ANCHUL (AnteNatal and Child Health care in Urban sLums) INTERVENTION

An intervention directed towards improving work performance of ASHA (Accredited Social Health Activist)

A toolkit for ASHA program implementers

The ANCHUL intervention was developed by the Indian Institute of Public Health-Delhi (IIPH-D), Public Health Foundation of India (PHFI) in collaboration with Delhi State Health Mission (DSHM), based on the existing ASHA program of the National Health Mission , Government of India. The project used principles of implementation research to address gaps and enhance work performance of ASHAs.

This toolkit aims to enable the medical officers and trainers to implement the ANCHUL model for selecting, training and supervision of ASHAs as well as enabling ASHAs to effectively execute their day to day responsibilities in urban poor communities.

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BACKGROUND

MATERNAL, NEONATAL AND CHILD HEALTH (MNCH) STATUS IN URBAN POOR SETTLEMENTS

India accounts for 21% (approx. 15.7 lakh)[1] of global under-five child deaths and 17% (50,000)[2] of all global maternal deaths with a slow progress in improvement of MNCH status. The urban poor fare poorly on MNCH indicators than their rural counterparts and face unique challenges related to MNCH care. These MNCH care issues can be attributed to both demand as well as supply side constraints. Apart from financial insecurity and lack of social support, the other key demand side factors include lack of awareness regarding MNCH care and facilities available for the same. The key supply side factors include inadequate infrastructure and supplies, weak referral systems, suboptimal allocation of resources and lack of coordination among various stakeholders thereby leading to inadequate reach of services among this vulnerable community.

ROLE OF COMMUNITY HEALTH WORKERS (CHWs) IN IMPROVING CONTINUUM OF CARE

The health and wellbeing of women, newborn and children are interdependent and managing it in an integrated manner can lead to improvement in their health status. The continuum of care approach is a seamless and unified continuity of care for women and children through lifecycle (adolescence, pregnancy, childbirth, postnatal and neonatal periods and childhood) and over dimension of care or level of care (household to hospital). It aims at improving the capacity of health workers, strengthening health systems and improving health practices at household and community level. CHWs play an important role in promoting continuum of care by working as a link between the community and the health system, thereby increasing the access to health services.

ASHAs IN URBAN SETUP

The National Health Mission (NHM) has made remarkable achievements in delivery of health care services in rural areas through National Rural Health Mission (NRHM) as evident from reduction in infant mortality rate (IMR), maternal mortality rate (MMR), total fertility rate (TFR), increase in institutional deliveries and complete immunization[3,4]. However, there is an urgent need to address health issues of the urban poor.

The GoI launched National Urban Health Mission (NUHM), based on key features of the pre-existing NRHM, to tackle the health related issues of the urban population. In 2008, Delhi State Health Mission (DSHM) pioneered implementing the ASHA model in the urban areas of Delhi with modifications to the rural model owing to wide differences in access, availability and delivery of health care between these environments. However, specific implementation issues like lack of a structured training, ambiguity in the ASHA support structure including roles of support staff and the ASHAs themselves and ineffective use of a performance monitoring system for program planning and monitoring have led to sub-optimal performance of the program[5].

[1] Who.int. WHO | Trends in Maternal Mortality: 1990 to 2013 [Internet]. 2015 [cited 6 October 2015]. Available from: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/
[2] Ministry of Health and Family Welfare. India Newborn Action Plan. Government of India; 2014 [cited 6 October 2015]. Available from: http://www.newbornwhocc.org/INAP_Final.pdf.
[3] Pib.nic.in. Evaluation of Accredited Social Health Activists (ASHA) [Internet]. 2015 [cited 7 October 2015]. Available from: http://pib.nic.in/newsite/PrintRelease.aspx?relid=116029
[4] Pib.nic.in. Achievements Under The National Rural Health Mission (NRHM) [Internet]. 2015 [cited 7 October 2015]. Available from: http://pib.nic.in/newsite/PrintRelease.aspx?relid=123670
[5] Sixth Common Review Meeting [Internet]. Ministry of Health and Family Welfare, Government of India; 2013 [cited 2 October 2015]. Available from: http://nrhm.gov.in/images/pdf/monitoring/crm/6th-crm/report/Delhi_6th%20CRM_report.pdf

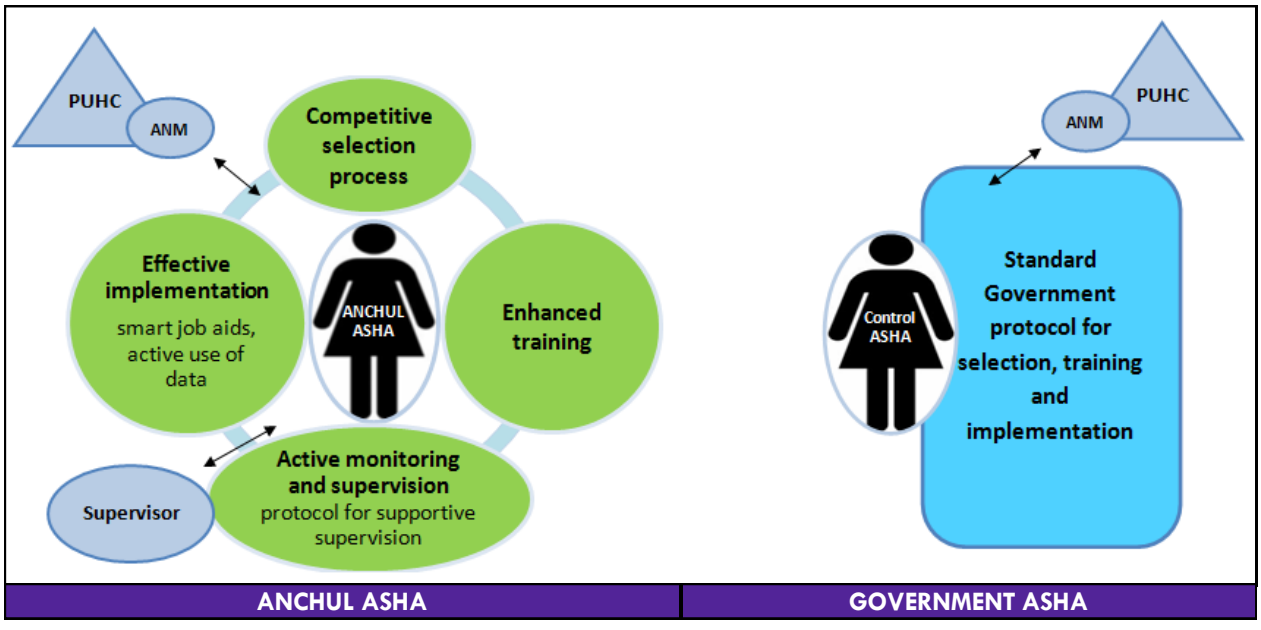
ANCHUL INTERVENTION

The focus of ANCHUL intervention is same as that of Government ASHA program. ANCHUL ASHA focuses on MNCH care along with other health promotional activities. However, the purpose of this intervention was to explore the feasibility of improving the work performance of ASHAs by addressing issues related to their selection, training and supervision as well as enabling ASHAs to effectively execute their day to day responsibilities which may have an impact on MNCH care in the urban poor communities. The various activities performed by the ANCHUL ASHAs are in line with those proposed under NHM and comprise of community based MNCH promotion activities, early referral to heath care services and increase awareness for utilization of institutional care during pregnancy, childbirth, immediate post-partum period, childhood illnesses, family planning measures and other general health promotional activities for the community members.

HOW IS ANCHUL ASHA DIFFERENT FROM GOVERNMENT ASHA?

The various components of ANCHUL ASHA intervention listed below are stepped up processes of the existing Government ASHA program.

- Competitive selection process - Modified to select motivated and competent candidates;
- Enhanced training - Modules that are restructured and presented to the ASHAs in an organized and phased manner to facilitate better assimilation and retention;
- Active monitoring and supervision - A protocol for supportive supervision while introducing a cadre of ASHA supervisors similar to ASHA facilitators;
- Effective implementation - Introduction of smart job aids for day to day execution of voluntary activities of ASHAs and active use of data from community for decision making.



ASHA SELECTION PROCESS

PURPOSE: To identify, select and induct motivated candidates who are willing to volunteer as ASHA in the community

Toolset 1
ASHA selection manual
Nominator's leaflet
ASHA nomination format
Screening booklet, MCQ test
ASHA screening checklist
ASHA training assessment score sheet

Candidates selected

NOMINATION

Nomination committee (3-4 members)

Can be constituted administrative block/area wise

One nomination committee can nominate for 5-10 clusters

Potential Members:
- From health department (MO-IC and ANMs)
- ICDS officials and AWWs
- Individuals from the community like local *Pradhan*, active NGO representative, social worker, religious leader, active *dai* of the area

Who are to be nominated?

Women aged 25-45 years, married/ widowed/ divorced, literate with formal education upto class 10*, belonging to same cluster and community, having good communication skills, willing to volunteer as a social worker, ability to reach out to the community

How do we sensitize the nominators?

One to one meeting or community meeting moderated by MO-IC/ ANM of PUHC

Tool for nomination

2 page nominator's leaflet

Each cluster with a population of 2000

Atleast 3-4 nominated candidates per cluster

SCREENING

Screening and selection committee (3-4 members)

Potential Members:
- MO-IC
- ANM
- ICDS officials
- One community representative from the nomination committee

SCREENING PROCESS

Step 1

Distribution of reading material on maternal and child health to nominees
Tool: A screening booklet
A written test: Administering a Multiple Choice Question (MCQ) test
Selection criteria: Passing marks- Atleast 50% in written test
Candidates to be selected: Atleast 2-3 candidates per cluster

Step 2

Personal interview: 2-3 candidates per cluster selected on the basis of written test will appear for personal interview
Tool: ASHA screening checklist
Candidates to be selected: 1-2 candidates per cluster for training

Step 1

Atleast 2-3 best performing candidates per cluster

Step 2

1-2 most suitable candidates per cluster

TRAINING AND FINAL SELECTION

Training more candidates than positions available

Selecting the best performers as ASHA; in addition to performance those with leadership and managerial skills as ASHA supervisors; rest as backup ASHAs

ASHA/ Supervisor | Back-up ASHA

MO-IC - Medical Officer In-charge; ANM - Auxiliary Nurse Midwife; ICDS - Integrated Child Development Services, NGO - Non-Government Organization

* Educational qualification may be relaxed to 8th class if no suitable person with formal education upto class 10 is available

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TRAINING OF ASHAs

Toolset 2
Training modules
Trainer's manuals
Training aids

PURPOSE: To restructure the training modalities and deliver the training in a phased way with regular refreshers for better retention and reinforcement of knowledge and skills of ASHAs

To provide structured training protocols for the trainers for systematic execution of trainings

The training schedule involves a 10-day induction training followed by 5-6 refresher trainings (allotted duration - 16 days) spread over one year

Induction training - 10 days

1. Using a set of 8 training modules along with 7 trainer's manuals
2. Extensive induction training followed by field orientation which includes 1-day visit to PUHC and referral hospital for rapport building
3. Assessment of participants during training (group work, games, written test etc.)

Refresher training

Timing, frequency and topics of refresher training based on felt needs of the community/ ASHA or as per Government recommendations - Standard modules to be used for this purpose.

Training modules

आशा पुस्तिका 1 - आशा की भूमिकाएं और ज़िम्मेदारियाँ

आशा पुस्तिका 2 - कौशल विकास

आशा पुस्तिका 3 - किशोर स्वास्थ्य और परिवार कल्याण

आशा पुस्तिका 4(a) - प्रसव पूर्व देखभाल

आशा पुस्तिका 4(b) - प्रसव के दौरान और प्रसव के बाद देखभाल

आशा पुस्तिका 5 - नवजात शिशुओं और 5 साल से छोटे बच्चों की देखभाल

आशा पुस्तिका 6 - संचारी, गैर-संचारी रोग और संबंधित स्वास्थ्य कार्यक्रम

आशा पुस्तिका 7 - सूपर्वाइज़र की भूमिकाएं और ज़िम्मेदारियाँ

Trainer's manuals

Manual 1

Manual 2

Manual 3

Manual 4(a)

Manual 4(b)

Manual 5

Manual 6

Training modalities

- Didactic teaching
- Group discussions
- Group activities
- Brainstorming and buzzing
- Role play
- Skill demonstrations
- Field visits (community and health facilities)

Training aids

- Power point presentation
- Chalk board
- Videos
- Live demonstrations
- Games
- Flip books, flip charts, posters

INDUCTING THE ASHAs

PURPOSE: Handholding of ASHAs to orient them to their community and the health system where they would be referring the target population

Induction and handholding phase (Facilitated by ANM and ASHA supervisor)

1. Field visits to the health centres and catchment area
2. Introduction to the cluster, walking through lanes, teaching right hand rule for lane mapping
3. Knowing the area, community and learning to use the map
4. Initiating the household survey

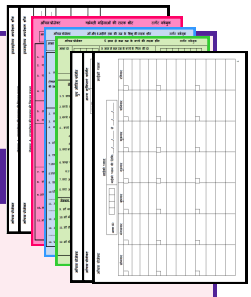
DAY TO DAY EXECUTION OF WORK BY ASHA

Toolset 3
ASHA forms
IEC material
Referral slips

PURPOSE: To support the ASHAs in doing their job effectively and reporting data accurately

1. A **dedicated ASHA corner** (space where ASHAs can interact with supervisor and peer ASHAs)
2. **Household risk profiling** and visit scheduling of target population (pregnant women, mothers who gave birth during the past 6 months, under-5 children) using specific forms
3. Use of **enhanced IEC material** (stickers, brochures and flipbooks) for health promotion and counselling
4. **Community group meetings** using flipbooks
5. **Documenting referral** using referral slips
6. Use of **monthly master calendar*** generated from data entered in data driven decision making (D3M) software# (toolset 5) for micro-planning. The **micro-plan**** is a visit schedule prepared by ASHA for timely home-visitation of target population.
7. **SMS notification** to ASHAs for scheduled visits
8. **Periodic update** of households
9. Deliverable based **incentivization**
10. **Coordination** with various stakeholders including frontline workers of other departments

ASHA Forms



- HOUSEHOLD SURVEY - पॉपुलेशन वर्कबुक
- HOUSEHOLD UPDATE - हाउसहोल्ड अपडेशन शीट
- TARGET GROUP FORMS - टार्गेट वर्कबुक
  - गर्भवती महिलाओं की टास्क शीट
  - माँ और 6 महीने तक की उम्र के शिशु की टास्क शीट
  - 5 साल से कम उम्र के बच्चे की टास्क शीट
- GROUP MEETING - ग्रुप मीटिंग फॉर्मेट
- OTHER SERVICES - अन्य सुविधाएं फॉर्मेट
- MICRO PLAN - माइक्रो प्लान

Flipbooks

- सामान्य संदेश कार्ड
  - भाग 1: गर्भावस्था के दौरान और प्रसव के बाद देखभाल के लिए सामान्य संदेश
  - भाग 2: नवजात शिशु और 5 साल से छोटे बच्चों के लिए सामान्य संदेश
- किशोर स्वास्थ्य और परिवार कल्याण

- प्रसव पूर्व देखभाल
- प्रसव के दौरान और प्रसव के बाद देखभाल
- नवजात शिशुओं और 5 साल से छोटे बच्चों की देखभाल
- संचारी, गैर-संचारी रोग और संबंधित स्वास्थ्य कार्यक्रम

Stickers

- गर्भावस्था के दौरान खतरों के संकेत
- नवजात शिशु में खतरों के संकेत
- शिशु जन्म के लिए सुरक्षित प्रसव की तैयारी
- जननी सुरक्षा योजना

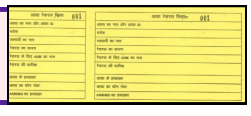
Posters

- बच्चे में वृद्धि और विकास के अहम पड़ाव
- प्रसव कराएँ अस्पताल में
- रखें गर्भवती महिला का ध्यान
- स्तनों की स्वयं जाँच के 5 स्टेप्स
- जन्म के तुरंत बाद देखभाल
- अपनाइये परिवार नियोजन के साधन

Leaflet

- पूरक आहार

Referral slip



IEC - Information Education and Communication

*Master calendar- A list of ASHA's scheduled home visits of pregnant women, mothers who gave birth during the past 6 months, under-5 children for that month

#D3M software developed and validated by ANCHUL team using CS Pro 6.0 software, it is user friendly and requires basic computer configuration for functioning

** Micro plan - A list where she plans her monthly activities according to need, target group's preference and proximity of households of various target population

MONITORING AND SUPERVISING ASHAs

Toolset 4
Supervisory module
Supervisory formats

PURPOSE: To bring clarity and structure to the support system for ASHAs and objective appraisal of their work

One ASHA supervisor monitors and provides supportive supervision to 10 ASHAs

Job responsibilities of ASHA supervisor

1. Monitoring and supportive supervision
   - Involvement during induction and handholding phase
   - Routine handholding of ASHA
     - Monitoring community based activities of ASHA and problem solving on monthly basis
     - Reviewing ASHA's records and suggesting for improvement (if any)
   - Monthly performance appraisal of ASHA by **Head, Heart and Hand (HHH) score**
2. Facilitating monthly review meeting in the PUHC
3. Reporting to MO-IC/ ANMs periodically

In order to facilitate objective assessment of ASHA's performance a scoring system has been developed. There are three components of the scoring system

Head score (Knowledge)

This score denotes the knowledge level of ASHA in relation to her core work area and its application in the community

How to assess?

Monthly knowledge tests

Heart score (Behaviour, Compassion and Communication skills)

This score provides information on the attitude of ASHA, i.e. how well she interacts and communicates with her community, how compassionate she is towards her work and how responsive she is towards the problems of her community

Hand score (ASHAs skills in execution of her work)

This score provides information on ASHA's practical skills, how well she is performing her job. Precision and accuracy in her overall work is assessed using the Hand score

How to assess?

Household Profiling (Accuracy of household survey done by ASHA)

The supervisor to randomly check 10 households of ASHA's area and collect data on Hand score

Monitoring Home Visitation

The supervisor to randomly visit households of pregnant women, mothers who gave birth during the past 6 months, under-5 children every month and collect information on performance assessment indicators, Heart and Hand score

Monitoring Community Group Meeting

The supervisor to randomly attend group meetings of 2 ASHAs every month out of all ASHAs allotted to her and collect information on performance assessment indicators, Heart and Hand score

Pre-planning monthly activities

The supervisor to assess ASHA's responsiveness for her scheduled tasks (Hand score) by using a record sheet. She has to check the master calendar, micro plan and actual visits done by ASHA and score her based on her performance

Indicates head score Indicates hand score
Indicates heart and hand score

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EFFECTIVE USE OF DATA BY ASHA

Toolset 5
D3M software

PURPOSE: Day to day data entry of information collected by ASHA for their performance assessment, self appraisal and incentive calculation

The data driven decision making (D3M)* software can be effectively used for generating reports to assess ASHAs' performance and facilitate their work in the field

ASHAs' reports that can be generated using D3M are listed below

Report	What information it gives?	Used for
Household log sheet	Specific details of all households surveyed by ASHAs in a particular cluster	Home visits and periodic updates of the households in her area
Target population sheet	Specific detail of all the households with target population i.e. pregnant women, women who gave birth during the past 6 months, under-5 children, adolescent girls and eligible couples	Home visits, immunization drives, family planning drives and conducting group meetings
Master calendar	A list containing scheduled home visits (as prepared by ASHAs) for pregnant women, women who gave birth in the past 6 months and under-5 children for a particular month	ASHA would use this list to prepare a micro-plan for her entire month's scheduled visit with a window period of 7 days around the date of visit generated by master calendar
Incentive sheet	A calculation of ASHA's incentives based on her core activities as well as specific activities while she serves the target population and provides other services like referral for cataract etc. to the community	Providing incentives to the ASHAs

Cluster	HHID	Participant Id	Name of Member	Name of HOH	Address	Landmark	Contact Number	HH Member Status
21	21008	2100801	MAHAT RAM YADAV	MAHAT RAM YADAV	C-880	SHIVAS SCHOOL	9811886763	EC
21	21008	2100802	AASHA YADAV	MAHAT RAM YADAV	C-880	SHIVAS SCHOOL	9811886763	EC
21	21008	2100803	MADHOOR YADAV	MAHAT RAM YADAV	C-880	SHIVAS SCHOOL	9811886763	NA
21	21008	2100804	RITU YADAV	MAHAT RAM YADAV	C-880	SHIVAS SCHOOL	9811886763	AG
21	21008	2100805	GOLDI	MAHAT RAM YADAV	C-880	SHIVAS SCHOOL	9811886763	AG
21	21011	2101101	SOMWATI	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	NA
21	21011	2101102	SANJEEV	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	EC
21	21011	2101103	LEELA DEVI	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	EC
21	21011	2101104	SONI	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	NA
21	21011	2101105	KRISNA	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	NA
21	21011	2101106	RIYA	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	NA
21	21011	2101107	PRADEEP	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	EC
21	21011	2101108	PREETI	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	EC
21	21011	2101109	TANISH	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	NA
21	21011	2101110	ANIKET	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	UC
21	21011	2101111	POOJA	SOMWATI	C-877	SHIVAS SCHOOL	9911727349	AG
21	21003	2100301	OMPRAKASH	OMPRAKASH	C-884	SHIVAS SCHOOL	9212870105	NA
21	21003	2100302	MAYA DEVI	OMPRAKASH	C-884	SHIVAS SCHOOL	9212870105	NA
21	21003	2100303	NARENDRA	OMPRAKASH	C-884	SHIVAS SCHOOL	9212870105	EC
21	21003	2100304	POOJA	OMPRAKASH	C-884	SHIVAS SCHOOL	9212870105	EC
21	21003	2100305	NISHITA	OMPRAKASH	C-884	SHIVAS SCHOOL	9212870105	NA

Household log sheet

MASTER CALENDAR							Cluster 21
Date	cluster	asha	partcipantname	hhid	pid	Status	visitname
20150716	21	BB21	KHUSHBOO	21034	2103409	CP	Second Visit after EDD
20150716	21	BB21	VANDANA	21457	2145702	CP	Month 6
20150716	21	BB21	SUMAN	21458	2145802	CP	First Visit after EDD
20150716	21	BB21	AARAV	21443	2144303	U5	3 Month Visit 3
20150716	21	BB21	ABHIRAJ	21442	2144203	U5	3 Month Visit 2
20150716	21	BB21	JOY	21193	2119306	U5	3 Month Visit 2
20150716	21	BB21	ALFAZ	21190	2119008	U5	3 Month Visit 2
20150716	21	BB21	SIDHANT	21456	2145603	U5	3 Month Visit 2
20150716	21	BB21	PALAK	21455	2145503	U5	3 Month Visit 2
20150716	21	BB21	BHAWANA	21205	2120503	U5	3 Month Visit 2
20150716	21	BB21	AAYUSH	21205	2120504	U5	3 Month Visit 2
20150716	21	BB21	AMAN	21193	2119307	U5	3 Month Visit 2
20150718	21	BB21	MADHU	21147	2114702	CP	Second Visit after EDD
20150718	21	BB21	GUDDI	21375	2137504	CP	Month 6
20150718	21	BB21	ANITA	21316	2131604	CP	Month 9 End
20150719	21	BB21	AAYUSH	21348	2134803	U5	3 Month Visit 2
20150720	21	BB21	MUSKAN	21178	2117806	U5	3 Month Visit 3
20150720	21	BB21	SAURAV	21447	2144705	U5	3 Month Visit 3
20150720	21	BB21	FAVIYA	21381	2138105	U5	3 Month Visit 3
20150722	21	BB21	ANJALI	21196	2119604	U5	3 Month Visit 2
20150722	21	BB21	AARTI	21196	2119603	U5	3 Month Visit 2
20150723	21	BB21	KHUSHBOO	21034	2103409	CP	Third Visit after EDD
20150723	21	BB21	SUMAN	21458	2145802	CP	Second Visit after EDD

Master calendar

Several such reports can be generated periodically based on requirement (e.g. no. of women who had an institutional delivery, complete antenatal checkups, complete immunization upto 1 year, etc.)

Also periodic reports can be generated on ASHA performance based on Head, Heart and Hand (HHH) scores

*D3M software developed and validated by ANCHUL team using Census and Survey Processing System (CSPro) 6.0 software, it is user friendly and requires basic computer configuration for functioning

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RECOMMENDATIONS FROM ANCHUL EXPERIENCE

Selection

Nomination - Constituting a nomination committee and use of nominator's leaflet	Better accountability
Screening test - To identify motivated candidates	Better selection
Training - Systematic chapterization and focused sessions Strong emphasis on interpersonal skills (need for specialized trainers on Behaviour Change Communication) Counselling - In-depth training with practice sessions Hands-on-sessions on processes for better quality of data	Better skills of ASHAs
Selection after training - Training more number of candidates and selecting the best performers as ASHAs, those with leadership and managerial skills as ASHA supervisors and the rest as back-up ASHAs	Efficiency in training

Supervision

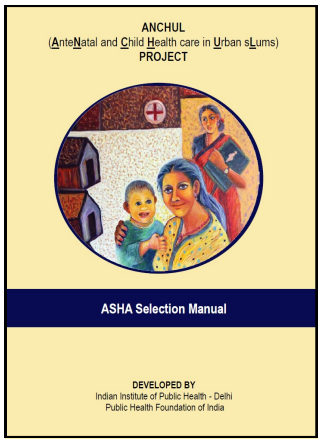
Objective assessment of ASHA using Head, Heart and Hand (HHH) scores Supportive supervision with the help of ASHA supervisor	Better monitoring

Effective use of data

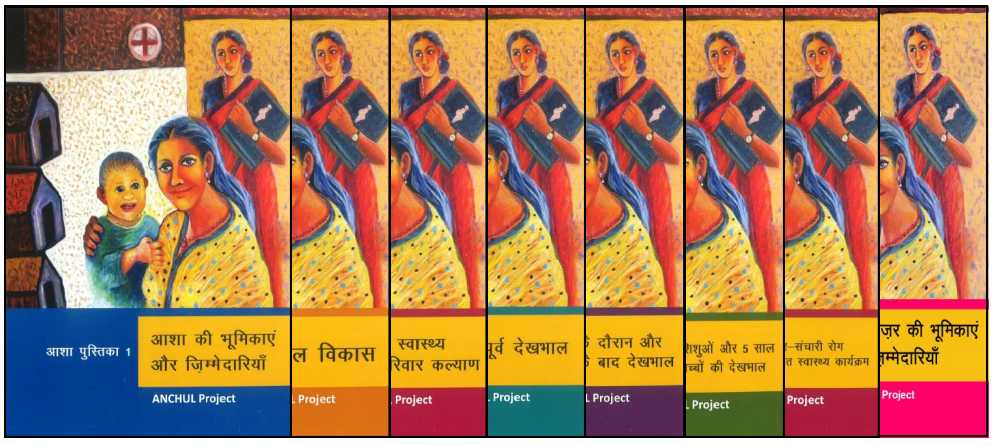
Day to day entry of data into the system and use of data for * Performance assessment * Incentive calculation	Better monitoring, timely assessment, timely payment

Day to day activity

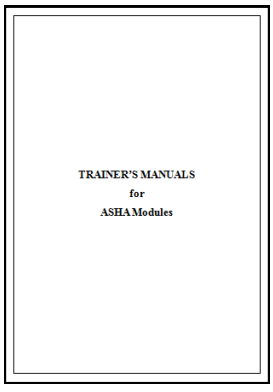
Allocation of space for ASHA corner at PUHC	Better communication, peer support and supportive supervision
Use of enhanced IEC material	Better communication, counselling and knowledge transfer
Community group meetings	Better motivation among target population to avail health services



ASHA selection manual



Training modules



Trainer's manuals

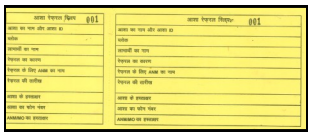
General message card

Flipbooks

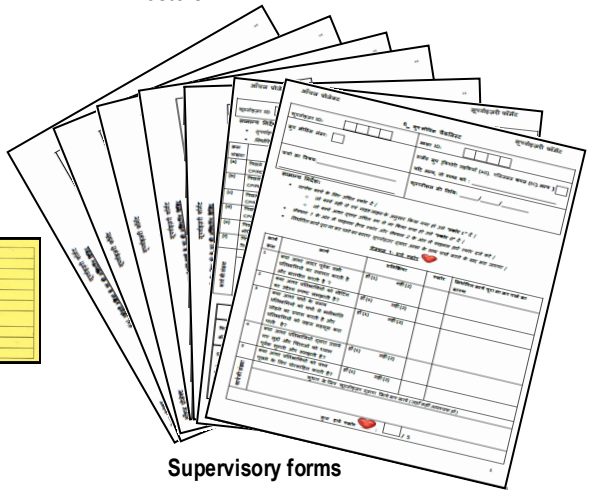
Stickers and leaflet

Posters

ASHA forms



Referral slip



Supervisory forms

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ANCHUL team, Indian Institute of Public Health-Delhi, PHFI

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