CONCEPT & OPERATIONAL GUIDELINES
URBAN ACCREDITED SOCIAL HEALTH ACTIVITIST (U-ASHA)
Conceptual Background, Role/Responsibilities, Selection/Removal Criteria, Institutional Arrangements and Grievance Redressal for U-ASHA

1. Conceptual Background of U-ASHA:

The Government of India launched the National Urban Health Mission (NUHM) in 2013-14 to address the health needs of urban population, especially the slum, marginalized and vulnerable sections of the society. The Urban-PHC (U-PHC) is the most peripheral level of contact with the community through U-ASHA at the public health infrastructure under NUHM. One U-PHC is expected to cater to an urban slum-like population of around 50,000.

Thus, provision for a new band of community based functionary, named as Urban Accredited Social Health Activist (U-ASHA) is made to fill this void on the line of ASHA in rural areas. The U-ASHA shall be the first port of call for any health related demands of the slum population, especially women and children, who find it difficult to access RMNCH+A health services. The role responsibilities and profile, selection and removal procedures, provisions of modular training and modalities of compensation package for U-ASHA is given ahead, which will be on the line of ASHA in rural areas. It has been envisaged that States have flexibility to adapt the Government of India guidelines keeping in view their local situations.

The U-ASHA shall be the volunteer health activists from the local communities, who shall be generating awareness on RMNCH+A health services and its social determinants mobilizing the community towards local health planning and increase utilization, as well as, accountability of the existing public health services. The U-ASHA shall be a promoter of/for the best RMNCH+A health services/practices among the community members.

The U-ASHA will be entitled for performance based incentives fixed by the NHM State HQ for prefixed activities only. The performance based incentives shall require to be given on monthly basis to them and there shall be no provision of fixed honorarium/incentive/salary under NUHM. The U-ASHA shall also be entitled for all monetary/non-benefits made available to ASHA in the state.

2. Roles & Responsibilities of U-ASHA:

The roles and responsibilities of U-ASHA shall include the functions of a community based health activist, a community motivator, a healthcare facilitator, and a service provider. Broadly, her functions shall involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to the marginalized communities for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services; participation in health campaigns and enabling people to claim health entitlements.

U-ASHA shall also provide a minimum package of curative care as appropriate and feasible for that level and making timely referrals for further treatment. Her roles and responsibilities are as follows:

- U-ASHA shall have to take steps to create awareness and provide information to the community on determinants of health such as proper diet and nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services at doorsteps.

- U-ASHA shall have to conduct home visits of the pregnant women/mother/newborn under Home Based Post Natal Care (HBPNC), and they are supposed to counsel pregnant women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- U-ASHA shall have to mobilize the community and facilitate them in accessing RMNCH+A facilities and health related services available at the public health institutions, such as Routine Immunization (RI), Ante Natal Check-ups (ANCs), Post Natal Check-ups (PNCs), Family Planning (Vasectomy/Tubectomy/IUCD/PPIUCD/Spacing etc.), Personal Hygiene, Sanitation and other public health services being provided by the Government.
- U-ASHA shall have to work with the Ward *Swasthya Samiti* (WSS) and Mahila *Arogya Samiti* (MAS) under the Municipality to facilitate a comprehensive Ward Health Plan facilitating the ANMs, AWWs and ULB members.
- U-ASHA shall have to mobilize targeted community once in a month for the celebration of Ward Health Nutrition Days (WHND) at their Aanganwadi Centre. The ANM, AWW, Members of WSS, MAS and community people are expected to participate in the celebration of UHND.
- U-ASHA shall have to arrange escort/accompany pregnant women & children requiring treatment/admission to the nearest pre-identified health facility i.e. U-PHC/CHC/FRU/GH.
- U-ASHA shall have to provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries after their modular trainings.
- U-ASHA would also act as Dot Providers of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme (RNTCP) after training.
- U-ASHA would also act as Treatment Providers for Pf/Pv^{+} Malaria cases under Malaria Control Programme after training.
- U-ASHA would also act as a Depot Holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), Chloroquine, Disposable Delivery Kits (DDK), Contraceptives (Condoms, Oral Contraceptive Pills, and Emergency Contraceptive Pills), etc.
- Provision of Drug Kit and HBPNC Kit shall be made for U-ASHA. Contents of the Drug/HBPNC Kits shall be based on the line of ASHA in rural areas and on the basis of recommendations of the expert/technical advisory group set up by the Govt of India and State Government.
- U-ASHA role as a service provider shall be enhanced subsequently. State shall make provision of graded training to U-ASHA for providing RMNCH+A health care and management of a range of common ailments particularly maternal and childhood illnesses.
- U-ASHA shall be expected to provide first information about all the births and all the maternal/ infant/other deaths in their areas and any unusual health problems/disease outbreaks in the community to the U-PHC or directly to the District or even to the State HQ.
- Fulfillment of all these roles by U-ASHA is envisaged through continuous training and up-gradation of their skills over the years.

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

i. **Home Visits**: For upto 2 hours every day, for at least four or five days a week, the U-ASHA should visit the families living in her allotted area, with first priority being accorded to marginalized families. Home visits are intended for health promotion and preventive care. They are important not only for the services that U-ASHA provides for reproductive, maternal, newborn and child health interventions, but also for non-communicable diseases, disability, and mental health. The U-ASHA should prioritize homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child. Home visits to these households should take place at least once in a month. Where there is a new born in the house, a series of six visits or more becomes essential.

ii. **Attending Ward Health Nutrition Day (WHND)**: The U-ASHA should promote attendance at the monthly Ward Health Nutrition Day by those who need Aanganwadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services.

iii. **Visits to Urban Health Facility**: This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility based care. The U-ASHA is expected to attend the monthly review meeting held at U-PHC.

iv. **Holding Ward level Meeting**: As a member or member secretary of the Ward Health, Sanitation and Nutrition Committee (WHSNC), the U-ASHA is expected to help convene the monthly meeting of the WHSNC and provide leadership and guidance to its functioning. These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community and required information to the U-PHC.

v. **Maintenance of Records:** Maintaining records help her in organizing her work and help her to plan better for the health of the people. The first three activities relate to facilitation or provision of healthcare, the fourth is mobilization and fifth is supportive of other roles.

3. Selection of U-ASHA: The general norms are of 'One U-ASHA for every 1500-2000 slum population' and the norm could be relaxed to one U-ASHA per habitation, dependant on workload etc., who may also be enrolled in the un-served/under-served slum like areas; being covered periphery of U-PHC.

3.1 Selection Criteria for U-ASHA:

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

3.2 Selection Process for U-ASHA:

- Selection of U-ASHAs would have to be done carefully. The District Health & Family Welfare Society envisaged under NHM would oversee the process.
- DHFW Society would designate a District Nodal Officer, preferably the Dy CS NHM, who is able to ensure that the Health Department is fully involved. S/he would also act as a link with the community and with other Departments.
- DHFW Society would designate Block Nodal Officers, preferably Block Medical Officers, to facilitate the selection process of U-ASHA as per the guidelines.
  i. The Block Nodal Officer is supposed to constitute a Committee comprising 4-5 members of the local WSS (i.e. Chairperson of the Committee (Woman Counselor of MC), Convener of the WSS (ANM), AWW(s), Local School Teacher, Representative of MAS, alongwith MO I/c U-PHC, District ASHA Coordinator (DAC), and one Block ASHA Coordinator (BAC).
  ii. Selection Committee is required to make public announcement in the local community/ Urban Ward for requirement of U-ASHA in particular area with prior information to the Municipal Committee/Local Counselor.
  iii. Interested and eligible women as enrolment of U-ASHA are required to submit formal/informal application with any of the Committee member(s). Committee Members would call a joint meeting and scrutinize the application/candidates for selection as U-ASHA.
  iv. Committee members shall be required to interact with all eligible women candidates by way of conducting Focused Group Discussions in presence of the local Municipality Counselor and local community, for whom U-ASHA is to be selected. This should lead to awareness of roles and responsibilities of U-ASHA and acceptance of U-ASHA as a concept in the community. This interaction should result in short-listing of at least three names from each Urban Ward/area concerned.
  v. Subsequently, a meeting of the *Ward Sabha* would be convened to select one out of the three shortlisted names. The minutes of the approval process in *Ward Sabha* shall be recorded. The Ward Committee would enter into an agreement with the women as U-ASHA. The name will be forwarded by the Selection Committee to the Block Nodal Officer for record, with a copy to District Nodal Officer for information.
  vi. The Block Nodal Officer, finally send the finalized name of the particular woman to their Chief Medical Officer, who is the Executive Secretary of District Health & Family Welfare Society (DHFWS) for her enrolment as a U-ASHA in the District.
  vii. After approval of the DHFWS concerned, the District ASHA Coordinator/Community Mobilizers would enroll her as U-ASHA in their respective ASHA Master Charts by way of putting all particular information in the ASHA Web Portal about her with information to the State NHM HQ.

4. Removal of U-ASHA:

Following is criteria for declaring any U-ASHA as an inactive/dormant U-ASHA, drop-out:

- If, she has submitted a letter of resignation to the WSS and her Facilitator OR
- If, she has not attended three consecutive UHNDs; without giving any information/reason for the same to WSS or her Facilitator OR
- If, she has not attended 03 consecutive Monthly Meetings at U-PHC; without giving any information/reason for the same to MO I/c, DAC/BAC/AF OR
- If, she has not been active in most of the RMNCH+A activities, like mobilization of pregnant women/mother/newborn for routine immunization services, home visits for HBPNC and population stabilization services etc. in her area OR
- If, MO I/c Facility, DAC, BAC, AF visited the area of U-ASHA and ascertained through discussions with all WSS members that she is indeed not active.

- If there is a genuine problem, she should be supported until it is overcome through the WSS or MAS. If the problem persists and the community also agrees that U-ASHA should not continue, a signed letter stating this should be obtained from her and approved by BAC after due validation from WSS.
- In case of contesting her removal, it should be referred to the MO I/c Facility and DAC or other person appointed by the Executive Secretary of the DHFWS, who would listen to her views, record them and then take a final view. Such matter may be put-up before the AGRC.
- It is desirable in case of all 'dropouts' whatever the reason, to conduct and document an exit interview. Vacancies howsoever they arise, should be filled in by the same selection process as laid down by State Government, based on these guidelines.

5. Institutional Arrangements

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

i. District Health & Family Welfare Society under the Chairmanship of the District Magistrate/ President *Zila Parishad* will oversee the selection process. Society will have representation from all related departments and civil society and the Urban Local Bodies (ULBs). The Society will designate a District Nodal Officer and a Block Nodal Officer preferably a senior health person. The job of the Nodal Officers at the District and Block will be to facilitate the selection process by involving the *Ward Sabha*.

ii. At Ward level, it is recognized that U-ASHA cannot function without adequate institutional support. The women's committees (like self help groups or women's health committees), WSS and MAS under the Municipality Corporation/Zila Parishad, peripheral health workers especially ANMs and AWWs, and the trainers of U-ASHA and in-service periodic training would be major source of support to U-ASHA at U-PHC/GH.

iii. At Block level, U-ASHA scheme will have a Block Co-ordination Committee with Municipal Counselor as Chairperson. This Committee will ensure involvement of ULBs and Civil Society and support of all related departments at the Block.

iv. The WSS would lead the U-ASHA initiative in three ways:
   - *Ward Sabha* undertakes (through the process outlined earlier) the selection of U-ASHA.
   - It is involved in supporting the U-ASHA in their work and itself undertaking many health related tasks through its statutory health committee and all U-ASHA will be involved in this.
   - It develops the Ward Health Plan in coordination with U-ASHA.
   - A part of the incentive may be provided by/routed through Urban Health Facility.

v. State NHM Committee would have to monitor and support the DHFWS and District Nodal Officers through a network of coordinators/support structure established in the State.

vi. U-ASHA strategy would be reflected in the State Action Plan, for which funds shall be released under the overall allocations under NHM/Mission Flexi-pool.

5.1 Role and Integration with ANM/MPHW(F):

Concerned Auxiliary Nurse Midwife/Multi-Purpose Health Worker-Female (ANM/MPHW-F) will guide the U-ASHA in performing the following activities:

- ANM will hold weekly/fortnightly meeting with U-ASHA and discuss the activities undertaken during the week/fortnight. ANM will guide her in case U-ASHA had encountered any problem during the performance of her activity.
- ANM will act as resource person(s) for the training of U-ASHA.
- ANM will inform U-ASHA regarding date and time of the outreach session and will also guide her for bringing the beneficiary to the outreach session.
- ANM will participate & guide in organizing the UHND at AWC.
- ANM will take help of U-ASHA in updating eligible couple register of the village concerned.
- ANM will utilize U-ASHA in motivating the pregnant women for coming to SC/Health Facility for early registration and initial checkups.
- ANM will guide U-ASHA in motivating pregnant women for taking full course of IFA Tablets and TT Injections etc.
- ANM is expected to go with U-ASHA at the home of pregnant women for preparing birth plan.
- ANM will supervise the home visits conducted by U-ASHA under Home Based Post Natal Care (HBPNC) and follow-up the identified danger sign cases of pregnant women/newborn/mother along-with U-ASHA in the community.
- U-ASHA will also help ANMs in bringing married couples to Health Facility for adopting family planning. ANMs will also orient them about dose schedule and side effects of oral pills.
- ANMs will educate U-ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.
- ANMs will inform U-ASHA on date, time and place for initial and periodic training schedule. She will also ensure that during the training U-ASHA gets the compensation for performance and also TA/DA for attending the training.
- ANM also requires to convene the Meeting of USNCS and they are expected to also coordinate with Counselor alongwith AWW and U-ASHA the conducting the activities.

5.2. Role and Integration with Anganwadi Worker (AWW)

Anganwadi Worker (AWW) will guide the U-ASHA in performing the following activities:

- AWW will organizing Urban Ward Health Day (UWHD) once in a month at her AWW and U-ASHA alongwith ANMs are required to participate in the UHNDs.
- AWWs, ANMs and U-ASHAs are required to jointly plan the celebration of UHND on rotation basis at different Aanganwadi. AWW is also requires to inform ANMs to participate and guide organizing the Health Days at Anganwadi Centre (AWC).
- U-ASHA is required to mobilize all the expected women, pregnant women, adolescent girls and children alongwith their close relatives on the occasion of UHND for their orientation on health related issues, such as importance of Peri/Pri-Conception Counselling, Nutritious Food, Menstrual & Personal Hygiene, Pregnancy Care, Importance of time ANCs, Institutional Delivery, timely PNCs, Importance of HBPNC, Home Remedies for Minor Ailment, Importance of Immunization, Counseling target couples for spacing/terminal methods for family planning etc..
- U-ASHA will support the AWW Helpers in mobilizing pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific days of immunization, health checkups/health days etc. to AWCs.
- AWWs, ANMs and U-ASHAs to act as resource persons for the UHNDs.
- AWW requires to ensuring all relevant IEC activity through display of posters, folk dances etc. during UHNDs, which are being undertaken to sensitize all beneficiaries on health related issues.
- AWW and U-ASHA can act as a joint-depot holder for drug kits. The replacement of the consumed drugs can also be done through ANMs, if required in between the month.
- AWW will update the list of eligible couples and also the children upto 2 year of age in the Urban Ward with the help of U-ASHA.
- AWW also requires to convene the Meeting of USNCS and they are expected to also coordinate with Counselor alongwith ANM and UASHA the conducting the activities.
- AWW is expected to coordinate with A-ASHA for identification of malnourished children and their referral for management at Nutrition Rehabilitation Centers (NRCs)

6. Working Arrangements of U-ASHA:

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

A. At the AWC: She will be attending the AWC on the day when Immunization/ANC sessions are being organized. At least once or twice a week, she would organize health days for health IEC, rudimentary health checkup and advice including medicine and contraceptive dispensation.

B. At the Home: She will be available at her home so as to work as depot holder for distribution of supplies to needy people or for any assistance required in terms of accompanying a woman to delivery care centre/FRU or Medical/Health Camps.

C. In the Community: She will organize/attend meetings of MAS and UHSNC and other group meetings and attend Ward Health Committees. She will counsel and provide services to the families as per her defined role and responsibility.

7. Provision of Modular Training for U-ASHA

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

- **Induction training:** After selection, U-ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. Considering range of functions and tasks to be performed, 08 days Induction Training required to be completed within one month after her joining. The first round may be of eight days, to be followed by another 5 days training (Module-V).
- **Home Based Post Natal Care (HBPNC) Training under Module VI-VII:** 20 days Module VI-VII training (Round-I, II, III, IV–each Round of 5 days) is required to be given to each U-ASHA within 2 months after their joining. If Module-V training are pending for such U-ASHAs (who have been imparted Induction Training) and Module VI-VII trainings are round the corner, than Module VI-VII/HBPNC trainings can be imparted directly to fresh U-ASHA.
- **Training materials**: would be prepared according to the roles and responsibilities that the U-ASHA would need to perform. Their envisaged functions and tasks will be expanded into a listing of competencies and the training material would be prepared accordingly. The training materials produced at the national level would be in the form of a general prototype which may be modified by State and will be adapted as per local needs. The training material will include facilitator's guide, training aids and resource material for U-ASHAs
- **Periodic trainings:** After the induction training, periodic re-training will be held for about two days, once in every alternate month at appropriate level for all U-ASHA. During this training, interactive sessions will be held to help refresh and upgrade their knowledge and skills, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest. The opportunity will also be used for replenishments of supplies and payment of performance linked incentives. U-ASHAs will be compensated for attending these meetings.
- **On-the-job training**: U-ASHAs needs to have on the job support after training both during the initial training phase and during the later periodic training phase; it is needed to provide on the job training to U-ASHAs in the field by their ANMs, Facilitator, District/Block Coordinator/ Community Mobilizers, so that they can get individual attention and support that is essential to begin and continue her work. ANMs while conducting outreach sessions in the villages will contact U-ASHA of the village and use the opportunity for continuing education.
- **Training of trainers**: Provision of a cascade model of training is there in the State. At most peripheral level, District/Block Trainers (who are the members of identified Block training teams) would have to spend at least the same number of days in acquiring the knowledge and skills as U-ASHAs. These ToTs will also have to be similarly phased. These trainers should be largely women and chosen by Block Nodal Officer. The block teams would be trained by a State/District Trainer's team by the Master Trainers, who are in turn trained by the National Training Team. The duration of ToTs for District Training Teams (DTT) and State Training Teams (STT) will be finalized by the States depending on the profile of the members to be selected as DTT and STT.

- **Constitution of Training Teams:** It follows that State, Districts and Blocks, would have a training team compromising of three-four members. Existing NGOs especially those working on community health issues at the District/Block level may also be entrusted with the responsibility for identifying trainers and conducting of TOTs. The trainers would be paid compensation for the days they spend on acquiring or imparting training–both camp based training and on the job training. The similar guideline applies to the district level also where trainers would be drawn in from Programme Managers and NGOs. The Community Processes Division already constituted a team of Master Trainers, District Trainers for training of ASHA, who will also impart training to U-ASHA in their respective areas. State level training structures to be used for trainings under various National Health & Family Welfare Programmes Trainings may be adhered wherever feasible.
- **Continuing Education and skill up-gradation**: A Resource Agency in the district of State (preferably an NGO) will be identified by the State. The Resource Agency in collaboration with open schools and other appropriate community health distance education schemes will develop relevant illustrated material to be mailed to U-ASHAs, periodically for those who would opt for an eventual certification.
- **Venue of training**: The principle of choice of venue shall be that the venue should be close to their habitation that the training group should not be more than 25 to 30. In most situations this could be the PHC or alternatively Community Bhavan or other facilities that are available.
- **National level**: At the national level the NIHFW would in coordination with the NHM and its Technical Support Teams, i.e. NHSRC will coordinate and organize periodic evaluation of the training programmes. The findings of these concurrent evaluations should be shared with State Governments by the Ministry.
- **State level**: At the State level, the Community Processes Division at SPMU will oversee the process of training, monitor and organize concurrent evaluation of training programme.

8. Compensation/Performance Based Incentives to U-ASHA:

U-ASHA would be an honorary volunteer and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood. However, U-ASHA could be compensated with performance based incentives for her time in the following situations:

a) For the duration of her training both in terms of TA and DA (so that her loss of livelihood for those days is partly compensated)

b) For participating in the monthly/bi-monthly training, as the case may be *(for situations (a) and (b) payment will be made at the venue of the training when U-ASHA come for regular training sessions and meetings).*

c) Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks should be assigned to U-ASHAs on priority (i.e. before it is offered to other village volunteers) wherever they are in position. *(For situation (c) disbursement of compensation to U-ASHAs will be made as per the specific payment mechanism built into individual programmes).*

d) Other than the above specific programmes, a number of key health related activities and service outcomes are aimed within a village (For example all eligible children immunized, all newborns weighed, all pregnant women attended an antenatal clinic etc). The budgetary provision for prefixed activities and rates has been made under Mission Flexi-pool, which could be used as monetary compensation to U-ASHA for achieving these key processes.

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

- Provision of performance awards considered for their motivation.
- Provision of non-monetary incentive, like Dress, CUG Sims etc. considered to support them.
- Provision of drug kit containing basic drugs and HBNC Kits containing Baby Weighing Scale, Digital Thermometer, Digital Watch, Torch etc. have been made.

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

9. **ASHA Grievance Redressal Committee:** Grievance Redressal Committee for U-ASHA is a mechanism to address their grievances. It flows from a direction given by a Parliamentary Standing Committee. Grievances may be in any form/issues related to their work, e.g. incentive payment, supplies, record keeping, referral system, services at health facilities, gender issues. A 05/07 member Committee required to be notified by the DHFWS (under the leadership of the Dy. Commissioner and the CMO. The composition of the Committee would be as follows:

- 02 of the 05/07 members will be representatives from non- governmental Agencies, of which one could be from an academic institution.
- 02 would be government representatives from a non health sector, like WCD, ICDS, Education, Rural Development, PRIs), and
- 01 member would be a nominee of the CMO.
- District ASHA Coordinator/Community Mobilizers will be convener of the Committee.

An office space should be allocated for U-AGR Committee. Post Box and functional landline number should be provided. They are to be widely publicized and displayed at PHC, CHC and District Hospitals. The U-ASHAs should be aware about the existence of the Grievance Redressal System and the processes by which they can communicate grievances.

Main Highlights about the Committee:

- At least 03 of the selected members of U-ASHA would be women in leadership positions or from within academic institutions.
- U-ASHA should be made aware of the existence of the Committee.
- Complaint may be initiated telephonically but should be submitted in writing and a signed receipt of the complaint should be provided to the U-ASHA.
- Written documentation of the Action Taken Report will also be maintained and certified by the members of the Committee. If the officer denies the substance of the complaint, that too has to be recorded.
- The Committee will meet once a month to review the grievances (if received) and action taken.
- The Committee will decide on the appropriate action for commonly recurring grievances.
- Signed receipt of the complaint should be provided to the ASHA. A reply has to be sent within 21 days to the complainant.
- If Complainant is not satisfied with action taken an Appeal can be made to Chairperson of DHFWA or to the Mission Director, National Health Mission (Haryana) or directly to the Chairman, State Health Society (Haryana)

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