancy complications
- Post-partum danger signs
- Contraceptive use

High-Risk Signs

- Anemia
- High BP/sugar
- Abnormal bleeding

- Poor weight gain during pregnancy
- Fever after delivery
- Abnormal foul smelling discharge
- Convulsions

Immediate referral required

F. Elderly (60+ years)

Assessment focuses on:

- Chronic diseases
- Physical activity
- Tobacco/alcohol use
- Joint pain
- Muscle weakness
- Abnormal/sudden weight loss
- Falls, memory loss
- Dependency for daily activities
- Oral health and vision/hearing problems

ASHA's Role

- Ensure regular check-ups
- Support elderly-friendly services



Hypertension screening based on CBAC risk assessment

5. Part B: Early Detection of Symptoms (MOST IMPORTANT)

You as an ASHA asks symptom-based questions to detect:

- TB, Leprosy, other common communicable diseases
- NCDs (diabetes, hypertension, oral, breast, cervical cancers)
- Visual / hearing impairment
- Childhood illnesses

Golden Rule

If answer is “YES” to ANY symptom → REFER IMMEDIATELY

Special instructions:

- Cough >2 weeks → **TB sputum test**
- Mouth ulcers >2 weeks → **Oral cancer screening**
- Postnatal danger signs → **Immediate referral**



6. Part C: Mental Health Screening

Asked to: (all ages)

- Children
- Pregnant women
- Post-partum women
- Adolescents
- Adults
- Elderly

Questions check for:

- CMI including
- Depression
- Anxiety
- Any other

ASHA's role

- Ask gently and confidentially
- Generate awareness/ Educate regarding availability of care
- Encourage care-seeking

7. Referral and Follow-up: ASHA's Key Responsibility

When CBAC identifies:

- Risk factors
- Symptoms
- Mental health issues

ASHA must:

1. Refer immediately
2. Inform ANM/CHO
3. Ensure referral and follow-up
4. Record outcome

Quick Tip for Trainer

Show a CBAC form to all trainees.

Divide trainees into groups and get CBAC form filled by ASHAs of selected volunteer ASHAs

8. Key Messages for ASHAs

- ✓ CBAC helps save lives through early detection
- ✓ One “YES” answer can prevent a big disease
- ✓ CBAC strengthens **AAM** and community trust
- ✓ You as an ASHA is the **first health responder**



You as an ASHA must remember that:

- All answers are based on asking, not guessing
- Waist to Hip Ratio is measured, not assumed
- Score is added carefully in PHQ 2. A score ≥ 3 requires referral.
- Confidentiality is maintained
- CBAC form is for screening only and does not provide diagnosis or cannot diagnose.

*TELEMANAS
HELPLINE NO.*

14416



Date: DD/MM/YYYY



• Gaining weight on day 14 after birth					
3) If the newborn is identified as 'at-risk'; whether follow up visits were done in designated facility (FRU/SDH/DH)	Yes ☐ No ☐	NA	NA		
4) Immunization at time of Birth • BCG • Hepatitis B – Birth dose • OPV-0	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	NA	NA	
5) Immunization status – Is your child taking timely vaccination?	Yes ☐ No ☐	NA	NA		
6) Any missed dose? *If yes, reasons for missed dose	Yes ☐ No ☐ (if Yes, specify the disease for which immunization missed/ vaccination name)				
7) Breastfeeding 7.1) Exclusive breastfeeding continued up to 6 months of age? 7.2) Complementary feeding started at 6 months and above and continued	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	NA	NA		
8) SSBK visits done as per the schedule? Newborn care- Day 3, 7, 14, 42 Child Care- 3, 6, 9, 12, 18, 24, 30, 36 months	Yes ☐ No ☐	NA	NA		
9) Was the child admitted in NRC in last 3 months? If yes, has the child completed at least four follow ups at NRC?	Yes ☐ No ☐ Yes ☐ No ☐	NA	NA		
10) Does the child (0-6 years old & above)/					



14-18 years for NE states, go to Anganwadi Centre (AWC) or school? • AWC for 0-6 years old • Govt. school • Others (specify in Remarks section)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
11) Has your child/ adolescent been screened for anaemia?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
12) IFA Dose compliance	Child received IFA syrup biweekly every month? Yes ☐ No ☐	Does the child consume IFA tablet (pink tablet) every week? Yes ☐ No ☐	Do you consume IFA Blue tablet every week (provided in govt/govt aided school/AWC)? Yes ☐ No ☐	
13) Was the child/ adolescent given tablet for deworming /Albendazole in last 6 months	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
14) Was the child given Vit A dose in last 6 months?	Yes ☐ No ☐	NA	NA	
15) Child having any 4D's (Defects/ Deficiency/ Diseases/ Developmental delay)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
16) Duration of Screen time (hours spent watching TV, using computers, mobile, playing video games) <i>*Ask for children 1 years and above as appropriate</i>	☐ <3 hours per day ☐ >= 3 hours per day	☐ <3 hours per day ☐ >= 3 hours per day	☐ <3 hours per day ☐ >= 3 hours per day	
17) Physical activity performed in last 7 days (how much time did the child spent on physical activities like playing, running etc) • More than 60 minutes /day • Less than 60 minutes /day	Infants, toddlers and preschoolers active throughout the day Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐	

18) Does the child/ adolescent brush his/her teeth daily (or done by parent/care giver), cleaning of gum pad in children below 6 months? If yes, then are you aware of the teeth brushing /cleaning method?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
19) Is your child/ adolescent a school going child? 19.1) If drop out, does your child/ adolescent earn for the family?	Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐	
20) Any type of substance abuse like Smoking/ Alcohol/ Smokeless products like Gutka, Khaini, Sniffed or inhaled products like Whitener, Glue, Petrol, Sulochan, Kerosene/Injectable drugs? (validate from family member/neighbor)	NA	Yes ☐ No ☐ If yes, mention frequency	Yes ☐ No ☐ If yes, mention frequency	Yes ☐ No ☐ If yes, mention frequency	
21) Do you notice that your child/ adolescent has the 4 Ts i.e. Toilet (frequent urination), Thirsty (excessive thirst), Tired (fatigue), and Thinner (unexplained weight loss)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
22) Does your child/ adolescent find difficulty in mixing with other children, e.g. playing with them? ** <i>Applicable to 2 years and above</i>	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
23) Does your child/ adolescent seem excessively sad, worried, withdrawn or irritable often? **	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	



***Birth to 2 years (Reaching, grasping, pulling, pushing, moving their head, body, and limbs, and crawling); 3–5 years (moving, rolling, playing, skipping, hopping, dancing, running, jumping, climbing a frame, chasing games and ball games in group play, and swimming); 5–18 years (cycling, walking, skate-boarding and games, and activities (aerobic and nonaerobic) in the playground) Source: [IAP Guidelines for Normal Sleep and Physical Activity](#)**
****Question from PHQ 6 for children. Yes, to any question should be immediately referred to nearest AAM-SHC/ PHC**

Assessment questions for Adolescent Girl		
Questions	Yes/No If yes, specify the age of starting	Remarks
1) Menstruation started? 1.1) Age of menstruation starting?	Yes (specify- sanitary pads, cotton cloth, reusable cloth pads, menstrual cup, tampons) No	
2) Menstrual hygiene products used		
3) Changing frequency	• Once in a day • Twice in a day • More than twice a day • Don't change the entire day	
4) Where do you dispose of the used sanitary pads/cloths?	• Don't dispose, reuse, after washing • Wrapped and thrown in household/ community dustbin • Burnt at home / community level • Buried in the ground • Thrown in open areas (fields, drains, roadside) • Flushed in toilet • Any other method	
5) Last menstrual period (LMP)	Specify date	
For Adults (20-59 years)		
For Women of Reproductive Age (WRA) 1) Do you take/ consume IFA Red tablet every week?	Yes ☐ No ☐	

2) Any type of substance abuse like Smoking/ Alcohol/ Smokeless products like Gutka, Khaini, Sniffed or inhaled products like Whitener, Glue, Petrol, Kerosene/ Injectable drugs/ Hukka/ Bidi/ Taudi/ any other area specific addictive substance?	Yes ☐ No ☐ If yes, what is the frequency?	
3) Do you engage in any physical activities***	Yes ☐ No ☐ If Yes, select one:- ☐ At least 150 minutes in a week ☐ Less than 150 minutes a week	
4) Have you been examined for the following in the last 6 months?	Hemoglobin- Yes ☐ No ☐ Blood Sugar- Yes ☐ No ☐ Blood Pressure Yes ☐ No ☐	
5) If women (married for the period of last 6 months), are you planning to have a baby?	Yes ☐ No ☐	
5.1) If you are planning for a baby, are you taking the following medicines currently? (please tick (✓) the suitable options)	☐ Folate ☐ Medicine for BP ☐ ☐ Medicine for Diabetes ☐ Medicine for Anaemia ☐ Any other medicines ☐ (specify illness)	
6) Are you using any type of contraceptive?	Yes ☐ No ☐	
7) Remarks (if any)		
***Physical activities (as per MoSPI TUS classification) include any bodily movement across work, domestic chores, caregiving, and leisure, such as farming, construction, manual labour, fetching water, livestock care, household work like cooking, cleaning, washing clothes, walking, sports, exercise, yoga, walking, recreational physical activity etc. (Source: https://www.mospi.gov.in/sites/default/files/publication_reports/TUS_Factsheet_25022025.pdf)		
Pregnant and Postnatal/ Lactating Women		
1) Last menstrual period (LMP) 1.1) EDD	(put in MM/DD/YYYY)	
2) ANC Visit completed	1 2 3 4 5 6 7 8 9	





		NA								
		4	5	6	7	8	9			
3) PMSMA Visits completed										
4) Are you taking any medicine		• Iron Tablet (Once a day/ Twice a day) • Calcium Tablet (Once a day/ Twice a day) • Medicine for BP • Medicine for Blood Sugar • Any other, specify	Yes ☐ Yes ☐ Yes ☐ Yes ☐	No ☐ No ☐ No ☐ No ☐						
5) Type of delivery		• Normal • Caesarean								
6) Any previous/ pregnancy-related complication (postnatal mothers only)		Specify (Severe Anaemia/ Heavy bleeding post childbirth/ High BP/ High blood Sugar/ Severe headache/Blurring of vision/Convulsion/ Stillbirth/ Caesarean section/ Low birth weight/Swelling of face/hands/Vaginal bleeding during pregnancy/others)								
7) If severely anaemic, were you given iron through IV injection/ Blood transfusion?		Yes ☐ No ☐								
8) Have you adopted any contraceptive method post-delivery?		Yes ☐ No ☐								
9) Were you or your partner using any contraceptive method before pregnancy?		Yes ☐ No ☐								
Elderly population (60 years and above)										

1) Are you able to do physical activity daily?***	Yes ☐ No ☐ If Yes, Specify the type of physical activity and time spent (in minutes or hours)
2) Any type of substance abuse like Smoking/ Alcohol/ Smokeless products like Gutka, Khaini, Sniffed or inhaled products like Whitener, Glue, Petrol, Kerosene/Injectable drugs/ Hukka/ Bidi/ Taudi/ any other area specific addictive substance?	Yes ☐ No ☐ If yes, what is the frequency
3) Do you brush your teeth daily?	Yes ☐ No ☐
4) Have you been examined for the following in the last 6 months?	Hemoglobin- ☐ Yes ☐ No Blood Sugar- ☐ Yes ☐ No Blood Pressure ☐ Yes ☐ No
5) Remarks (if any)	

Part B: Early Detection: Ask if the respondent has any of these Symptom/ s#		
B1: For all age groups	Yes/ No	Yes/ No
CNS/Mental Health		CVTS and Respiratory
1. History of Fits		21. Difficulty in breathing (while sitting/ walking/ running/ climbing stairs)
2. Fatigue/ Weakness/ Dizziness frequency		22. Chest Pain
3. Do you have trouble remembering things – like forgetting names of your near ones, home address or require support in everyday activities?*		23. Coughing more than 2 weeks*
Eyes		24. Blood in sputum/spit*
4. Difficulty seeing at night		Gastroenterology





5. Inability to close eyelid			25. Frequent stools/ blood in stools/ unusual bowel movements	
6. Persistent puffiness around the eyes.			Urinary	
7. Cloudy/blurred vision/difficulty in reading			26. Blood in urine/ Foamy/ Frothy urine	
8. Squint (deviation of one or both eyes) and/ or white reflex in the pupil of either/ both eyes)			27. Any increase or decrease in frequency of urination/ uncontrolled urination	
ENT			Skin and Hair	
9. Nasal discharge/ bleed/ smell			28. Persistent itching	
10. Recurrent ear discharge/foul-smelling fluid			29. Any hypopigmented patch(es) or reddish lesion(s) with definite loss of sensation	
11. Difficulty in hearing or redness/ pain in the ear			30. Clawing of fingers in hands and/or feet	
12. Any thickened/ lump /nodules on the skin esp. on the earlobes			31. Recurrent/ nonhealing ulceration on palm or sole	
13. Any change in the tone of your voice			32. Loss or brittleness of hair	
14. Ringing in ears			General	
Oral Care			33. Fever for >2 weeks*	
15. Difficulty in opening the mouth			34. Swelling over the face and legs	
16. Any ulcer or growth in the mouth that has not healed in two weeks			35. Swollen ankles/feet/hands	
17. Pain while chewing			36. Night Sweats*	
18. Bleeding from gums/ gingival bleeding			37. Recurrent tingling/ numbness on palm(s) or sole(s)	
19. Swelling/ nodules in Neck*			38. Loss of weight (gradual/ within 2 weeks/ more than 2-3 kgs in a week/ Visible Wasting)	
			39. Weakness in the hands/ fingers leading to difficulty in holding objects	
			40. Fever with rash	

B2A: Women only	Yes/ No	Yes/ No
-----------------	---------	---------

1) Is the woman aware of self-breast examination? If yes, does the woman do self-breast examination and how frequently?		b) Lump in the breast...	
2) Blood stained discharge from the nipple**		7) Bleeding after menopause**	
3) Change in shape and size of breast		8) Bleeding after intercourse**	
4) Bleeding between periods cycles		9) Foul smelling vaginal discharge**	
5) Irregular or no periods/ excessive bleeding/ prolonged or painful periods)**		10) Difficulty to conceive**	
B2B: Pregnant/ Postnatal women only			
Pregnant women	Yes/ No	Postnatal women	Yes/ No
1) High Fever**		1) High Fever**	
2) Vaginal bleeding**		2) Heavy vaginal bleeding **	
3) Severe Abdominal pain**		3) Severe Abdominal pain**	
4) Swelling of face and hands		4) Foul smelling discharge**	
5) Severe headache**		5) Severe headache/Blurring of vision/ Convulsion**	
6) Blurring of vision**		6) Breathlessness	
7) Convulsion**		7) Anxiety/Depression/Suicidal thoughts**	
PHQ-2 (applicable to all age groups)**			
Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days
1) Little interest or pleasure in doing things?	0	+1	+2
2) Feeling down, depressed or hopeless?	0	+1	+2
B3: For elderly#			
Yes/ No			
1) Feeling unsteady while standing or walking		2) Forgetting names of your near ones or your own home address	
3) Needing help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking/ assisted through stick, walker/ helper, or using the toilet		4) Frequent falls	





5) Do you feel require assisting devices like hearing aid, spectacle, walking stick, wheelchair etc.			
<i>In case of individual answers is Yes to any one of the above-mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available</i>			
<i>*If the response is Yes- action suggested: Sputum sample collection and transport to nearest TB testing center</i>			
<i>**Immediate referral to AAM-PHC in consultation with ANM (If total score is >=2 in case of PHQ 2 assessment)/ If yes to Fever with Rash report these cases immediately to Medical Officer or District Surveillance Officer</i>			
<i>#Refer to AAM-SHCs OR CHOs</i>			

Key Messages:

- Knowing every household and its members is the foundation for understanding the health needs of the community.
- Special attention is needed for pregnant women, newborns, children, persons with disabilities, elderly people, migrants and other vulnerable or marginalised families.
- Updated household and population information helps in planning daily work, follow-up and timely services.
- Reaching the unreached means mapping, prioritising, communicating, understanding needs, counselling, repeated follow-up, coordination and community mobilisation.
- Population enumeration and CBAC help identify families, beneficiaries and people who need additional attention, screening, referral or follow-up.



A6

Records Maintained by ASHA



PART A

A6 Records Maintained by ASHA

During this section you as an ASHA will learn about:

- Importance of accurate record keeping for tracking health status and services provided to individuals and families.
- Correct documentation in formats used during home visits, VHSNDs/ UHSND, and community activities.
- Support planning, monitoring and reporting of health services by sharing complete and reliable data with ANM, CHO, and health facilities.

INTRODUCTION

In this chapter, you as an ASHA will learn about the significance of maintaining organized records as an ASHA. Maintaining organized records is crucial for you effective functioning. Your role is vital in improving access of the population to existing healthcare services, and keeping well-organized records is a fundamental requirement for follow-up, reaching the unreached and helping the vulnerable. This chapter will explain why record management is crucial, what records are important and how to use them in effectively doing your daily work.

A.6.1 RECORDS

You as an ASHA play a vital role in providing healthcare services to the community, and it is difficult to remember the relevant details of all individuals needing services. Thus, establishing and maintaining a robust record management system would not only help you to stay organized but also track your progress and boost confidence that things are running smoothly.

You as an ASHA must maintain the following records to facilitate action at the local level.

Table 14: Recording Format required by ASHAs

S.No.	Recording formats/registers maintained by ASHAs
1.	CBAC form with Family Folder
2.	Village/ Household health register
3.	Line listing of eligible couples

S.No.	Recording formats/registers maintained by ASHAs
4.	Due list for pregnant women and children (immunization)
5.	Delivery forms
6.	Line list of at risk pregnancies
7.	Format for Individual Birth Preparedness Plans
8.	Format for the first examination of newborns
9.	Primary informant form for maternal and child death
10.	SSBSK formats
11.	Line list of 'At risk' and Home Visit Form for At Risk Baby
12.	Line listing of adolescents
13.	Malaria register
14.	Line Listing of NCD patients- Hypertension, Diabetes, Oral Cancer, Cervical Cancer, Breast Cancer, Respiratory and Kidney Diseases
15.	Line listing of individuals with poor vision including children and adults
16.	Line listing of individuals with hearing loss or reduced hearing including children and adults
17.	Line listing of elderly people
18.	Line listing of specially abled, bedridden patients and others needing palliative care
19.	Format for palliative care services provided
20.	Home visit case sheet and follow-up case sheet for palliative care patients
21.	Drug kit stock register card
22.	Meeting minutes of the VHSNC plus meeting

Reports are made from the records and are submitted to higher levels of programme management. Documents are necessary for information on a regular basis and for actions to be taken. The reports tell about:

- Pregnant women: numbers, registered, ANC, danger signs.
- Deliveries: numbers, institutional and home deliveries, danger signs.
- Newborn Care: Numbers, At risk newborns / infants, referrals with danger signs , weak feeding practices.
- Children: Immunization and feeding practices.
- VHSND: beneficiaries given services, participation of VHSNC plus members.
- Home visits: Birth preparedness plan.
- Deaths: mothers, newborns, infants and children, elderly.



ASHA filling records and updating ASHA Diary



ASHA Diary: The ASHA Diary is used to record and track Your work and follow-up. Other prescribed registers, forms and digital records are maintained separately or linked electronically, as applicable. It serves as a record of our work and helps in tracking beneficiaries. It also forms the support document for performance-based payments. It provides valuable information about the beneficiaries under her care.

ASHA diary helps to

- Organize the work
- Keep track of the tasks
- Tracking the beneficiaries
- Verification of incentives

A.6.2 LEVERAGING THE DIGITAL PLATFORMS AND DATA MANAGEMENT

Leveraging use of digital portals/ mobile applications for data management by ASHAs

You as an ASHA play a vital role as a link between the community and the health system. With the introduction of mobile-based applications under the National Health Mission (NHM), ASHAs are now supported in service delivery, reporting, monitoring, and incentive management. These digital tools enhance efficiency, transparency, data accuracy, and timely health interventions at the community level. Continuous support from the Ayushman Arogya Mandir team is ensured to enable you to learn, adapt, and effectively use mobile applications. By leveraging these digital platforms, You as an ASHA can improve beneficiary tracking, follow-up of health services, reduce paperwork, and promote greater health awareness in the community.

Currently, You as an ASHA mainly use following digital platforms:

1. **SWASTH BHARAT**
2. **UWIN**
3. **NCD Portal**
4. **FPLMIS (Family Planning Logistics Management Information System)**
5. **State Specific App/ Portals- ASHA Incentives**
6. **Integrated Health Information Platform (IHIP)**
7. **NikShay Application/ Portal**
8. **AYUSHMAN Bharat Card generation and use**
9. **Creation of ABHA IDs**
10. **SASHAKT Portal/ Application**
11. **JANANI Application**
12. **SHAISHAV App**

UWIN Application

The UWIN Application is a digital platform for recording and tracking beneficiaries for immunization services.

Key Features:

- Registration of beneficiaries
- Maintaining digital record of their immunization and updating regularly
- Scheduling and tracking vaccination sessions
- Follow-up of missed children or drop-outs

Advantages:

- Improves immunization coverage
- Reduces duplication of records
- Ensures timely vaccination

Uwin Videos –

<https://uwin.mohfw.gov.in/videos>

1. How Can I Create ABHA Through U-WIN
2. How Can a Pregnant Women Book Appointment
3. How Appointment for Infant or Children can be Booked
4. FAQs

https://www.youtube.com/watch?v=WB7jlwh_O50

NCD Portal

The National NCD Portal includes multiple applications to support population-based screening and NCD management.

Use of NCD Application:

- Use the **ASHA NCD mobile app** for population enumeration and CBAC.
- Application works in **online and offline mode**, ensuring no data loss. Real-time data entry during field visits with a **simple dashboard** for tracking enumeration, CBAC, and follow-ups.

Role of ASHA:

- Conduct **household visits** to enumerate all adults **30 years and above**.
- Register eligible individuals and update NCD-related details.
- Maintain records using prescribed **registers/family folders**.
- Ensuring adults diagnosed with common NCDs in your area.

Key Activities:



Estimate population to be screened.

- Enumerate adults (30+ years) during routine home visits.
- Complete **CBAC** and **create individual health records**.
- Assess risk, identify priority individuals, and **mobilize for screening**.
- Identify population **with and without NCD risk factors**.

Support and Monitoring:

- You as an ASHA will receive **training** on the app and **on-the-job support** from ASHA Facilitators/ Block Community Mobilizers (BCMs).
- Data is reviewed by **CHO/MO** during monthly meetings at AAM-SHC/PHC/UPHC.
- **IEC materials** on MCH, immunization, nutrition, health promotion, NCDs, and government schemes are available on tablets/smartphone.

ASHA Mobile App – To capture population enumeration and CBAC Assessment. The **Non-Communicable Disease (NCD) Application** supports early detection, prevention, and management of NCDs such as diabetes, hypertension, and cancers.

1. Prerequisites Before using the NCD App, ensure: • Charged android smartphone • Internet connectivity (mobile data/ Wi-Fi) • ASHA ID and registered mobile number • App installed and updated	2. Login to NCD App 1. Open the NCD App on the mobile phone 2. Enter: • Registered mobile number / User ID • Password / OTP 3. Click Login 4. Home dashboard will appear
3. Dashboard Overview The dashboard usually shows: • Total population covered • Eligible population (30+ years) • Screened cases • High-risk / referred cases • Under treatment	4. Identify Eligible Beneficiary 1. Go to “Beneficiary List” / “Population Enumeration” 2. Select household or add new household 3. Identify individuals aged 30 years and above 4. Verify name, age, gender, address
5. Add / Register New Beneficiary 1. Click Add New Beneficiary 2. Enter details: • Name • Age / Date of Birth • Gender • Mobile number • Address 3. Save beneficiary details etc.	6. NCD Screening (Support Role) ASHAs assist MPW/ANM in screening. App entry may include Risk Assessment – CBAC form

7. Referral Entry

If beneficiary is high-risk:

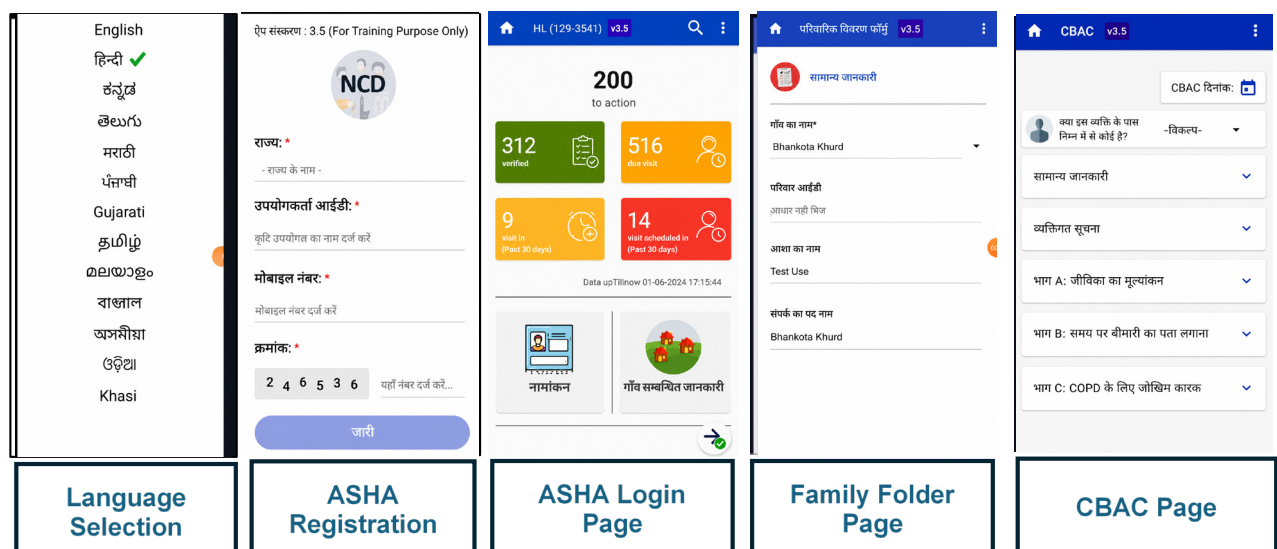
1. Select Refer option
2. Choose referral facility: AAM / PHC / CHC / DH
3. Save referral details
4. Inform beneficiary about:
 - Facility name
 - Date of visit

8. Logout

- After completing work, click Logout
- Do not share login credentials

ASHA Format:

On choosing the ASHA format icon, one can digitize the ASHA format recorded by ASHA in the paper form. However, she can also search the CBAC form of an individual. Please check video for NCD App Usage Guide for ASHA.



Quality Data Tips for NCD Portal

- Ensure correct age and mobile number (important for follow-up)
- Enter BP and Blood sugar values exactly as measured
- Update follow-up outcomes after visits
- Do not leave entries incomplete

FP-LMIS Application (Family Planning Logistics Management Information System)

The FP-LMIS is used to manage the supply chain of family planning commodities and ensure uninterrupted availability at community and facility levels. Covered in Family Planning section.



NIKSHAY PORTAL AND NIKSHAY APP.

Nikshay App is a useful application used by the NTEP staff to track TB patients and their treatment adherence.

ASHA does not typically have full login access to NIKSHAY the same way facility staff or TB programme officials do.

You as an ASHA obtain a **Nikshay ID** and use the system for specific field-level tasks such as registering cases during surveys for ACF (Active Case Finding). NIKSHAY ID is generated to record presumptive TB cases and inform programme staff. You then enter accurate patient details attached to the appropriate health facility for full enrolment and follow-up in the NIKSHAY system. The concerned NTEP staff will provide with user ID and login passwords to enable access of the NIKSHAY App for ACF surveys. You will be trained on how to create NIKSHAY IDs for presumptive cases. These applications collectively support comprehensive healthcare delivery at the community level.



IDSP / IHIP Portal / Application and Reporting –

In IDSP program, Form S shall be submitted by you as an ASHA either manually or digitally through the application, in the prescribed format, containing the information as detailed below -

How to fill IDSP portal - <https://www.youtube.com/watch?v=Mh4kvj3tRGw>

Download and installation of the 'IHIP android application' on tablet/smartphone

- Open web browser in android tablet/smartphone.
- Type following URL in the browser's address bar to download the application file (for production server): <http://idsp.nhp.gov.in/downloadapk> Same application also available at Google Play Store with name of 'IDSP'.
- Once the download is complete open the file to begin the installation.

Follow the on-screen instructions to install the application as shared in video and refer the resource guideline.

For detail submission of form S follow the instructions in the link mentioned below - <https://idsp.mohfw.gov.in/showfile.php?lid=4773>

Pradhan Mantri Jan Arogya Yojana (PM-JAY)

Ayushman Bharat–PMJAY provides health insurance cover of up to ₹5 lakh per family per year for secondary and tertiary care. You as an ASHA play a key role in facilitating access to PMJAY services.



Role of ASHA:

- You as an ASHA shall generate awareness regarding AB PM-JAY entitlements and guide eligible households to authorized enrolment platforms.
- **Identify and facilitate eligible households through authorized BIS assisted mode, Ayushman App and Ayushman Sarthi and support card distribution/ delivery to beneficiaries wherever such facilitation mechanism is approved by the State under PM-JAY implementation framework and inform beneficiaries about helpline support under PM-JAY.**
- Guide beneficiaries to nearby empanelled hospitals and facilities for secondary/tertiary care.
- Explain the process of using the Ayushman Card during hospitalization and referrals.

Videos of Ayushman card by opening the QR code below



Ayushman Bharat Digital Mission (ABDM) - The Ayushman Bharat Digital Mission (ABDM) aims to create an integrated digital health ecosystem by enabling seamless digital health services.

Role of ASHA -

- Mobilize community members for creation of **Ayushman Bharat Health Account (ABHA) ID**.
- Educate beneficiaries on benefits of ABHA ID, including access to digital prescriptions, lab reports, diagnoses, and online consultations.
- Support generation of ABHA ID at health facilities and ensure **seeding of ABHA ID** in portals such as NCD, NIKSHAY, PMNDP, and e-Sanjeevani.
- ASHAs may clearly explain the distinction between ABHA and the Ayushman Card to avoid community level confusion.



ABHA ID

Key ABHA Profile Details: Name, date of birth, gender, address, mobile number/email, and valid ID (Aadhaar/Driving Licence/PAN).

SWASTH BHARAT - The Swasth Bharat Portal and App brings different health programme applications together in one place. The App is currently being developed and will be made available soon. With one login, you can access the applications available to you through a single window.



For example, you can use Swasth Bharat App to fill the CBAC form in the NP-NCD App, view due lists in U-WIN, and register beneficiaries in Janani. This means you can use one login to access different applications and update data.

The App will also help you manage your daily work more easily by providing a workplan to help you keep track of beneficiaries and daily tasks. This will help you save time and make your daily work easier.

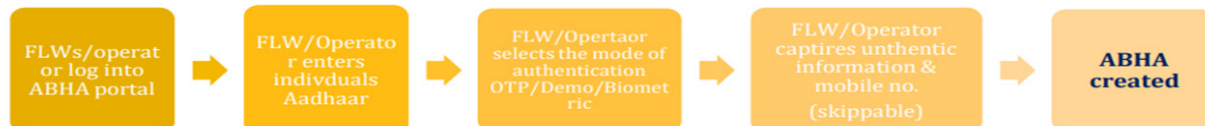


Process flow for ABHA ID creation:

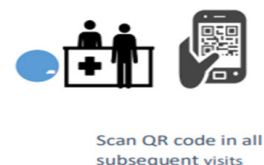
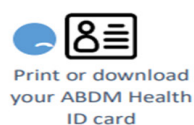
Self-mode through ABHA portal:



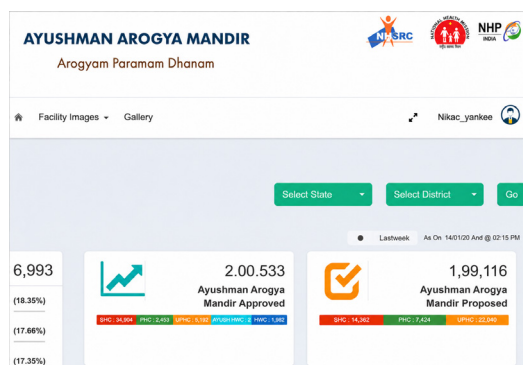
Assisted mode using ABHA portal:



OR



SASHAKT (Systematic Assessment of Healthcare Providers Knowledge and Training): SASHAKT focuses on strengthening maternal and child health services and empowering frontline health workers and also capturing the detail of training for all primary healthcare providers. SASHAKT portal hosts skill videos for various subjects linked with NHSRC YouTube channel. The SASHAKT portal also has a feature of self-learning tool which is known as e-Modules which are available for Expanded Packages of services (MNS Care, Emergency care, Eye care, ENT Care, Oral care, Elderly & Palliative care)



Users can directly login in the SASHAKT Portal using the URL -

<https://sashaktabhwc.nhp.gov.in>

Teleconsultation services:

As a part of Comprehensive Primary Health Care services at the AAM, telemedicine services are provided through the e-Sanjeevani platform using a Hub-and-Spoke model. You as an ASHA play a key facilitatory role by informing families about the availability of teleconsultation services and supporting them to access specialist care at AAM-SHCs or PHCs. During home visits and community meetings, ASHAs create awareness about e-Sanjeevani and guide eligible beneficiaries to avail timely teleconsultations, especially when specialist services are not available locally.

JANANI Application

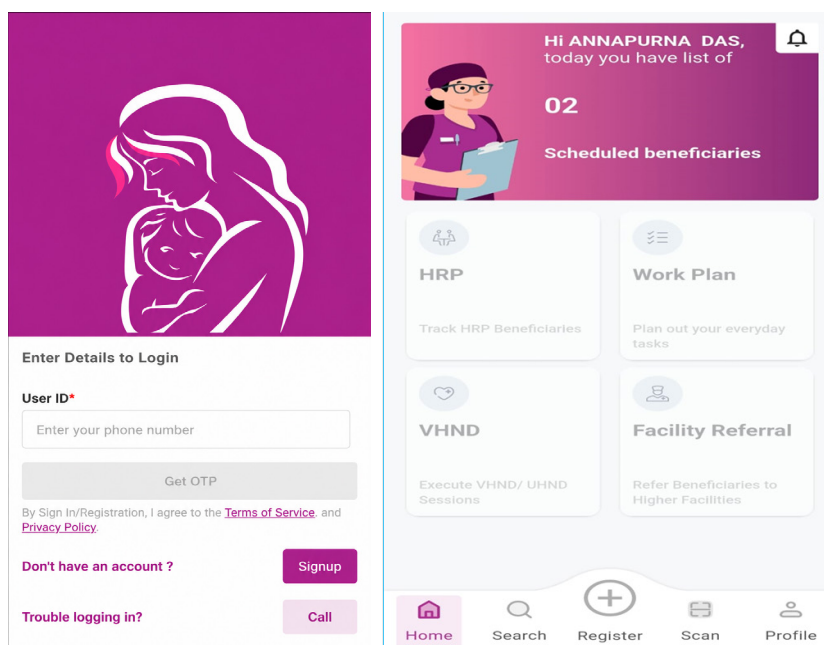
(Journey of Antenatal, Natal and Neonatal Integrated care- Sehat ke Saath, Every step of Care): -

The Ministry of Health and Family Welfare (MoHFW), rolled out an upgraded version of the Mother Child Tracking System, called Reproductive and Child Health (RCH) Portal in December 2015, with an addition of a module for early identification and tracking of the individual beneficiary throughout the reproductive lifecycle, and promote, monitor, and support the Reproductive, Maternal, New Born and Child Health (RMNCH) schemes/programme delivery and reporting by addition of certain data elements in the existing modules. The MoHFW has developed JANANI—a robust web and mobile-based application aimed at capturing and monitoring beneficiary services throughout the entire continuum of maternal and child health care.

The JANANI application is a comprehensive digital platform that integrates various modules for managing beneficiary data, health professional records, health facility records, services provided to beneficiaries and other related information. The primary goal is to streamline the processes involved in maternal and child health services, making it easier for healthcare providers and administrators to deliver quality care.

Landing page of JANANI - application

- Mobile application for ASHAs (Latest version should be downloaded from the Play store)



Key features of JANANI application-

- **National Search/ Advance search and Service updation:** National Search by ABHA/ mobile number/ RCH ID 1.0 and Advance search by these three features along with beneficiary name/DOB/Beneficiary type- Functionality to search and update beneficiary records using multiple identifiers such as ABHA ID, registered mobile number, or RCH ID 1.0. This enables efficient retrieval, verification, and real-time updating of beneficiary information across PAN India.
- **Beneficiary Registration Methods in JANANI**

Beneficiary (Male/ female) may be registered through ABHA ID (OTP-based)/ Aadhaar (OTP-based)/ Aadhaar (Demo Authentication – without OTP)/ Face Authentication (without OTP)/ Phone Number (OTP-based)/ Temporary Registration (without OTP)/ Self-registration. You as an **ASHAs** should ensure all beneficiaries under your jurisdiction should be **ABHA** verified.



REPRODUCTIVE & CHILD HEALTH (RCH) PORTAL

Welcome, ASHA

ASHA

Beneficiaries

Search by Name / ID / Mobile No.

All All Status

+ New Entry

List of Beneficiaries (Total : 1205)

S.No.	Name	Mobile No.	Status	Age	Sex
	Sita Devi			28	F
	Pooja			22	F
	Rani			30	F
	Meena			26	F
	Sunita			24	F
	Anita			29	F

New Beneficiary

Beneficiary ID *

Full Name *

Mobile No. *

Mother / Husband Name *

Enter Beneficiary ID

Enter Full Name

Enter Mobile No.

Select Name

Date of Birth *

Age (Yrs) *

Sex *

Address

DD/MM/YYYY

Enter Age

Select Sex

Enter Address

Cancel

Save

Rows per page: 10

1-10 of 1205

1 2 3 ... 121

Beneficiary Profile

Seemalata Das
25 yrs, Female

Pregnant

ABHA Number

91654450834662

Mobile No

8596060875

LMP

22/12/2025

15 Weeks

EDD

28/09/2026

Profile

Services

HRP Tracking

Child Trac

Pregnancy Services

Pregnancy Registration

11/03/2026

Completed

ANC 1

22/12/2025 To 23/03/2026

Missed

ANC 2

24/03/2026 To 29/06/2026

Ongoing

Hi ANNAPURNA DAS,
today you have list of

02

Scheduled beneficiaries

HRP

Track HRP Beneficiaries

Work Plan

Plan out your everyday

Register using

ABHA Number

Aadhar Card

Phone Number

Temporary Registration

Face Authorization

Back

Service (Only View):

Modules in JANANI are designed to view the health of mothers and newborns after the registration. The Key components are:

Pregnant Woman Modules (Only view)-

- ANC (PE & Obs history, Routine ANC check up, Additional ANC services, Special test, Td injection, USG)
- Delivery (Delivery preparedness, Delivery details)
- PNC Services
- Other services (Abortion care, Death details)
- Family Planning Services

Child Modules (Only View) -

- Child Tracking (New born care, Sick child care, HBNC, HBYC)

High Risk Pregnancy (HRP) and Referral Module (Only View) -

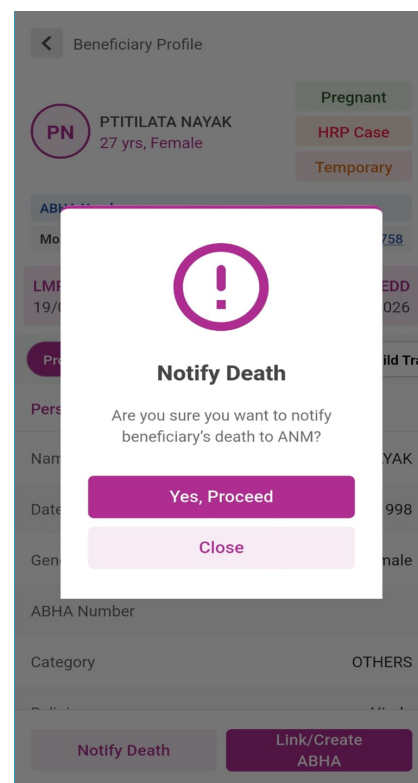
- HRP Tracking
- Referral Module
- All the HRP cases will be listed in this module.

Notify Death –

- Maternal and Child death should be notified by the ASHAs.

Key responsibilities of ASHA:

- Ensure timely registration of beneficiaries with biometric authentication (ABHA/Face Authentication)
- Early identification of High Risk Beneficiaries
- Mobilization of Beneficiaries for services as per the work plan.
- Notification of Maternal and Child Death



SHAISHAV App for Samagra Shishu Bal Swasthya Karyakram (SSBSK): Guide for ASHA

What is the Shaishav App

The SHAISHAV App is a simple mobile app developed for Samagra Shishu Bal Swasthya Karyakram (SSBSK) integrated with JANANI Portal which helps capturing data in both offline and online mode. It helps you as an ASHA during home visits to the newborn, child and mother. You will enter what you'll see during the visit, and the app help you decide what to do next; counsel, refer, or do an extra visit. It saves your work and save paper.

In short, the app does three things:

- It tells you which baby or child is 'At-risk'.



- It tells you when to refer and where to refer.
- It gives you the right counselling points and videos for the family.

Features of the Application

Table 15: Features of the Shaishav application, each derived from the home-visit formats:

Feature	Description
Classification into 'At-risk' newborn and children	• Based on the observations, the DSS app helps in the classification of 'At-risk' newborns and children • It opens up additional contact points and joint home visits for the 'At-risk' case • It generates the list of 'At-risk' cases to share with ANM, CHO and MO
Scheduling of home visits	• The app plans, schedules and tracks home visits and follow-up visits • It sends reminders for due and missed visits
Symptoms and danger signs	• The app presents the danger-sign checklist for the newborn, child and mother and opens up related educational videos • On any danger sign, it prompts an immediate referral • It indicates the place of referral based on facility mapping
Counselling points on emerging gaps	• Based on the gaps that emerge during the visit, the app prompts the relevant counselling points • It guides the caregiver on feeding, caregiving, safety and maternal well-being focusing on mental health concerns
Joint home visits and collaboration	• The app facilitates joint home visits with ANM/ CHO
Geo-enabled supervision	• The app records geo-tagged visits and activity • It supports supportive supervision in real time
Digital case management	• The app maintains child and family profiles and history in one place • It records at-risk conditions, referrals and follow-ups against each case
Household profile assessment and new age issues in child	• The app records the household profile and prioritised follow-up • Captures new age issues and related counselling for children on; ✓ Screen time ✓ Effect of digital exposure on children ✓ Family involvement ✓ Effect of heat related illness and indoor air pollution
IEC and Educational videos	• The app provides counselling videos at the point of care • Videos cover breastfeeding, Kangaroo Mother Care (KMC), wrapping, breast feeding hand washing, complementary feeding, ECD
Dashboard for Decision making and monitoring	• The app provides dashboards and reports • It gives quick insights for data-driven decisions and timely action • The app tracks ASHA/ ANM/ CHO performance and service Coverage • It monitors key indicators for effective implementation

3. How does the app help ASHA in decision-making and referral?

- You as an ASHA does not have to remember all the rules. When you fill the baby's details, the app itself says if the baby is 'At-risk'.
- If you tick any danger sign in the baby, child or mother, the app tells you to refer at once.
- The app shows the place of referral; PHC, CHC, Civil Hospital, District Hospital or Medical College, so you know exactly where to send them.
- The app opens extra visits and joint visits with ANM/CHO for an at-risk case, so the family is not missed.
- The summary gives you a clear answer 'At-risk' or not, the reason, and danger sign present or not.

4. How does the app help ASHA in counselling? (Counselling points and videos)

- Based on what is entered, the app shows the right counselling points for that family; you do not have to guess.
- It guides you on breastfeeding, KMC (skin-to-skin care) for small babies, the mother's nutrition, and protecting the child from heat in summer.
- It shows short, easy videos that you can play and show to the mother and family during the visit.
- This makes your counselling accurate, simple and the same for every family.

Remember: Enter what you as an ASHA see correctly, follow what the app suggests, refer when the app prompts for referral, and show the counselling videos to the family. The app is your helper in every home visit.

Key Messages:

- Accurate and updated records are an important working tool for ASHA, not just paperwork.
- Records help in tracking beneficiaries, preparing due lists, planning visits and ensuring follow-up.
- Different records cover families, pregnant women, children, adolescents, newborns, NCDs and other health needs.
- Complete and reliable information supports planning, monitoring, reporting and continuity of care at the health-facility level.
- Digital records are useful when information is entered correctly, completely and updated after follow-up.







A7

**ASHA Supervision and Support Structures,
ASHA Kit and ASHA Incentives (Monetary &
Non-Monetary) and other Entitlements**



PART A

A7 ASHA Supervision and Support Structures, ASHA Kit and ASHA Incentives (Monetary & Non-Monetary) and other Entitlements

Going through this section, you as an ASHA will come to know about:

- Supervision process and the support structures
- ASHA kit
- Understand the different types of incentives available to you, along with the activities linked to each incentive
- Calculation of incentive amounts for common ASHA activities using the approved incentive rates
- Other monetary and non-monetary benefits for ASHAs

A.7.1 ASHA DRUG AND EQUIPMENT KIT

The ASHA drug and equipment kit provides medicines, supplies and basic equipment needed for the activities that You as an ASHA is authorised and trained to perform. It includes some basic medications and equipment which are listed below. The kit is to be replenished on a regular basis from the nearest PHC or Ayushman Arogya Mandir (AAM). To keep a record of consumption of the drugs, and for effective re-filling and ensuring adequate/timely availability, a drug kit stock card is maintained.



ASHA Drug Kit

Table 16: Contents of ASHA Drug Kit

Contents of ASHA Drug Kit	
DDK for Clean deliveries at home	G.V. Paint
Paracetamol tablet and syrup	Cotrimoxazole syrup
Tab. Iron Folic Acid (L)	Paediatric Cotrimoxazole tablets
Tab. Punarvadu Mandur (ISM Preparation of Iron)	Sterilized Cotton
Tab. Dicyclomine	Spirit, Soap and Sterilized Cotton

Contents of ASHA Drug Kit	
Tetracycline ointment	Betadine, Gentian violet
Zinc Tablets	Condoms
Povidine Ointment Tube	Oral pills (In cycles)
ORS Packets	Emergency Contraceptive Pill
Nischay Kit	Rapid Diagnostic Kit
Slides for Malaria & Lancets	Sanitary napkins (to promote menstrual hygiene amongst adolescent girls)
List of Items in ASHA Equipment Kit	
Digital Wristwatch	Digital thermometer
Weighing Scale (for newborn)	Kit bag
Baby Feeding spoon and small bowl	Torch with cells
Communication Kit	Warm sleeping bag for neonates

Table 17: ASHA Drug Kit Stock Card

Month & Date of Refill			1		2		3		4	
S.No.	Name of Drug	Symbol	Balance	Refill given	Balance	Refill given	Balance	Refill given	Balance	Refill given

- You as an ASHA should record monthly refills in the stock card. You can also reach out to the ASHA Facilitator / ANM for the refill of the kit, as she oversees the refills. She must ensure that drugs have not expired and there are no stockouts. While refilling, She must put the drugs in the appropriate containers with familiar labels so that you as an ASHA does not get confused if there is any change in size, colour, or dose of the drug.
- ASHA Facilitators / ANM would take the refills from the AAM-PHCs/UPHC /AAM-SHC depending on the state norms. The quantity of drugs collected and distributed by the facilitator should be duly mentioned in their own records and should also be kept in the store.



A.7.2 SUPERVISION OF ASHA WORK

The following ten suggested tasks/areas may be used for supportive supervision and review of ASHA's work by ASHA Facilitators / ANM / BCM / Supervisors.

For a proper record keeping and maintenance of data, one should use registers and diary/ ASHA application (wherever applicable), specific formats (eg.SSBSK) during home visits, as these are your planning and recording tools. This information is to be gathered by the facilitators from the ASHA at the monthly cluster meetings. Facilitators use this data collection process as a tool for supportive supervision. The ten suggestive indicators on which detailed information has to be maintained are as below:

Table 18: List of suggested indicators for supervision of ASHA's performance

1	Creation of ABHA ID, conducting population-based enumeration and risk assessment using CBAC
2	Supporting ANC check-up and institutional delivery of pregnant mothers in your area
3	Supporting institutional deliveries for HRPs/ care of SNCU discharge babies/ HRBs care and follow-up.
4	Set of home visits for newborn care as specified in the SSBSK guidelines
5	Management of childhood illness
6	Attending VHSND and promoting opportunistic screening/ immunization/ ANC, PNC checkup
7	Holding VHSNC plus/MAS meetings
8	Successful referral for IUD, female sterilization or male sterilization cases and/or providing OCPs/condoms
9	Facilitating patient support group meetings
10	Follow-up of individuals who have dropped out of treatment for NCDs, CDs, Eye, Oral, ENT, Elderly, Palliative, and Emergency Care

Tasks Verification Process

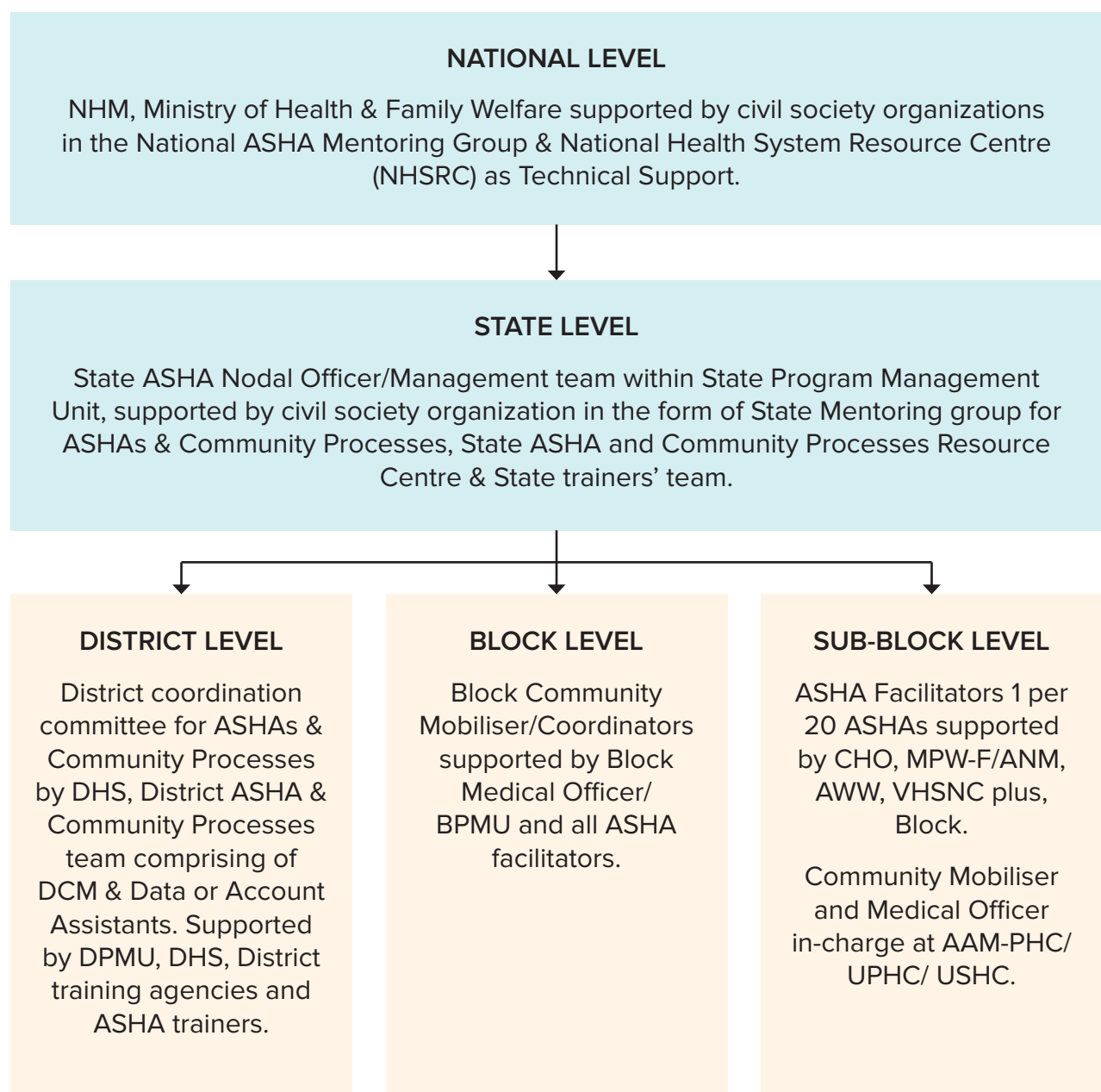
- The main source of data for performance monitoring and task verification used by the ASHA Facilitator/ ANM/ CHO, is the ASHA Diary, the formats filled during your home visits. This is checked against service delivery records of the health centre / linked facilities at the time of verification. AAM-SHC meeting and cluster meetings or review meetings are used to discuss the performance and also verify the work. The periodicity of this meeting should be at least once a month, though once in two weeks is desirable.
- The ASHA facilitator shares the report prepared by her with the linked CHOs at AAM-SHC or linked MO at the AAM-PHC/UPHC/USHC for review.
- Further, data of indicators related to your performance is also cross validated with data available in portals like HMIS, RCH, AAM, NCD etc.
- At the district level, the district coordinator consolidates and reports the functionality grade of each block to the state on a quarterly basis. Grading of blocks is done on each of the indicators as well as on the percentage of ASHAs who are functional on more than 50% of the total tasks i.e. in six out of ten tasks.

ASHA Discontinuation:

To be a functional ASHA, you are required to complete at least 6 out of 10 tasks as per the functional indicators identified. If you are unable to complete 6 out of 10 tasks, you will be provided handholding and mentoring support in the field by ASHA facilitators. If you face difficulties in performing your work, you should first receive supportive supervision, mentoring and appropriate handholding. Any decision regarding continuation/discontinuation should follow the current approved state/NHM policy and due process. New ASHA shall then be selected in your place as per the approved selection process.

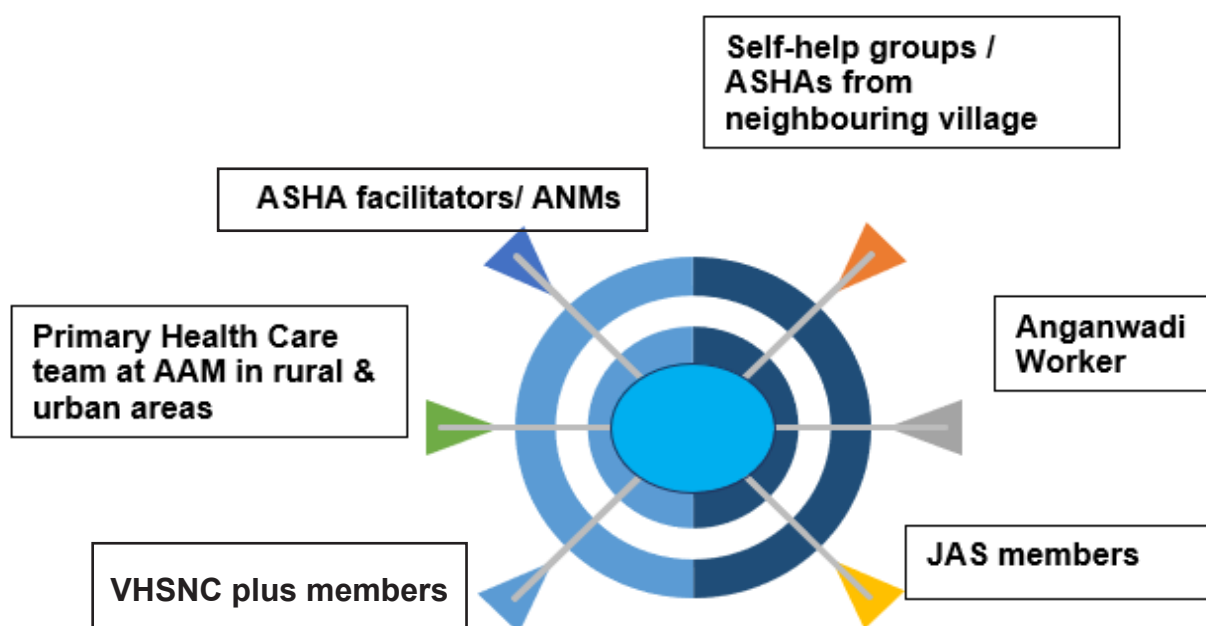
A.7.3 ASHA SUPPORT STRUCTURES

To ensure ASHAs' effectiveness and fulfil the National Health Mission vision of active community participation and convergence, a support structure at all levels of program implementation (at National, State, District, Block and Sub-block level) is set up for training, supportive supervision, mentoring and handholding.



For you as an ASHA to be effective and to continuously improve your skills, you need support and mentoring while working in the community and need refresher training.

ASHA's Support mainly comes from:



ASHA Facilitator

The first level of support for ASHA is the ASHA Facilitator. In most states there is full time woman employee for this role. In a few states the ANM/MPW-F plays the role of an ASHA Facilitator.

There is one facilitator for every 10 to 20 ASHAs. She will meet with the you as an ASHA at least twice a month. One of these interactions will be in the form of a “mentoring” visit to the households where you as an ASHA provides services. You will also meet your facilitator in the monthly review meeting or a cluster meeting (with other ASHAs from neighboring villages).



Primary healthcare team

Primary healthcare team is working at the AAM-SHC/USHC and AAM-PHC/UPHC and you as an ASHA is an essential part of the primary healthcare team.

You will need to work closely with- team of AAM-SHC including Community Health Officer (CHO) and Multi-Purpose Worker- Female/Male (MPW-F/M) and Medical Officer and Staff Nurses of your linked AAM-PHC / UPHC/ USHC.

The ASHAs at AAM-SHC will be supported by CHO. You need to report to the CHO for any technical, administrative, or managerial issues. Similarly, ASHAs at AAM-PHC/UPHC/USHC will report to the PHC-MO.

You will receive trainings for communication and technical skills required for your work in the field. You will also be provided the essential kit to carry out your work in the field.

A.7.4 ASHA INCENTIVES

Why are ASHA Incentives Important?

ASHA is a community-based health volunteer who plays a critical role in improving the health of women, children, families, and the entire village/ urban slum. As an ASHA you are a community health worker who receives incentives for specified activities under NHM and, where applicable, additional state-specific incentives or benefits.

These incentives are meant to:

- Recognise the **time, effort, and responsibility** taken by You as an ASHA
- Encourage **quality performance and accountability**
- Motivate you as an ASHA to support **priority national health programmes**
- Support you financially while continuing voluntary service



Amount can be accessed at the given QR Code-

Important to remember:

You as an ASHAs are compensated based on the work they perform, rather than receiving a fixed salary. Therefore, understanding incentives is essential to ensure no eligible payment is missed.

Principles of ASHA Incentives

All ASHA incentives are based on the following principles:

1. Task-based: Paid for completing defined activities
2. Performance-linked: Paid only after verification of work
3. Outcome-oriented: Linked to results such as service uptake, follow-up, or completion
4. Direct Benefit Transfer (DBT): Paid directly into ASHA's bank account
5. Transparent and verifiable: Based on records, registers, or digital entry



A.7.5. ASHA CERTIFICATION PROGRAMME

The ASHA Certification Programme aims to strengthen ASHAs' knowledge and skills and formally recognise their learning and competencies.

The major components of the program are as follows:

- **Certification:** NIOS provides certification to ASHAs after successful assessment.
- **Purpose:** The programme helps ASHAs improve their knowledge, skills and confidence to perform their role effectively.
- **Learning:** ASHAs use the ASHA training modules and supplementary learning materials for their studies.
- **Training support:** Accredited Vocational Institutions (AVIs) support ASHAs with registration, training, learning materials, practical sessions and examinations.
- **Assessment:** ASHAs are assessed through internal assessment, theory and practical skills.
- **Recognition:** Certification recognises the knowledge and skills gained by ASHAs through training and field experience.

Remember:

ASHA certification is not only an examination. It is a way to recognise the knowledge and skills that ASHAs develop through training and field work.

SN	Activities	Incentive
ASHA Incentive for Routine and Recurrent Activities		
1	Mobilizing and attending Village Health and Nutrition Days or Urban Health and Nutrition Days	Rs.200/session
2	Conveying and guiding monthly meetings of VHSNC /MAS	
3	Attending monthly meetings at Block PHC/UPHC	Rs. 150
4	a. Line listing of households done at beginning of the year and updated every six months	Rs. 300
	b. Maintaining village health register and supporting universal registration of births and deaths to be updated on the monthly basis	Rs. 300
	c. Preparation of due list of children to be immunized on monthly basis	Rs. 300
	d. Preparation of list of ANC beneficiaries to be updated on monthly basis	Rs. 300
	e. Preparation of list of eligible couple on monthly basis	Rs. 300
ASHA Incentives under National Health Program		
I	Maternal Health	
	JSY financial package	
1	a. For ensuring antenatal care for the woman	Rs.300 for Rural areas and Rs. 200 for Urban areas
	b. For facilitating institutional delivery	Rs. 300 for Rural areas and Rs. 200 for Urban areas
2	Reporting death of women (15-49 years age group) by ASHA to PHC Medical Officer	Rs. 200 for reporting within 24 hours of occurrence of death by phone
3	Mobilization of HRPs under E-PMSMA	Rs 300 per ASHA to mobilize high risk pregnant woman to facility for follow up @Rs 100/-per visit for maximum up to 3 visits
4	Healthy outcome for HRPs under E-PMSMA	Rs 500 after ensuring survival of baby and mother duo after 45 days of delivery.
5	Identification of HRPs and their healthy outcome during Post Natal Period under Optimization of PNC	Rs 250 after ensuring survival of baby and mother duo after 45 days of delivery



SN	Activities	Incentive
II	Child Health	
1	Home visit for the newborn and post-partum mother (2) -Six Visits in Case of Institutional Delivery (Days 3, 7, 14, 21, 28 & 42) – Seven visits in case of Home Deliveries (Days 1, 3, 7, 14, 21, 28 & 42)	Rs. 250
2	Home visits for young child for strengthening of health & nutrition of young child- (recommended schedule- 3, 6, 9, 12 and 15 months) - (Rs.50X5visits)	Rs. 50/visit with total Rs. 250/per child for making 05 visits
3	Ensuring quarterly follow up of low-birth-weight babies and newborns discharged after treatment from Specialized Newborn Care Units.	Rs. 50/ Quarter-from the 3rd month until 1 year of age
4	Child Death Review for reporting child death of children under 5 years of age	Rs. 50
5	Week-1 & 2-ASHA incentive for prophylactic distribution of ORS to families with under-five children	Rs. 1 per ORS packet for 100 under five children or Rs. 100 per ASHA
III	Immunization	
1	Full immunization for a child under one year	Rs. 100
2	Complete immunization per child up-to two years age (all vaccination received between 1st and 2nd year of age after completing full immunization after one year	Rs. 75
3	Mobilizing children for OPV immunization under Pulse Polio Programme	Rs. 100/day
4	DPT Booster at 5-6 years of age	Rs. 50
5	Mobilisation of children for Routine Immunization	Rs 150/session
IV	Family Planning	
1	Ensuring spacing of 2 years after marriage	Rs. 500
2	Ensuring spacing of 3 years after birth of 1st child	Rs. 500
3	Ensuring a couple to opt for permanent limiting method after 2 children	Rs. 1000

SN	Activities	Incentive
4	Counselling, motivating and follow up of the cases for tubectomy	High focus states (Odisha, Uttarakhand, Haryana, Gujrat) - Rs.200/Case Mission Parivar Vikas (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura) – Rs.300/Case. Other High focus states (Sikkim, Ladakh, Jammu and Kashmir, Himachal Pradesh)- Rs. 150/Case Non-High Focus States- Rs. 150/Case.
5	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	High focus states (Odisha, Uttarakhand, Haryana, Gujrat) - Rs.300/Case Mission Parivar Vikas (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura) – Rs.400/Case. Other High focus states (Sikkim, Ladakh, Jammu and Kashmir, Himachal Pradesh)- Rs. 200/Case Non-High Focus States- Rs. 200/Case.
6	Female Postpartum Sterilization	High focus states (Odisha, Uttarakhand, Haryana, Gujrat) - Rs.300/Case Mission Parivar Vikas (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland and Tripura) – Rs.400/Case
7	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	Rs. 300/per case
8	Escorting or facilitating beneficiary to the health facility for the PAIUCD insertion	Rs. 300/case
Mission Parivar Vikas- MPV Extended in all districts of the seven high focus states (Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan and Assam) as well as six North-Eastern states of the country.		



SN	Activities	Incentive
9	Injectable Contraceptive MPA (Antara Program) - Incentive to ASHA	Rs 100/dose (1st, 2nd and 3rd doses) Rs. 200 only for Fourth Dose
10	Mission Parivar Vikas Campaigns Block level activities-ASHA to be oriented on eligible couple survey for estimation of beneficiaries and will be expected to conduct eligible couple survey- maximum four rounds	Rs. 150/ ASHA/round
11	Nayi Pahel- a Family Planning kit for newlyweds- a FP kit would be given to the newlywed couple by ASHA	Rs. 200/ASHA/Nayi Pahel kit distribution
12	Saas Bahu Sammelan- mobilize Saas Bahu for the Sammelan- maximum four rounds	Rs. 200/ Sammelan
V	Adolescent Health	
1	Distributing sanitary napkins to adolescent girls	Rs. 1/ pack of 6 sanitary napkins
2	Organizing monthly meetings with adolescent girls pertaining to menstrual hygiene	Rs. 50/meeting
3	Incentive for support to Peer Educator (for facilitating selection process of peer educators)	Rs. 100/ Per PE
4	Incentive for mobilizing adolescents for Adolescent Health Day	Rs. 200/ Per AHD
VI	Participatory Learning and Action- (In selected 10 states that have low RMNCH+A indicators – Assam, Bihar, Chhattisgarh, Jharkhand, MP, Meghalaya, Odisha, Rajasthan, Uttarakhand and UP)	
1	Conducting PLA meetings- 2 meetings per month- Note-Incentive is also applicable for ASHA Facilitators @Rs.100/- per meeting for 10 meetings in a month	Rs. 100/ASHA/per meeting for 02 meetings in a month
VII	Nutrition	
1	Referral of SAM children to NRC and follow up of SAM children after discharge from NRC	Rs 300 per SAM child/ASHA. Break-up as below: Rs 100 for referral and Rs 200 follow up
2	For mobilising and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole.	Rs. 100/ ASHA/Bi-Annual
3	MAA (Mother's Absolute Affection) Programme Promotion of Breastfeeding- Quarterly mother meeting	Rs. 100/ASHA/ Quarterly meeting
4	Anaemia Mukht Bharat	
4a	ASHA incentive for mobilizing children and ensuring compliance of IFA for 6-59 months children	Rs 100/month/ASHA

SN	Activities	Incentive
4b	ASHA incentive for mobilizing and ensuring compliance of IFA for women of reproductive age	Rs 50/month/ASHA
VIII	Comprehensive Abortion Care	
1.	ASHA transportation incentive for accompanying women for availing safe and legal abortion services:	Rs.200/- transportation incentive for abortion by Surgical Methods of abortion at a public health facility Rs. 400/- transportation incentive for abortion by Medical Methods of Abortion at a public health facility
IX	National Tuberculosis Elimination Programme	
1	Honorarium to treatment supporter to be disbursed upon completion or cure of TB patient for Drug Susceptibility TB patients	Rs 1000
2	For treatment and support to drug resistant TB patients	Rs. 5000 (Rs. 2000 for IP and Rs. 3000 for CP) for Drug Resistant TB patients (including shorter regimen, MDR and XDR TB patients)
3	Incentives to informant for notification	Rs. 500 for referral of presumptive TB patient to public health facility and diagnosis as TB
4	Incentive to ASHA/Community Volunteers for ensuring seeding of bank account details of TB patients in Nikshay portal within 15 days of treatment initiation for enabling DBT Payments under NTEP	Rs 50/notified TB patient for seeding of bank account details on the Nikshay portal
5	Incentive to ASHA / Community Health Volunteer for supporting treatment adherence and completion of TB Preventive Treatment among eligible individuals	Rs. 250/- per individual for successful completion of TB Preventive treatment
6	Mobilization of beneficiary through ASHA or other mobilizers for additional adult BCG beneficiaries	Rs 150 per session, Two mobilizers will be present at each session site (ASHA/AWW/link worker). Each mobilizer may be paid Rs 75 with a maximum limit of Rs 150 per session site



SN	Activities	Incentive
7	ASHA incentive for due list preparation (For monthly updating of due list of beneficiaries for adult BCG Vaccination)	Rs 300/month ×3 months (if mop-up is required). This amount may be paid to the ASHA. If no ASHA is identified or available, the same may be paid to the link worker/AWW, subject to a total ceiling of Rs 300
8	ASHA incentive for house-to-house survey, before the campaign.	Rs 300 once for the campaign. This amount may be paid to the ASHA. If no ASHA is identified or available, the same may be paid to the link worker/AWW, Subject to a total ceiling of Rs 300
X	National Leprosy Eradication Programme	
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	Rs. 250 per case (for early detection) Rs. 200 per case (for late detection, any visible disability) Rs. 400 per case, for Paucibacillary Case (PB) case treatment completion
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy- for 33 states	Rs. 250 per case (for early detection) Rs. 200 per case (for late detection, any visible disability) Rs. 600 per case (for Multibacillary Case (MB) case treatment completion
3	ASHA Incentives for Leprosy Case Detection Campaign (LCDC)	Search Activity incentives for ASHA- Rs. 75 per day for 14 days , a total amount of Rs. 1050 for 14 days. ASHA incentives are given two times in a year if LCDC campaign is done twice in a year in few States/UTs.
XI	National Vector Borne Disease Control Programme	
A)	National Malaria Control Program	
1	Preparing blood slides or testing through RDT	Rs. 15/slide or RDT

SN	Activities	Incentive
2	Providing complete treatment for RDT positive Pf cases and Pv cases	Rs 200/ confirmed case for ensuring complete treatment.
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regime	
B)	Lymphatic Filariasis	
1	For one time linelisting of lymphoedema and hydrocele cases in all areas of non-endemic of endemic and non-endemic States	Rs 200.
2	For annual Mass Drug Administration for cases of Lymphatic Filariasis	Rs 3000/- for 15 days for a population (approx. 1000 population or 250 houses)
C)	Acute Encephalitis Syndrome/Japanese Encephalitis	
1	Referral of AES/JE cases to the nearest CHC/ DH/Medical College	Rs 300/ case
D)	Kala Azar Elimination	
1	Involvement of ASHAs during the spray rounds (IRS) for sensitizing the community to accept indoor spraying	Rs. 100/- per round during Indoor Residual Spray i.e. Rs 200 in total for two rounds
2	ASHA incentive for referring a suspected case and ensuring complete treatment.	Rs. 500/per notified case
3	Incentive to ASHAs for referring Post Kala-Azar Dermal Leishmaniasis (PKDL) case	Rs. 500/- per case (Rs. 200/-at the time of diagnosis and Rs. 300/- after treatment completion)
E)	Dengue and Chikungunya	
1	Incentive for source reduction and IEC activities for prevention and control of Dengue and Chikungunya in all States	Incentive @ Rs. 200/- (1 Rupee per house for maximum 200 houses per month). The time period for involvement of ASHAs may be throughout
F)	National Iodine Deficiency Disorders Control Programme	
1	ASHA incentive for salt testing	Rs. 25 a month for testing 50 salt samples
XII	Incentives under Comprehensive Primary Health Care (CPHC) and Universal NCDs Screening	
1	Filling up of CBAC forms of every individual –onetime activity for enumeration of all individuals, filling CBAC for all individuals 30 or > 30 years of age	Rs. 10/- per form/ per individual as one time incentive
2	Follow up of patients diagnosed with Hypertension/Diabetes and three common cancers for initiation of treatment and ensuring compliance	Rs. 50/- per case/ Bi-



SN	Activities	Incentive
3	Delivery of new service packages under CPHC component	Rs. 1000/ASHA/PM (linked with activities)
XIII	Drinking water and sanitation	
1	Motivating Households to construct toilet and promote the use of toilets.	Rs. 75 per household
2	Motivating Households to take individual tap connections	Rs. 75 per household
XIV	ASHA Certification	
	Incentive award in cash for ASHAs and ASHA Facilitators who have certified in two independent certificates: 1 - RMNCHA+N 2 - Expanded Service Package from NCDs to Palliative Care	Rs. 5000 for all ASHAs and ASHA Facilitators who successfully receive certification by NIOS in two independent certificates: A. RMNCHA+N B. Expanded package of new services from Non - Communicable Diseases to Palliative Care Total incentive: Rs 5000*2 (two independent certificates)= Rs 10,000/- (Introduced in 2022)

Disclaimer: The incentive amounts mentioned for ASHAs are subject to revision based on the revision in financial approvals of the National Health Mission (NHM). The amounts include routine recurring and performance-based incentives approved under NHM. State-specific incentives and additional incentives provided by States/UTs are not included and may vary across States/UTs.

Here are 3 examples of ASHA incentive calculations using actual incentive rates from the ASHA Incentives (2025-26) official PDF published under the National Health Mission:

Example 1 — Incentive for Antenatal Care (ANC) and Institutional Delivery

Under Maternal Health, the NHM ASHA incentive schedule specifies:

- Incentive for ensuring antenatal care (ANC) for a woman: ₹300 (Rural) or ₹200 (Urban)
- Incentive for facilitating institutional delivery: ₹300 (Rural) or ₹200 (Urban)

Scenario

You as an ASHA in a **rural area** supports:

- 4 pregnant women for ANC completion (completed all 4 ANC's) and
- 3 of those women deliver in a government facility

Calculation

Activity	Rate (Rural)	Count	Total
ANC support	₹300	4	$300 \times 4 = ₹1,200$
Institutional deliveries	₹300	3	$300 \times 3 = ₹900$

Total incentive earned = ₹1,200 + ₹900 = ₹2,100

Note: If you were an ASHA in an **urban area**, replace with ₹200 per service:

- ANC = $200 \times 4 = ₹800$
- Delivery = $200 \times 3 = ₹600$

Total = ₹1,400

Example 2 — Incentive for Home Visits for Newborn & Young Child

From the Child Health section, incentives include:

- Home visits for newborn and post-partum mother: ₹250 per eligible case
- Home visits of young child for nutrition (5 visits): ₹50 per visit, total ₹250 per child

Scenario

An ASHA's conducts:

- Home visits for 8 newborns (eligible for full newborn visit incentives)
- Nutrition home visits for 6 children (completing full 5 visits per child)

Calculation

Activity	Rate	Count	Total
Newborn & post-partum home visits	₹250	8	$250 \times 8 = ₹2,000$
Nutrition home visits (₹50 × 5 visits)	₹250	6	$250 \times 6 = ₹1,500$



Total incentive earned = ₹2,000 + ₹1,500 = ₹3,500

This assumes each child completed all the scheduled visits in the recommended months.

Example 3 — Incentive for Full Immunisation of a Child under 1 year

According to the immunisation incentives:

Full immunisation for a child under one year: ₹100

Scenario

An ASHA ensures full immunisation for 15 children under one year in her village.

Calculation

Activity	Rate	Count	Total
Full immunisation	₹100	15	$100 \times 15 = ₹1,500$

Total Immunisation incentive = ₹1,500

This is paid **per child** who has received all required immunisations up to one year of age, as per national schedule.

Key Learning Points for ASHAs

- Incentive amounts vary by **activity and location** (e.g., rural/urban).
- Payments are calculated **per case/service**, not as daily wages.
- **Accurate records and verification** are essential before incentive release.
- Always check the latest incentive list (as published by NHM) for updated rates and new activities.

States/ UTs should provide the complete list of incentives along with the amount ASHA is entitled under each activity per case for them to be clear on their entitlements and activity/ case incentives. You as an ASHA should ask their supervisors for the detailed list.

A.7.6. OTHER MONETARY AND NON-MONETARY BENEFITS

1. Social Security Benefits:

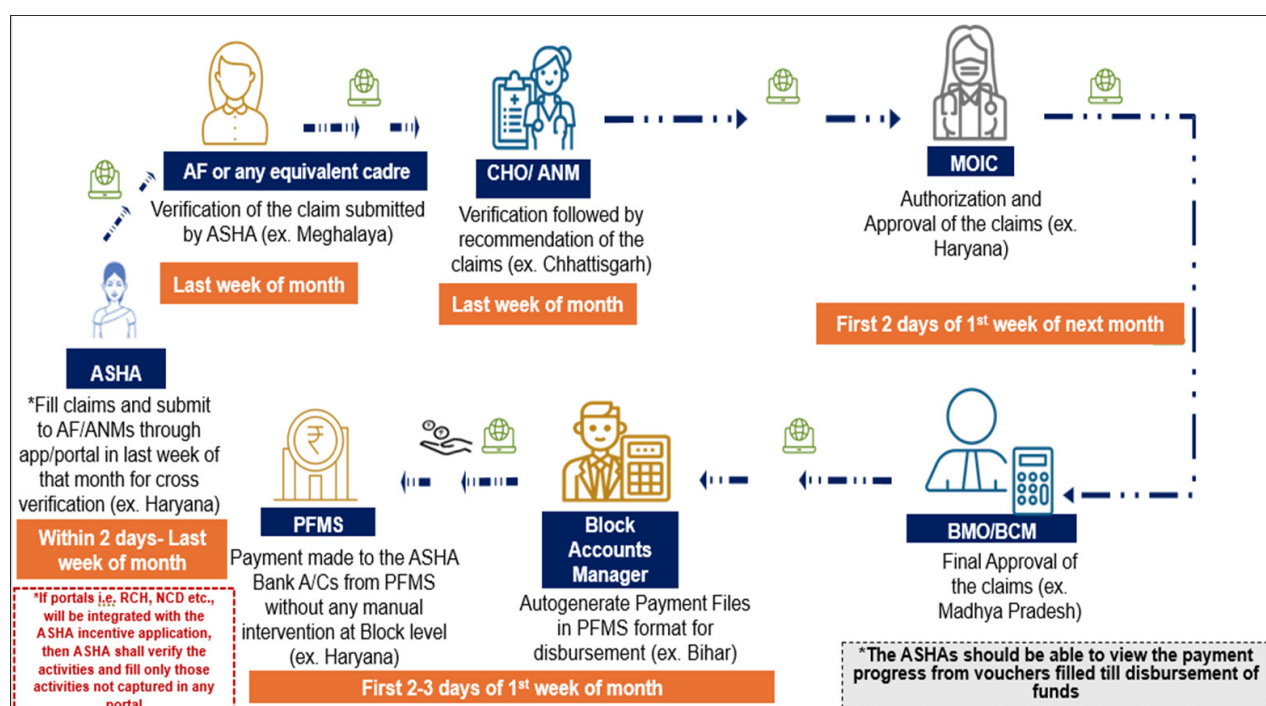
ASHAs and ASHA Facilitators (AFs) are enrolled in various social security schemes, ensuring financial protection and stability:

- Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY):** Provides Rs.2 lakh in case of death, with the premium fully covered by the Government of India.
- Pradhan Mantri Suraksha Bima Yojana (PMSBY):** Offers Rs. 2 lakh for accidental death or permanent disability and Rs.1 lakh for partial disability, with the premium funded by the government.
- Pradhan Mantri Shram Yogi Maan Dhan (PM-SYM):** Ensures a monthly pension of Rs.3,000 after the age of 60, with 50% of the contribution covered by the government.
- In March 2024, the **Government extended Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)** to cover nearly 10 lakh ASHA families, providing Rs. 5

lakh annual health coverage per family for secondary and tertiary care hospitalization.

2. **Non-monetary benefits:** ASHAs also receive non-monetary benefits which are essential work-related resources such as ASHA Uniform, Identity Card, mobile phone-based communication expenses, CUG Sim, ASHA Diary, Drug Kit etc.
3. **Golden Handshake Recognition:** To honour ASHAs who have dedicated at least 10 years to the program, ASHAs recognition amount when they opt out/ leave is Rs. 20,000 for completing 10 years of services.
4. **Career Progression for ASHA:** To support the career advancement of ASHAs, those aspiring to complete academic qualifications such as Class 10th and 12th, as well as professional training programs like ANM/GNM, are given priority and assistance.
5. **Grievance Redressal Mechanism:** MoHFW issued a directive on April 3, 2012, mandating the establishment of Grievance Redressal Mechanism for ASHAs in every district. This platform allows you as an ASHA to report workplace grievances, with a five-member District Grievance Redressal Committee, headed by the Chief Medical Officer (CMO) and District Collector overseeing the resolution process. The committee, notified by the District Health Society, must address grievances within 21 days as per the outlined guidelines.
6. **ASHA Award:** To recognize and reward ASHAs for their outstanding contributions to grassroots healthcare delivery, an annual ASHA Award is provided at district, and block levels. The MoHFW allocates funding for these awards through PIP proposals to states and UTs.

Recommended Process of Incentive Disbursement



Key Messages:

- The ASHA drug and equipment kit provides essential medicines, supplies and basic equipment needed for service delivery by you as an ASHA.
- Proper stock recording, checking expiry dates and timely refilling help keep the kit ready for use.
- Supportive supervision, mentoring, review and refresher training help you as an ASHA to strengthen your skills and improve your work.
- Your activities are linked with different incentives, with proper records and verification supporting incentive payment.
- You have access to work-related benefits, grievance mechanisms, career progression, certification and other entitlements.



A8

Understanding Fundamental Rights and Action Against Violence



PART A

A8 Understanding Fundamental Rights and Action Against Violence

During this section, you as an ASHA will learn about:

- Identification of different forms of violence, including physical, emotional, and social violence.
- Ways to strengthen your ability as an ASHA to respond sensitively and appropriately to individuals facing violence.
- To enhance knowledge about available support systems, legal provisions, and referral services for timely assistance.

You as an ASHA often find that people are not aware of their rights and face discrimination or injustice. Thus, knowledge about fundamental rights is important for every individual including you. This helps them to take proper decisions for the development of their community. It will help them to learn about you as an ASHA and your community's rights. It will also help them to take appropriate decisions for the development of their community.

The six fundamental rights granted by the Constitution are:

Right to Equality	This right ensures that same laws are applicable to every citizen. No citizen can be discriminated against based on religion, caste, sex, race or place of birth. He/she is entitled to have access to public places like shops, eating places, public health facilities, wells, tanks, bathing ghats, roads, playgrounds and places dedicated for the use of public.
Right to Freedom	The Right to Freedom is a cluster of the following six freedoms: Freedom of speech and expression; Freedom to assemble peacefully and without arms; Freedom to form associations or unions; Freedom to move freely throughout the territory of India; Freedom to live and settle in any part of India; Freedom to practice any profession or to carry on any occupation, trade or business. She/he should be able to live a healthy and civic life. This right is very crucial for democracy.

Education And Institution of their Choise	Any citizen with a distinct language or culture has a right to practice this. No citizen can be denied admission any educational institution maintained by government on the grounds of religion or language. All minorities have a right to establish and administer educational institutions of their choice.
Right to Constitutional Remedies	This right empowers citizens to approach the court in cases of denial of any of the Fundamental Rights. Under this right, it is the duty of the Judiciary to attend to all complaints pertaining to violation or rights.
Right to Freedom of Religion	This right allows every person a right to practice the religion he or she believes. All religions are equal before the state and no religion can be given preference over the other by the state.
Right Against Exploitation	This right grant clear provisions to prevent exploitation of weaker/ vulnerable sections of the community and prohibits “traffic i.e., Selling or buying of human beings, (usually women for immoral purpose). Forced labour, bonded labour or custody/detention of any human being as slave is completely barred and employment of a child below the age of fourteen to work in any factory or mine or any other hazardous work is not allowed.

A.8.1. GENDER AND HEALTH

Gender plays an important role in determining the health and well-being of individuals. In many communities, women and men have different roles, responsibilities, and access to resources, which directly affect their health. As frontline health workers, ASHA plays a key role in addressing gender-related health issues and promoting equitable health practices in the community.

Understanding Sex and Gender

- Sex refers to biological differences (male/female).
- Gender refers to socially constructed roles, behaviours, and expectations assigned to men and women.

Gender Inequality and Its Impact on Health

Table 19: Gender inequality often leads to poor health outcomes, especially for women and girls.

Common Issues	Health Impact
Malnutrition amongst girls and women	Failure to realize their full potential physically, mentally and intellectually
Early marriage and pregnancy	Increased susceptibility to diseases
Limited access to healthcare	Increased complications during pregnancy and childbirth
Gender-based violence	Increased maternal, neonatal and infant mortality
Low decision making power in the family	Mental health problems



A.8.2. ADDRESSING GENDER-BASED VIOLENCE (GBV)

Gender-Based Violence (GBV) refers to any harmful act directed at an individual based on their gender. It is a serious public health and human rights issue that affects the physical, mental, and social well-being of individuals, especially women and girls. GBV can occur within the home, workplace, or community and is often rooted in gender inequality, discrimination, and unequal power relations.

Types of Gender-Based Violence: GBV can take many forms, these forms of violence may occur separately or together, and often remain hidden due to fear, stigma, and social pressure.

1. **Physical violence** refers to the use of physical force that causes harm, injury, or pain to a person. It includes actions such as hitting, slapping, kicking, pushing, beating, or using objects or weapons to hurt someone. For example, a husband beating his wife during a domestic dispute or physically assaulting her for not completing household work is a form of physical violence. This type of violence often results in visible injuries like cuts, bruises, fractures, and sometimes long-term disability, along with fear and trauma.
2. **Sexual violence** involves any sexual act carried out without a person's consent and is a serious violation of an individual's dignity and rights. It includes forced sexual intercourse (rape), unwanted touching, sexual harassment, or forcing someone into sexual activities. For instance, forcing a woman into sexual relations against her will or inappropriate touching at the workplace are examples of sexual violence. This form of violence can lead to severe physical and mental health consequences, including unwanted pregnancies, sexually transmitted infections, and deep emotional trauma.
3. **Emotional or psychological violence** affects a person's mental well-being and self-esteem and may not leave visible marks but causes deep internal harm. It includes behaviours such as constant criticism, insults, humiliation, threats, intimidation, and controlling actions like restricting movement or communication. For example, a woman being repeatedly insulted, threatened, or prevented from meeting her family and friends is experiencing emotional abuse. Over time, this leads to stress, anxiety, depression, fear, and loss of confidence.
4. **Economic violence** occurs when a person is denied access to financial resources, making them dependent on others for survival. It includes not allowing a woman to work, controlling her income, taking away her earnings, or not providing money for basic needs like food, healthcare, or children's education. For example, a husband refusing to give money for medical treatment or forcing a woman to hand over all her earnings is economic violence. This creates financial dependency and limits a woman's ability to make decisions or seek help.
5. **Social or cultural violence** is rooted in harmful traditions, customs, and social norms that discriminate against individuals, especially women and girls. It includes practices such as child marriage, dowry-related harassment, honor killing, and discrimination against the girl child. For instance, marrying off a girl at a young age or harassing a woman for dowry are examples of this type of violence. These practices restrict freedom, education, and opportunities, and negatively impact health and overall development.
6. **Neglect and deprivation** refer to the failure to provide basic needs and care to an individual, which is also a form of violence. It includes not providing adequate food, healthcare, education, or emotional support. For example, giving less nutritious food to girls compared to boys or ignoring a woman's illness and not taking her to a health

facility are forms of neglect. This leads to malnutrition, poor health, delayed treatment, and increased risk of illness and mortality.

Violence against women leads to various physical, mental and social consequences. It results in women being denied their rights and entitlements, makes for low representation in public/ political spaces, denial in positions of decision making and even restricts their access to schools, health facilities and employment.

You as an ASHA is close to the women of your community and already share a rapport with them, which makes it easier for you to identify who is at risk or who is facing such forms of violence. You may address this issue with the help of your support structure available at the community level.

PRESERVING WOMEN'S RIGHTS

Some women in your area may not be able to exercise even their basic rights. Unlike most men, women must work hard both at home and outside. Thus, women spend considerable time and effort in managing the house as well as helping in the income-generating activity of the household, so they end up with twice as much work.

It is essential for you as an ASHA to understand the health status of women in your community, the common problems they face and your role in addressing some of these challenges. Violence against women is visible in different forms, throughout the life cycle of women are described below:

Adult	Female Child & Adolescent Girl	Female Foetus & Newborn
Domestic violence	Deprivation of adequate nutrition	Sex selection
Sexual exploitation at workplace	Neglecting illness by not seeking treatment	Female infanticide
Dowry demand	Girls not sent to school	Deprivation of breast milk for newborn girls
Blamed for giving birth to a girl child	Early child marriage	Neglected care during illness (delay or no treatment)
Inability to take independent decisions	Sexual abuse	
Lack of care during pregnancy		

Women also bear the burden and pain of childbirth and abortions. Women are also generally blamed for not giving birth to a baby boy, which is scientifically wrong.

It's important to note that neither the man nor the woman has control over whether a baby girl or a baby boy is born. The gender of the baby is determined by the combination of chromosomes present in the egg from mother and sperm from the father during fertilization.

Note: *It would be wrong to think that there is no violence against men. In fact, older men often face the same forms of violence that older women face.*



Initiatives taken by Government of India for the protection of the rights of women-

1. Article 21 of the Constitution of India under-
 - **Right to Privacy-** women have the right to make reproductive choices that include the woman's right to refuse participation in the sexual activity, freedom to make a choice regarding the use of contraceptive methods such as birth-control methods or sterilization procedures, right to access a range of reproductive health information, goods, facilities and services, to ensure that every woman survives pregnancy and childbirth.
 - **Right to life with dignity-** Every woman has the right to live in dignity—free of fear, coercion, violence and discrimination. She has a right to be in workplace free from any form of sexual harassment or abuse in both public and private sectors.
2. AAM with strengthened infrastructure ensures privacy of individuals (especially females, trans- genders etc.) during treatment.
3. The majority of committees like JAS, MAS, VHSNC plus in the public health system have women representatives.
4. The Government of India implements several schemes and programmes to improve the health, nutrition, safety, education and empowerment of adolescent girls and women. These include Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK) , Pradhan Mantri Matru Vandana Yojana (PMMVY); the Menstrual Hygiene Scheme (MHS) under the National Health Mission; the Scheme for Adolescent Girls (SAG) under Mission Saksham Anganwadi & Poshan 2.0 and Beti Bachao Beti Padhao (BBBP) under Mission Shakti,.

As the ASHA , you should be familiar with the schemes applicable in your area and guide eligible women, adolescent girls and families on accessing the appropriate services and benefits.

A.8.3. ASHA'S ROLE IN ADDRESSING GENDER RELATED ISSUES

You as an ASHA are the first point of contact with the community and share a relationship with them. Your role is to identify any person who is at risk or who is facing some form of violence in our community, provide support and help address the issue.

ASHA's role in addressing violence against women is two-fold:

Preventing violence and addressing violence

A. Preventing violence: by increasing awareness and mobilizing community against any act of violence against women

1. Build Community Support (Solidarity)

- Work with groups like JAS, MAS, VHSNC plus, Gram Panchayat, Mahila Mandals, SHGs, and women's groups
- Coordinate with other ASHAs during PHC/ cluster meetings to discuss and address violence issues
- Create a support system for women facing violence, including shelter and help
- Engage community leaders, parents, and local stakeholders to raise the issue
- Use community platforms to raise issues like dowry, gender discrimination, child

marriage, and trafficking

- Conduct campaigns and discussions to prevent harmful practices
- Ensure the issue of violence against women is openly discussed in village meetings without violating confidentiality / privacy of the involved individual

2. Promote Community Awareness

- Organize meetings with women, adolescents, and families
- Discuss and challenge harmful beliefs (e.g., violence is acceptable, victim blaming, early marriage)
- Encourage women and girls to speak about their experiences

3. Educate on Rights and Laws

- Inform community about laws against domestic violence, sexual harassment, and child marriage
- Spread awareness about women's rights and protection mechanisms

4. Link with Government Schemes

- Inform families about schemes for girls and women (education, financial support, empowerment)
- Motivate community to avail benefits of these schemes

5. Ensure Inclusion and Sensitivity

- Support women from all backgrounds, including those affected by caste, religion, or family conflicts
- Overcome personal biases and provide equal support to all

B. Addressing violence: Attending to the individual women who has suffered from violence.

1. Be Alert and Identify Signs

- Look for signs like controlling behaviour by husband/partner
- Notice unexplained injuries or frequent health complaints
- Be observant during home visits

2. Understand the Situation

- Gently try to know if the woman is facing violence
- Do not force her to speak; build trust slowly
- Discuss any action with her before taking steps

3. Take Immediate Action in Severe Cases

- Shift the woman to a safe place if there is danger
- Take help from trusted family/community members
- Contact police or arrange shelter/NGO support if needed



4. Ask Questions Privately

- Talk to the woman alone in a safe space
- Ask questions in a non-judgmental manner
- Maintain confidentiality at all times

5. Ensure Health Care Support

- Check for physical injuries and mental trauma
- Provide first aid if needed
- Refer to health facility for serious conditions and ensure follow-up

6. Provide Emotional Support

- Listen patiently and show empathy
- Reassure her that violence is not her fault
- Help her overcome fear, shame, and stress

7. Plan for Safety

- Help identify safe places (family, friends, shelters)
- Advise her to keep important documents ready
- Support her if she decides to leave the abusive situation

8. Inform About Legal Support

- Guide her about police, women helpline, and protection officers
- Inform about legal aid services and rights

9. Link with Community Support

- Take support from ANM, AWW, VHSNC plus, MAS and women's groups
- Involve community institutions to prevent further violence

10. Keep Emergency Contacts Ready

- Maintain contact numbers of police, NGOs, shelters, and support services

You as an ASHA should motivate girls and women and convince the community to enhance the safety of women in the community. To begin with, you should counsel and convince the community to change unfair and gender-discriminatory practices. You can make a start by:

- Increasing participation and voice of girls and women in village / slum meetings.
- Motivating girls and women to take part in making decisions in the family.
- Encouraging girls and women to eat well and take enough rest.
- Encouraging girls to complete school education.
- Ensuring that girls' and women's health problems are given due importance and that they receive appropriate care.

We can also:

- Discuss with men the need to share responsibility of childcare.
- Take collective action to stop physical or mental abuse of women.
- Counsel families to raise boys and girls equally in terms of nutrition, education, and opportunities.
- Increase awareness regarding illegality of prenatal sex determination as well as female foeticide and infanticide.
- Raise awareness in the community about delaying age of marriage until the legal age of marriage.
- Promote use of contraceptives for delay in first childbirth and maintaining gap between children.
- Increase participation of men in family planning.
- Provide counselling and ensure adequate care is received by women during pregnancy, childbirth and post- partum period.
- Help in creating awareness, especially among the women and girl child on their health rights, social rights, schemes, programme initiated for them.
- Educate and mobilize the community for action against gender- based violence with support of community level platforms like- VHSNC plus, MAS, during VHSND/ UHSND, other support groups, etc.



ASHA sensitizing on gender issues

How you as an ASHA can keep yourself safe

Like any other woman you can also be subjected to violence within your home or outside. It is possible that you might be tolerating any of the above forms of violence and is not able to stop it. The situation is compounded by the fact that even though you are empowered to take action for violence against other women, you may be hesitant to acknowledge to yourself or to others that you are also being subjected to abuse. Remember that you should help yourself before you begin to help others. Being able to articulate and address your own problems will instill empathy and give you more strength to support other women.

It is often individuals in positions of power who engage in inflicting abuse on women. There is a chance that your involvement in mobilizing support against the issue and helping women who encounter violence, may make you vulnerable to harassment and even abuse by dominant, powerful individuals in the community. You should always be conscious of this and actively seek the support of other individuals such as the elders in your area and members of the JAS, MAS and VHSNC plus. Make sure that the community is well aware that you are not alone and that you are trying to help the community as a part of a much larger team - the respected elders, VHSNC plus, JAS, MAS, the healthcare team of AAM-SHC /PHC / UPHC, the police. Also practice safety measures, such as avoiding visits alone to areas or households where you anticipate hostility. Whenever possible, visit such areas or households with an ANM or CHO. Avoid going out alone at night, stay away from isolated places, and follow other appropriate safety precautions.



Child Safety

Protection of Children from Sexual Offences (POCSO) Act, 2012

- The POCSO Act protects all children below 18 years from sexual abuse
- It applies irrespective of gender of child or offender
- Reporting of child sexual abuse is mandatory

What to Do When a Child Discloses Abuse

1. Stay calm

- Do not panic or show shock
- Your reaction should make the child feel safe

2. Believe the child

- Children rarely make false disclosures
- Take what the child says seriously

3. Reassure the child

- Tell the child: “It is not your fault”

4. Listen carefully

- Ensure privacy
- Do not interrupt or ask leading questions
- Do not blame or judge the person involved

5. Ensure safety of the child

- Make sure the child is not in immediate danger
- If the suspected abuser is at home, do not send the child back alone

6. Report immediately (MANDATORY)

- Inform CHO / ANM / Medical Officer immediately
- Ensure reporting to:
 - Police (mandatory under POCSO)
 - Childline – 1098
- Tell the child gently: “I will need to inform others to keep you safe.”

7. Support and referral

- Refer for medical care and counselling
- Contact Anganwadi / Childline (1098) for support services

Case study

Ms. K is an ASHA in a village. While going home today she saw a group of girls. The girls were serious and a bit worried and were standing around Ms. P who was crying. Ms. K was known well to the girls and had sessions with them regarding several health issues. The girls liked Ms. K as well.

Ms. K approached the girls to find out what was going on, but all the girls became quiet as she came. Even Ms. P became a bit conscious. When Ms. K asked again she replied, “My life is destroyed didi, I just don’t know what to do?!” Ms. K consoled her that perhaps she may be able to help her. As she calmed down, Ms. P told Ms. K that she had been in a relationship with a boy from her college. She said that during this time she had also had a sexual relationship with him. Her boyfriend had quietly taken some pictures of them getting intimate. A while ago when Ms. P tried to tell him that she was not interested in continuing the relationship with him anymore, he blackmailed her saying that he would make their pictures public. Ms. K told Ms. P, “I am here with you. You have not done anything wrong by being in a relationship with someone. In fact it is the boy who has done wrong by taking your pictures without your consent and is now using them to blackmail you. Don’t worry. Let me think what we can do in this situation. Until then, please feel free to come to me when you need to talk.” Ms. K understood that this was a sensitive issue and that it was important to get more support to deal with it. Taking care of Ms. P’s privacy, she inquired about organizations who work on these issues in their district and suggested to Ms. P that she seek their help. Ms. P got support from the concerned social organization, while Ms. K supported her and tracked the case closely.

Group discussion points

Question 1. What do you as an ASHA think about Ms. P’s situation?

Question 2. If you as an ASHA were in Ms. K’s place, how would you help/support Ms. P?

Key Messages:

- Every person has rights to dignity, equality, privacy, safety and access to health services, with particular attention to women and vulnerable groups.
- Violence can be physical, sexual, emotional, economic, social/cultural, or may occur through neglect and deprivation.
- Gender inequality and discrimination can directly affect health, including nutrition, healthcare access, decision-making and safety.
- ASHA’s close relationship with the community provides an opportunity to recognise people facing violence and connect them with appropriate support and services.
- Promoting women’s dignity, privacy, informed choices and freedom from violence and discrimination is an important part of community health.







National Health Systems Resource Centre
Ministry of Health and Family Welfare
Government of India