

# Planning, Implementation and Effectiveness of ANCHUL (AnteNatal and Child Health care in Urban slums) intervention

This policy brief is prepared by the ANCHUL project team at Indian Institute of Public Health-Delhi, Public Health Foundation of India

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## Background

Maternal, Neonatal and Child Health (MNCH) is a public health priority as it represents the well-being of a society and its potential future. India accounts for 21% of global under-five child deaths<sup>1</sup> and 17% of all global maternal deaths<sup>2</sup>. Continuum of care for women and children through lifecycle and at various levels of care aims at improving capacity of health workers, strengthening health systems and improving health practices at household and community levels<sup>3,4,5</sup>. The Community Health Workers (CHWs) play an important role in promoting continuum of care by working as an interface between the community and the health system, thereby strengthening the access to health services<sup>6</sup>. The status of MNCH and care provision among urban poor shows a significant disparity when compared to non-poor or urban average. There also exists a similar difference among the various strata of urban poor. These disparities can be attributed to both demand as well as supply side constraints. Apart from financial insecurity and lack of social support among urban poor, the 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. Recognizing the state of poor health service provision and utilization due to low demand and poor utilization of health services in urban slums, the Government of India (GoI) launched National Urban Health Mission (NUHM). This mission is based on key features of the pre-existing NRHM which has been successful in delivering safe services to mothers, infants and children through a team of rural health workers and ASHAs (Accredited Social Health Activist). In 2008, Delhi State Health Mission (DSHM) pioneered implementing the ASHA model in the urban areas of Delhi with modifications to the rural model



### Why is this policy brief prepared?

This policy brief is prepared to summarize the evidence on the effectiveness of ANCHUL project in addressing the gaps in the current ASHA program through use of simple processes and tools that can be adapted within the current health system

### Who is this policy brief prepared for?

Policy makers, program implementers, medical officers, program support staffs implementing ASHA program and those who are interested in scaling up similar kind of programs

### This evidence based policy brief includes

- Conceptualization and components of ANCHUL ASHA intervention
- Its implementation
- Findings of its evaluation
- Key recommendations for the policy makers

owing to wide differences in access, availability and delivery of health care between these environments. However, specific implementation issues affecting the performance of ASHAs that relate to their training, supervision and retention have been identified with the urban model.

ANCHUL intervention was thus conceptualized to address the gaps identified in the current ASHA model and design a remodelled ASHA program for the urban slum community in collaboration with Delhi State Health Mission (DSHM). In order to ensure acceptability of the processes suggested in the current model, the ANCHUL research team adopted principles of Implementation Research (IR). This method identifies optimal approaches for a particular setting, and promotes the uptake of research findings while addressing implementation gaps in a program<sup>7</sup>.

## Aims and objectives of ANCHUL project

To develop, implement and evaluate the effectiveness of a complex intervention package to improve work performance of ASHAs in urban slums of Delhi that would lead to increase in access to institutional deliveries and improve maternal, neonatal, child healthcare knowledge and practices.

### Objectives

- To develop a complex intervention targeted towards ASHAs working in urban slums of Delhi with improved processes that can enhance their work performance.
- To assess the impact of the improved processes of the program in work performance of ASHA.
- To evaluate the effectiveness of intervention in increasing institutional delivery in urban slums and improving maternal and child health care knowledge and practices.
- To provide recommendations to the policy makers to scale up this intervention and provide methods of monitoring.

## ANCHUL Intervention

**The ANCHUL intervention has a specific focus on selection, training, monitoring and supervision of ASHAs with smooth execution of their day to day activities using job aids and effective use of data.**

A formative research that involved a situational analysis, informal discussions with the stakeholders and review of relevant documents related to ASHA program was conducted. The intervention was then designed by an iterative process while engaging with a wide range of stakeholders including the policy makers, program implementers at DSHM and Medical officers in the

health system. The emphasis was to understand the key gaps in the program and develop a context specific intervention directed towards the ASHAs. Hence, ANCHUL intervention is based on existing components of ASHA program with modified processes.

### The key processes of the program that were modified included:

#### Selection

- Nomination of candidates by a committee using nomination guidelines
- Screening of participants using an screening test and interview
- Selection of ASHAs after completion of training leading to a team of back up ASHAs

#### Training

- Restructured training modules with accompanying trainer's manual for better assimilation and retention of information by ASHAs
- Skill based training
- Specific training to develop interpersonal and counselling skills
- A supervisory module
- Intense induction training and flexible need based refresher trainings

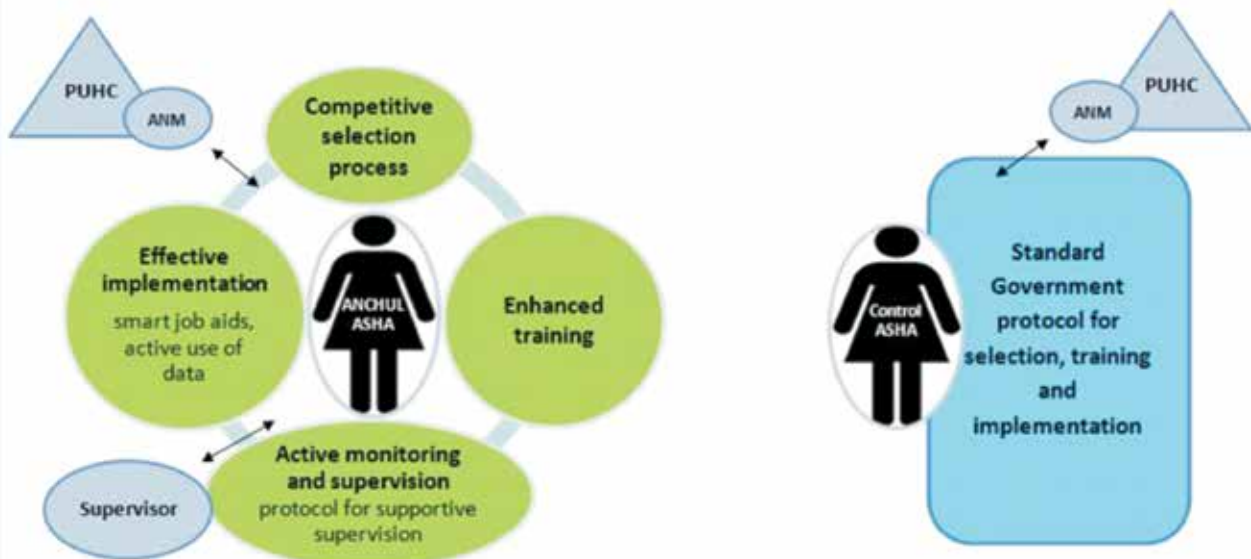
#### Supervision and monitoring

- A cadre of supervisors (ASHA facilitator) with clear cut job description and training
- Handholding of ASHAs and confidence building
- Supportive supervision and problem solving
- Objective periodic assessment of ASHA work performance (head score: knowledge; heart score: compassion and attitude towards work; hand score: practical skills in executing job responsibilities)

#### Facilitating execution of day to day activities with job aids and effective use of data

- Allocation of a dedicated ASHA corner at the health centre for meetings, supervisory activities and informal discussions
- Scheduling and conducting home visits using micro plan
- Conducting group meetings on key topics
- ASHA message cards, flip books, stickers, posters
- Regular update survey of households
- Forms and formats to monitor crucial indicators
- Data Driven Decision Making (D3M) Software
  - Day to day data entry and report generation to assess performance and linking with incentives
  - Master calendar and micro planning sheets for scheduling visits
  - SMS alerts to ASHAs before scheduled home visits

## Salient differences between ANCHUL ASHA and the Government ASHA model



### Evaluation of ANCHUL intervention

The effectiveness of ANCHUL intervention was evaluated using a quasi-experimental design in collaboration with DSHM. Catchment area under two Primary Urban Health Centres (PUHCs) namely Sangam Vihar (B-block) and Lalkaun, located in south-east district of Delhi with no ongoing ASHA program were assigned by DSHM for the study. ASHAs under Sangam Vihar (B-block) PUHC were exposed to the ANCHUL intervention while ASHAs under the other PUHC acted as control and were exposed to standard Government ASHA program. A total of 18 ASHAs along with 2 supervisors (supervisors also had coverage area like individual ASHA apart from their supervisory duties) and 19 ASHAs were recruited, trained, inducted and assessed in intervention and control arm respectively, with coverage of 9774 households in intervention area and 8014 households in control arm area. Quantitative methods were adopted at the community level with a focus on pregnant, recently delivered women and mothers of under 5 children to assess the effectiveness of the model. Qualitative enquires were done at health system's level, community level and with the recruited ASHAs to understand the barriers and facilitators to effective implementation of the model.

### Key findings

- **ANCHUL model** that included a modified selection process, training modalities, supervisory structure for ASHAs, smart job aids and effective use of data were piloted in real life settings in the intervention area and **was found to be feasible**. A user friendly tool kit has been developed for dissemination and uptake of the model by the implementers.
- The **presence of ASHA** in both the areas under the study **had an immense impact on MNCH knowledge**

transfer, care practices and utilization of health care services.

- **The ASHAs in the intervention area could facilitate a significantly higher knowledge transfer and percolation of key messages** on MNCH care in the community especially among the target population as compared to the control area.
- The **recall of key messages** on antenatal and postnatal care among respondents in both areas was higher with increase in number of home visits by ASHAs.
- **The compassion score** (in terms of how well ASHA interacted with the community, how compassionate she was towards her work and how well she responded to the community needs) and **performance indicators** (like home visits) as reported by the respondents **were significantly higher for the intervention ASHA** as compared to the control ASHAs.
- There was a **compelling felt need for ASHAs** by the community in both areas.
- The need for ASHA was clearly evident as **the MNCH care utilization indicators improved in both the areas** from baseline. **The complete immunization coverage in under 5 years old children was 2 folds higher in control area and 1.5 folds higher in intervention arm** from the baseline.
- **Significantly higher** number of mothers in the **intervention area went to health facility for seeking post natal care**.
- The qualitative enquiries with ASHAs **highlighted the key motivating factors** for ASHAs to work in their community were **social recognition, self-identity, job satisfaction and acquisition of new knowledge and skills**. The **key facilitating factors** for them to work as health workers **were family support and flexible work modalities**.

- The **major barriers** to ASHAs' work performance were **negative experiences while working in the community** due to initial non-recognition of ASHAs as a health cadre, **lack of support** from their **own families, health system's constraints** and **delayed payment** of incentives.
- Women in the community underscored the importance of **ASHAs as a reliable and easily accessible source of information** on maternal and child health issues. The community members also reported that **ASHAs' guidance helped save time and money** through reduced waiting times at the health care facilities and through appropriate referrals.
- The assessment of both PUHCs at three time points in 18 months indicated inadequate human resources in intervention area PUHC while irregular and insufficient supply of medicines, vaccines and laboratory supplies was observed in both the PUHCs. However, the infrastructure in the both the PUHCs was as per the Government standards.

## Key recommendations for policy makers

1. There is a **definite need for ASHAs** to facilitate linkage between vulnerable community in urban areas and the health facility
2. A space dedicated as **ASHA corner** (a place where ASHAs can interact) should be planned while setting up a PUHC
3. During **selection process**, a functional **nomination committee** with clear set of nomination guidelines could be constituted for better accountability
4. The selection process could include a **screening test** in addition to the interview for identification of motivated candidates who are willing to learn on the job
5. **Training more candidates than** number to be **selected** and final selection after training will lead to a pool of back up ASHAs
6. **The induction training** could be a comprehensive 10 day training with emphasis on skill development of ASHAs with focus on interpersonal communication and counselling skills and hands-on session for better data quality
7. **The components of refresher training** could be on need basis with topics selected on community health needs or skill needs of ASHAs
8. **A supervisory cadre** could be included in the current program who are given skill based training using ANCHUL supervisory module
9. **The cadre could provide supportive supervision** and do an **objective assessment of ASHAs' performance** using head, heart and hand score generated from supervisory forms and formats
10. **The D3M software** for use of data collected by ASHAs for their performance appraisal and incentive calculation may be merged with existing HMIS. This will however require **full time data entry staff** per PUHC OR eventual shift to **electronic data capture**
11. **Community group meetings** by ASHAs could lead to better awareness and uptake of services in the community
12. The **ANCHUL job aids** can be used for strengthening the performance of ASHAs in the field
13. **Sensitizing the family members of the ASHAs** regarding the value of their work through occasional meetings at the local health centre **would help ASHAs increase their availability** for the community
14. **A simultaneous health system strengthening** is required to **ensure that the increased demand** for health services generated by the ASHAs can be adequately met thereby making the **ASHA model efficient and effective** and ensuring the **community's trust on ASHAs**
15. This **feasible ANCHUL intervention model can be scaled up** to more number of PUHC to assess its effectiveness

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