Meeting Minutes: 6th May, 2014

Meeting of Technical Advisory Group on development of training modules for ASHA and Mahila Aarogya Samitis (MAS) under National Urban Health Mission

Background: A consultative workshop of Technical Advisory Group (TAG) was held on 6th May, 2014 in NHSRC on developing training modules for ASHA and Mahila Aarogya Samitis (MAS) under National Urban Health Mission.

Meeting started with brief round of introductions. Dr. Rajani Ved, Advisor, NHSRC set the agenda for the meeting. She highlighted that main tasks for the TAG are:

1. Development and adapting ASHA training modules for the urban contexts.
2. Use lessons and learnings from VHSNC modules under NRHM and develop modules for MAS.
3. Defining and developing guidelines for special outreach activities by ANMs in urban areas.

After discussing some of the key issues that need to be addressed in urban context, TAG members shared their experiences in their respective states or programs to which they were associated.

Mr. Sameer Garg shared his experience from Chhattisgarh where NUHM program is being implemented across 11 cities (with or more than 50,000 population) since 2012.

He explained that **process of ASHA selection in Chhattisgarh** started with the selection of ASHA facilitators first. ASHA facilitators were selected from the overlapping city/village areas from the existing group of rural ASHAs. Five day training was imparted to these facilitators. Thereafter, the facilitators listed all households and conducted meeting with all households in the slum clusters,. After 2 to 3 rounds of meetings the final selection of ASHA was done by the community. After finalizing the names of the ASHA, ward *parshads* were invited to sign ratify the selection. Once the selection of about 30 ASHAs was completed in the neighboring clusters, few ASHAs were made ASHA facilitators who further chose ASHAs in other areas. Required number of ASHAs was estimated based on slums cluster mapped which came around 1000 ASHAs required to be recruited to cover all slum areas.

After 6 months, MAS were formed (1 MAS per ASHA), one member was selected from cluster of every 10-20 households, comprising of total 10-20 members in each MAS. The MAS members also ratified the ASHA selection in their first meeting. ASHA works as the convener of MAS (and not the member of MAS).

Qualifications and Training of ASHA: ASHAs were primarily selected based on skills like Confidence, willingness and motivation. Though no education qualification was specified as selection criteria but preference was given to women with education qualification of upto class 10th.

Training cascade include SHSRC training city coordinators, which in turn train area coordinators. Area coordinators train the batch of 8-10 ASHA facilitators who train ASHAs. Till now, 3200 ASHAs

have been trained in urban areas. Training modules which are used under NRHM were used for urban areas also:

- Module 1(6 days) - include topics on what is health, role of ASHA.
- Module 2 (5 days) - Gender and health, maternal health, child health and adolescent health.
- Module 3 (5 days) – Drug kits
- Module 4 (5 days) – Technical training on Home Based Newborn Care

SHSRC has deputed two people for monitoring training quality and documentation, who conduct monthly visits to all 11 cities to monitor training and other activities under NUHM.

Outreach activities: Earlier, only immunizations activities were carried out in outreach sessions, but later range of services are been expanded and now, Urban health and Nutrition days are now being conducted at *anganwadi* centres with the help of *Anganwadi* workers and ANMs.

Urban Health Infrastructure in Chhattisgarh: To provide the institutional services in urban areas, UPHCs have been set up near slum areas which are staffed by 3 doctors and 6 nurses. . One U-PHC caters to the 50,000 slum population. There are total 32 U-PHCs have been established in 11 cities covered under NUHM in Chhattisgarh.

Funds for MAS: Total 3200 MAS are functional in Chhattisgarh. Funds of Rs. 20,000 (5000 from centre and 15000 from state budget) have been provided to MAS. The untied fund has been spent on activities like arranging for poor patients to seek treatment at institution; wall writing or campaigns (water borne diseases); insecticide spraying in slum areas etc.

Dr. Saroj Naithani from Uttrakhand:

Dr. Saroj Naithani, Joint Director, National Programmes also holds the charge for NUHM in Uttrakhand. She informed the TAG that the need to have ASHAs in urban areas of four districts Haridwar, Nainital, Dehradun and Haldwani was felt since the launch of the ASHA programme under NRHM.

Hence ASHAs for urban areas of these districts were selected for every 1000- 2000 population right from the beginning when rural ASHAs were selected in 2006. However, ASHA facilitators were selected for every 25 ASHAs, unlike rural areas where ASHA facilitators are selected for every 15-20 ASHAs. All ASHAs in urban areas were trained using the modules developed for ASHAs under NRHM. Funds for immunization in urban areas were provided to the CMOH office under NRHM. UHNDs are not held but immunizations sessions are being conducted by ANMs at Anganwadi centres in outreach sessions. About 11 urban health posts have been established in Dehhhradun with staff as one Medical Officer, two ANMs, one Health Visitor, one ICC and one aaya. Apart from urban health posts, state is running their **urban health centres (UHC)** in PPP mode**.** There are total 21 UHCs in four districts mentioned above. These are located within the major slum areas of the cities. According to the TORs developed for the NGOs, mapping of the slum areas by NGOs was one of the pre- requisite. The staff at these UHC includes one medical officer, three ANMs/ staff nurses, one aaya and one helper. The package of the services includes only basic immunization and RCH

services. She also shared that though the experience of PPP was satisfactory but the model was proving to be expensive for the state.

There are 21 MAS – one for each urban health centre, members of which are selected by ASHA and ASHA facilitators. MAS are provided with the fund of 5000 to run their basic activities. She also shared that unlike VHSNC where state has faced challenges in proper fund utilization, the MAS experience is encouraging since MAS members are managing the untied funds effectively.

Dr. Monica Rana from Delhi State Health Society

Dr. Rana elaborated about the ASHA program in Delhi. ASHA program for urban areas was approved by cabinet at the time of NRHM only and it was decided that ASHAs will cover not only slum areas, but also semi-urbanized villages and resettlement colonies. Thus about sixty percent of Delhi population is being covered by the ASHAs.

Currently, there are total 4400 ASHAs in place against the target of 5400. Two health centers were clubbed to form one ASHA unit for ease of monitoring and logistics. Each ASHA covers about 2000 population. One ANM at the each centre looks after 10,000 population and 5 ASHAs. Therefore, each unit has 10 ANMs and 50 ASHAs covering total population of one lakh.

There is ASHA unit level committee which carries out all the activities related to ASHA i.e ASHA selection, training and payments. There are total 231 ASHA centres with 110 ASHA units.

Selection of ASHAs: Pulse polio coordinator, ICDS supervisor, ANM, PHN and local person like NGO partner etc were identified as facilitator for ASHA selection and trained in one day orientation. The qualification criteria set was - minimum 8th pass but in absence of such candidates, selected ASHAs were tested by unit level committees for basic literacy skills. Names of final selected ASHAs were then conveyed to the District nodal officers.

In areas where Basti sewikas were functional under MCD, preference was given to them in ASHA selection. Basti sewikas who were paid an honorarium of Rs. 500 per month were given the choice to continue as sewikas or to get selected as ASHAs. In cases where they opted to continue as Sewiakas, was given – in case of basti sewika decided to continue then no ASHA was not selected in these areas.

Training of ASHAs: The First four Modules of GOI were converted into State specific three Modules. With regards to training of Module 6 &7, State trainers are trained by NHSRC which train district level master trainers. The unit level training committee consists of 5 trainers which may include MO, PHN or NGO partners. ASHAs are then trained by unit level coordinators/trainers which are trained by District level trainers. Some adaptation was done in modules used for training ASHA in rural areas.

Payment of ASHAs: ASHAs in urban areas are paid with the mix of fixed and incentive based e payments. A fixed remuneration of Rs. 1000 is given to ASHAs who complete a set of defined activities. The functionality status is assessed first and this decides the core incentive of ASHA. The functional ASHA is paid Rs. 1,000/-, and if they are not functional it is reduced to Rs. 500/- per

month. Low performing ASHAs are deleted from the system if the performance does not improve over a period of three months. State had revised the amount of many of incentives and added new incentives to address the issue of high attrition among ASHAs. Performance based incentives can range up to 4-5000 based on ASHAs performance.

VHSNC/ MAS – State had constituted 304 VHSNCs in some of the areas but Medical officers of the units were apprehensive in releasing funds to these VHSNCs mainly because of majority members being from migrant communities. MAS is yet to begin in the state and will be done with the help of PFI. Payments are done by e transfers for all ASHAs.

Dr. Armida Fernandez from SNEHA, Mumbai:

Dr. Armida Fernandize from Mumbai shared her experience from SNEHA, an NGO working in slum areas of Mumbai. After discussing unique challenges of addressing and catering to the huge slum population of Mumbai, she explained how her NGO started working in slum areas. They chose those slum areas where neonatal mortality rates were highest. The NGO worked closely with Community Health Volunteers from MCD with fixed honorarium of Rs. 1500-2000 pm.

Vulnerability assessment was done in slums based on 6 indicators and score card was prepared. It was followed by a process of micro-planning where participatory appraisal was done with volunteers from slums and slum action committees were formed. Thereafter, community organizers were selected who did research in the community.

She also emphasized the following major points:

1. **Different norms for different areas** – Considering the three models discussed from three states, Dr. Fernandize suggested it is worth to have pilot in different areas.

2. **Involvement of men** in all types of community processes: Women are disempowered – even if they have to come and work, they have to ask father/mother's permission. Involvement of youth and men can be very helpful in achieving the success of the program

3. **Well planned training curriculum for ASHAs and MAS members**: training should be well planned and organized in small parts along with refresher training instead of imparting continuous one time training. Special attention is required to maintain high quality of the Training of trainers.

4. **Close coordination with MCD** – She suggested that it would be better to focus on service delivery immediately through existing CHVs and ICDS staff or through mobile health units rather than planning for infrastructure development (which may take years before services can be started)

Dr. Devaki Nambiar from PHFI being part of the working group on vulnerable groups under Technical Resource Group (TRG) on NUHM, shared her opinions regarding vulnerability assessment and mapping of vulnerable groups in urban areas. She highlighted that this exercise should be done as 'Social Mapping' where vulnerable groups should be identified across the axes of habitational, occupational and social categories. Mapping of the health services should be

superimposed and access audits should be carried out for all the facilities. – to be done annually. She also emphasized the need to align the health goals with the priorities of the comm. Like electricity and water and also to plan for career trajectories for ASHAs. .

On the issue of vulnerability mapping, Ms. Preeti Pant, Director, NHM, MoHFW responded that innovative solutions are required to address the issue of convergence between different departments in order to respond to community's immediate demands. She also stressed data from the DUDA and HUPA can be used to do geographical mapping/household survey which can juxtapose over other processes which are already there.

In continuation with the discussion, all the members stressed that the survey tool has to be prepared for vulnerability mapping by ASHAs. Also, deliberations and discussions will be required to make the strategies to ensure coverage of left out households in mapping and involvement of men in MAS or perhaps male ASHAs. All participants agreed that JNNURM and HUPA data is city based GIS – which can be used to place an ASHA in an area while mapping of the area by ASHAs would help in better understanding of the vulnerable groups residing in her area.

Ms. Swati from PFI also shared her experiences from their HUP program in seven cities across the country. She mentioned that there is a cadre of link workers for 2500 population in their program. For every 5 to 6 link workers, there is a cluster coordinator who is a male. The states of MP had launched an urban programme before the launch of NUHM. The CHWs selected under that programme was named as USHA and social mobilizers for ASHAs could be male or female. However after the launch of NUHM, state has made the changes in the programme in line with the NUHM guidelines.

Under HUP program, the geographical mapping was done based on certain criteria and secondary data. Based on this, the vulnerable wards were identified and number of health facilities and Anganwadi centres in these wards were listed. Based on this listing, vulnerable slum areas were identified where program was established. Apart from setting the health services, convergence was sought with various stakeholders like local NGOs working in these slums, urban local bodies i.e *nagar palikas* to address various social determinants like water and sanitation.

MAS has also been constituted for every 200-250 households in each of these wards. To ensure convergence at state, city and ward levels, city level and ward level coordination committees have been set up. Around 50 MAS report to 1 ward coordination committee. All the MAS are given rotatory memberships to ward coordination committee which also ensure their accountability and provide them legitimacy i.e, each MAS has 8-10 fixed members and some rotator members. Ward coordination committees provided interface for MAS to interact with other departments which also provides them a platform for grievance redressal (Pune and Bhibneshwar). WCs are linked to City level convergence committees. WCS are expected to meet CLC on regular basis but the frequency varies from city to city. States lilke UP, MP and CG have agreed to form City level comm. Soon.

Mr. Biraj Kanti Shome from North Eastern States pointed out that seeking the support from NGOs can help in identifying vulnerable groups and selection of ASHAs and MAS as well. He also quoted the example of Sarva Shiksha Abhiyan where ward commissioners were involved to select NGOs.

Ms. Armida Fernandez stressed that what is needed to ensure mapping of each and every slum household is to do micro-planning.

On the issue of legacy management, the group agreed that existing CHWs should be selected as ASHA facilitators (provided they meet the criteria) given that they are experienced in urban community mobilization and the fact they are being paid as fixed salary and may not want to work in an incentive based system.

Topics to be covered in ASHA training modules:

1. How to do vulnerability mapping?
2. Training should cover topics on common communicable (Dengue, Chickengunia and Swine flu) and non-communicable diseases (Hypertension, Diabetes and Mental Health) based on disease burdens- danger signs and basic management.
3. Role of ASHA in birth and death registration. It was also suggested that ASHA help desk should be created at any facility with more than 30 beds.
4. Role of ASHA in notifying dengue, its breeding sites and surveillance.
5. Convergence functions of Municipal corporations and their role and contribution in public health.

Participant agreed that the role of ASHA as facilitator, mobilize and service provider is pertinent to NUHM. To perform these roles in urban context, few important topics which must be included in ASHA modules were suggested such as:

1. Chapter 1: Orientation of Urban Health Services
2. Chapter 2: Role of ASHA in navigating the complex public health facilities.
3. Chapter 3: Role of ASHA in financial protection
4. Chapter 4: Role of ASHA in trauma cases and Non Communicable Diseases
5. Chapter 5: Addressing social determinants of health (water, housing and sanitation)

After this, Induction Training Module for ASHAs under NRHM was discussed to adapt and modify its content as per the urban context. (Please see annexure 1)

Mechanisms for outreach sessions in urban areas: Moving forward with the discussions, the group then deliberated 'Defining and developing guidelines for special outreach activities in urban areas'.

Dr. Rajani Ved highlighted that providing services and ensuring coverage of left out and unreached areas where sub-centres do not exist will be a challenge for all of us to overcome. The guidelines should be developed to define:

- Set of activities
- Site of services
- Team Composition, roles and responsibilities
- Logistics- Equipments, drugs and consumables
- Records and reporting

- Follow up

As per the NUHM guidelines, there are provisions for two types of outreach sessions:

- Special outreach
- Regular outreach

As per the guidelines, budget of Rs. 10,000 is provided to each ANM per week to organize the special outreach camps in slum areas and the maximum number of camps she can do is three per month. It is upto the discretion of the state and head of the facility (Medical Officer) how to do planning for utilization of the funds for special outreach according to the local needs of the community. Flexibility to club at PHC level – 5 ANMs @ 50,000 per week or can be used by ANMs individually.

Group also decided that the states should be given a **'basket of choice'** where they could utilize these funds to address the specific needs and health burdens of their population. This should be taken as an opportunity for taking services to the people and to be seen in a total continuum care

Funds can be used as PHC on wheel s for these special categories – as per disease burden, population needing services – For eg. Special camps for people with disability, people residing in shelters/ rehabilitation homes, camp for cancer screening, Complete health check-ups for screening of chronic diseases, Eye screening camps, dental camps etc.). Monitoring of the sessions could be planned based on the design of the sessions and type of services that state decides to provide.

Training module for MAS:

Progressing towards the discussions on development of guidelines for MAS, the TAG insisted that the key areas which need to be addressed for MAS are:

1. Service/ Roles and responsibilities of MAS
2. Process of selection of MAS members
3. Signatories for MAS
4. Provision and utilization of untied funds to MAS
5. Developing public service monitoring tool for MAS (Add as annexure 5)

Ms. Swati, Mr. Sameer and Ms. Monica Rana shared their experiences with MAS from their respective states and the programs.

Mr. Bijit from PFI mentioned the roles and activities carried out by VHSNC under HUP programs. He mentioned that community based monitoring is done through strategies like facility report card, public hearings etc. At some places, these committees have been federated also by ward commissioners.

Ms. Swati mentioned that under HUP program, every MAS covers 200-250 households and have around 10 members. Each member is allotted with 10 HH who collects all the information and keep track and records of all the beneficiaries, deaths, births, deliveries and immunization status and

inform ASHA as well as link workers. Ward committee meetings are held regularly where MAS members meet once in a quarter. In Bhubaneswar, MAS members have been trained on important areas like grievance redressal mechanisms, awareness generation etc. They also maintain simple records of their activities.

Ms. Monica Rana explained the MAS process followed in Delhi. She mentioned that in Delhi, one MAS covers around population of 2500 i.e 400 households approximately and is looked after by one ASHA. Listening to Chhattisgarh experience, Dr. Monica enquired whether process of constitution of MAS can be piloted in Delhi. It was suggested that Delhi can have pilots in 4 districts where in two districts they can select MAS members as per their VHSNC trial and in the other two, they can follow the mechanism followed by Chhattisgarh.

She suggested that MAS should be linked to UPHC and ANM or ASHA should be pegged in to make sure the regular meetings are held and attended by all members and funds are utilized well.

Dr. Gautam raised the issue of constituting MAS only in notified slums because of the challenge of opening the bank account because of non availability of address proof. Ms. Pant suggested that during the first phase MAS should be rolled out in notified slums as it would be difficult to implement in areas with homeless population.

Thereafter, Mr. Sameer suggested some of the topics required to be added in VHSNC handbook to be adapted for MAS: **Importance/significance of MAS, Structure and formation of MAS, basic topics like what is health, actions to improve social determinants i.e water and sanitation, addressing nutrition or vector borne diseases**.

Dr. Monica Rana also suggested preparing **one page checklist** (based on certain parameters) to do a situational analysis when MAS starts it work so as they can measure the existing conditions at their locality and monitor it accordingly.

Following suggestions were also made to edit the VHSNC handbook for MAS-

   a. Edit public health and services monitoring tool according to the urban - Add about the urban local bodies
b. Add process of opening a bank account
c. Add leadership skills and how to convene a meeting
d. Appreciative inquiry (Trained would be trained in AI)
e. Support Strategies

Towards the end of the meeting, the key tasks were allocated to the three groups. The deadline of 31st May was decided to accomplish the task. Work allocation along with members is as follows:

   1. **ASHA Induction Module: CP Team(Rajani R.Ved)- NHSRC**
   2. **Outreach Guidelines: Mr. Gautam, PFI,(team leader), Dr. Monica, Mr. Arun Srivastava and Dr. Devaki**
   3. **MAS Guidelines: Ms. Swati Mahajan, PFI (Team Leader), Mr. Sameer Garg, Dr. Monica Rana and Dr. Saroj Naithani**

Annexure 1: Suggested Modifications in ASHA Induction Training Module

- Find/replace village with community, VHSNC—MAS, VHND—UHND, Village Health Plan—Community Health Plan, Village Health Register—Slum Health Register
- Pg 10- Add actions on social determinants of health, NCDs
- Pg 14 – local health plan'
- Pg 15 – improve drinking water facilities
- Pg 19 – have to add NCDs, violence, Mental Health, change illustrations (Ms. Swati will share her illustrations from their modules of HUP program)
- Pg 20- Hut—Slum
- Pg 22- Sexual orientation to the second bullet
- Add more infections under other diseases
- Add section on reaching marginalized groups—Change accordingly in the module
- Add importance and skills for community dialogue
- Add role of MAS in addressing sanitation issues
- Incorporate topic on 'Sex selective abortion' to highlight problem of adverse sex ratio
- Pg 26-Change table
- Pg 34- Leadership role- highlight in a blurb
- Pg 37- Change illustration
- Pg 43- Divide illustration in sections
- Pg 45- Highlight the headings
- Pg 47- Include junk foods with cross
- Pg 50- Change any pain with convulsion to pain which doesn't subside, pain with vomitings or any kind of persistent pain.
- Pg 54- Accidents need to be added (pick basic things from disaster module like how to handle victim)
- PG 59- Include DOTS??; Dengue and chickengunia
- Pg 89, 90- Change to WHO graph
- Include vulnerability mapping tool – Micro planning tool for AWW, ANM and ASHA to work together for reaching the margibalized.
- Include paragraph on NCDs
- Prepare clear directions for Household Survey (as Rs 500 are attached to it)

Annexure 2: List of Participants

1   Ms. Preeti Pant, Director(NRHM-III), MOHFW, Nirman Bhawan, New Delhi

2   Dr. Armida Fernandez, Founder Trustee SNEHA, Bandra, Mumbai

3   Dr. Monika Rana State Asha Nodal Officer, Delhi State Health Mission, Delhi

4   Dr. Saroj Naithani, Joint Director (NP), ASHA Nodal Officer, DG MH&FW, Uttarakhand

5   Sh. Biraj Kanti Shome, Regional Coordinator, RRC-NE, Six Mile, Khanpara, Guwahati

6   Sh. Samir Garg, Sr. Programme Coordinator, SHRC, Kali Badi, Raipur, Chhattisgarh

7   Dr. Rajani Tomar Consultant (Urban Health) MOHFW, Nirman Bhawan, New Delhi

8   Ms. Seema Pati, Consultant (ADB), Delhi

9   Ms. Devaki Nambiar, Research Scientist, Public Health Foundation of India, Delhi

10   Dr. Swati Mahajan, Programs Manager, Population Foundation of India, Delhi

11   Mr. Bijit Roy, Programs Manager, Population Foundation of India, Delhi

12   Dr. Rajani R. Ved, Advisor(Community Processes), NHSRC, New Delhi

13   Dr. Garima Gupta, Sr. Consultant (Community Processes) NHSRC, New Delhi

14   Dr. K. Shashikala, Sr. Consultant, (Public Health Planning) NHSRC, New Delhi

15   Dr. Manoj Kr. Singh, Consultant (Community Processes), NHSRC, New Delhi

16   Mr. Arun Srivastava, Consultant (Community Processes), NHSRC, New Delhi

17   Ms. Abha Tewary, Consultant (Community Processes), NHSRC, New Delhi

18   Mr. Syed Mohd. Abbas, Consultant (Community Processes), NHSRC, New Delhi

19   Ms. Jyoti Jagtap, Consultant (NUHM/PHP), NHSRC, New Delhi

20   Ms. Shikha Gupta, Fellow, NHSRC, New Delhi