THREE

3

Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

SUKSHEMA'S COMMUNITY LEVEL INTERVENTIONS

Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit: Sukshema's Community Level Interventions is the third module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

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SUKSHEMA'S COMMUNITY LEVEL INTERVENTIONS

ಸುಕ್ಷೇಮ
sukshema
Improved Maternal, Newborn & Child Health

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

PREFACE

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 3: Sukshema's Community Level Interventions is aimed at Resource Persons (RPs) to provide an overview of the community level interventions planned under the Sukshema project. Enhancing communication is highlighted in the family focused communication intervention and the enumeration and tracking intervention seeks to bridge the gaps that occur in the Maternal Neonatal and Child Health (MNCH) continuum of care. Two other tools are introduced: one to improve the quality of interaction during home based care, the Home Based Maternal Newborn Care (HBMNC) Tool; and the other to enhance planning, accountability and monitoring of health service delivery through the Supportive Community Monitoring (SCM) Tool. This module also gives participants the opportunity to clarity roles and responsibilities of a number of field level workers in the Sukshema project and in the Government of Karnataka (GoK) health service.

CONTENTS

ACRONYMS

ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARS	Arogya Raksha Samitis
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BPL	Below Poverty Line
CBO	Community Based Organization
CDL	Community Demand List (CDL1) Tool
DOH	Department of Health
EDD	Expected Date of Delivery
ETT	Enumeration and Tracking Tool (ETT1)
FLW	Frontline Health Worker
FP	Family Planning
FRU	First Referral Unit
GoK	Government of Karnataka
HBMNC	Home Based Maternal Newborn Care
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
JSY	Janani Suraksha Yojana
JHA	Junior Female Health Assistant
KHPT	Karnataka Health Promotion Trust
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
PRI	Panchayat Raj Institution
RP	Resource Person
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
SCM	Supportive Community Monitoring
SHRC	State Health Resource Centre
SHS	State Health Society
SRS	Sample Registration System
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHW	Village Health Worker
VHSNC	Village Health and Sanitation Nutrition Committee

GETTING STARTED

The Doorway to Successful Training **in Part 11 of Module 1** should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. The Doorway to Successful Training contains a detailed plan of sessions that sets the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

SESSION 1: UNDERSTANDING SUKSHEMA'S COMMUNITY INTERVENTIONS

Objective

- To help the participants understand the Sukshema project's MNCH interventions package as a whole.
- The circles of influence

Methodology

Discussion and group work

Duration

1 hour

Training Materials

Markers and brown sheets/ chart paper

Tips for facilitators

The circle of influence starts with family members including mother, father, husband, mother-in-law, father-in-law, grandmother, etc., but extends much further than the family. It reaches to the village elders, such as caste leaders, sanghas, Panchayat members, and then to community structures, such as the PHC and SC. Participants will need help to understand the extent of these influences on a woman's health making decisions. They will also need to see the link between the interventions as a whole, although they will be implemented separately in the Sukshema project's MNCH intervention.

Process

1.1 CIRCLES OF INFLUENCE

- Ask the participants, 'Who has the most influence on a woman's health making decisions?'
- Encourage them to come up with ideas. Ask probing questions until you get some responses.
- Note their responses on a flip chart.
- Ask if other people, groups and institutions also have an influence on woman's health making decisions?
- Probe further and ask who are the main influencers at the village level are.
- Tell them that in addition to all the influences they have listed, there are also larger influences such as religious leaders, media, political leaders/ policy makers and customs and traditions.
- Tell them that all these people/institutions at different levels have the power to influence MNCH related opinions and decisions both positively or negatively.
- Display the 'Circle of Influence' diagram at the front of the training room.

- Tell the participants that woman and child's health is determined by various factors beyond just medical factors.
- Start at the inner circle and explain that many external forces determine a woman's health making decisions or her ability to make those decisions.
- Working with all these different circles of influence is important to support both mothers and children.
- Divide the participants into five groups.
- Assign each group a 'circle' in the Circle of Influence and ask them to discuss what they could do to get support for mother and child access to MNCH continuum of care services.
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to share their main discussion points.
- Ask other groups to share any other key information.
- Introduce the Sukshema project's MNCH interventions. These focus on the first three 'circles': the family, the FLWs and Community Structures:
  - Family focused communication – to address the family 'circle'.
  - Enumeration and tracking using the Community Demand List (CDL) Tool – to address the FLWs 'circle'.
  - Home Based Maternal Neonatal Care (HBMNC) Tool - to address the FLWs 'circle'.
  - Supportive Community Monitoring (SCM) Tool - to address the community structure 'circle'.
  - Arogya Mantap – to address all three 'circles'.
- Consolidate the main points of Session 1:
  - The focus of the community interventions is to build the skill of the FLWs and help them work better with the mothers, children and their families. The tools will enhance the skills, guide and improve the quality of work of the FLWs, which in turn will help enhance MNCH outcomes.
- Tell the participants that in the following sessions they will learn more about each of these interventions and how they are linked.

SESSION 2: ENHANCING COMMUNICATION AND COORDINATION USING FAMILY FOCUSED COMMUNICATION

Objective

- To help the participants understand the concept and importance of family focused communication
- To understand how gender and family influence the behaviour of pregnant women

Methodology

Role play, group work and discussion

Duration

2 hours

Training Materials

Markers and brown sheets/ card sheets

Tips for facilitators

This session highlights the family focused communication (FFC) intervention. It will help FLWs understand that the family is a very crucial component of gaining access to the MNCH continuum of care and to help them improve their communication skills. FLWs must understand why conveying MNCH messages to the pregnant woman alone will not be enough, but that they must involve key family members for the intervention to successful. They must also understand the concept of gender and how gender norms can influence a pregnant woman's health making decisions. For the role play, the facilitator could develop a script for each actor and give it to the volunteers ahead of the session so they could practice before performing.

Process

2.1 FFC COMMUNICATION

- Ask 6 participants to volunteer to act out the following role play. Tell them to make their own dialogues and develop the role play using their own experiences from the field.

  A woman is 8 months pregnant. The ASHA visits her house to tell her about the importance of institutional delivery and about birth preparedness. When the ASHA reaches her home, the mother-in-law refuses to let her in and tells a lie that the woman is sleeping. The ASHA takes the JHA along with her the next day to meet the same woman. This time the pregnant woman opens the door and looks scared and uneasy at the ASHA and JFA. They tell her about institutional delivery and birth preparedness. The woman refuses and says she is not interested and that she will deliver at home. The FLWs try to convince her. They ask her why is she not interested. After much probing the woman confesses that her grandmother is very against institutional delivery. The ASHA and JFA don't know what to do. They go back and discuss together. They decide to talk to the grandmother alone the next day. After much opposition, the grandmother agrees to hear them. They try to explain about the advantages of institutional delivery. After they finish, the grandmother tells that she has given birth to 10 children in her house and she doesn't need to be told anything. She asks the ASHA and JFA to leave without paying heed to their words.

- Ask the volunteers to present the role play for all other participants to watch and listen carefully.
- After the role play ask the following questions and discuss:
  - What happened in the role play?
  - What stopped the woman from making her own independent decision?
  - Who influenced her decisions?
  - Was the communication by the FLWs proper?
  - Did it result in making the right decision in favour of the woman?
  - Did it address the woman alone or the family?
  - What could have been done to make the communication more effective?
  - What can we learn from this role play that can be used in our intervention?
- Ask all the participants to share similar experiences that they know of in their families or in the course of their field work.
- Consolidate the role play and discussion:
  - A woman is not empowered to make her own decisions in our current rural context because of power issues.
  - A female is taught to be subjected to the decisions of elders in the family.
  - Decision makers are usually the men and the other powerful figures of the family.
  - Therefore, working only with the woman in isolation will not achieve access to the MNCH continuum of care services.
  - Communication with the entire family is key for behaviour change

- Divide the participants into three groups and give each of them one of the following situations:
  1. *The husband of a family living below the poverty line (BPL) is refusing to let his wife go for family planning. She is pregnant with her fourth child and has three daughters. What will your communication message be, for whom and using which method?*
  2. *The mother is not allowing her pregnant daughter to take iron and folic acid pills for fear that baby will become dark. The mother is illiterate. What will your communication message be, for whom and using which method?*
  3. *The woman does not want to breastfeed the baby because her mother-in-law has warned her that if she does then the baby will be cursed. What will your communication message be, for whom and using which method?*

- Allow 15 minutes to discuss and develop a communication message. Ask a representative from each group to take 5 minutes to share their message.
- Ask other groups to comment.
- Tell the participants that the FLWs need the skills to assess the situation, know whom to focus on, design an appropriate communication message, and communicate it effectively with a positive impact.
- The FFC intervention will train FLWs to communicate effectively using appropriate tools such as flipcharts, picture cards and other innovative methods.

2.2 FFC COORDINATION

- Ask the participants who the three key groups of FLWs are:
- Display a flip chart divided into three columns at the front of the training room.
- Note their responses in the first column of the flip chart.
- Ask them to define the duties of each of these groups: the ASHAs, the JFAs and the AWWs.
- Note their responses in the second column of the flip chart.
- Ask them how these three groups coordinate their work in the field.
- Note their responses in the third column of the flip chart.
- Ask them to share their perceptions and experiences, both positive and negative, on the nature of coordination between the three FLWs.
- Tell them that the FFC encourages the three FLWS to work together to achieve the same objective. Avoiding duplication and enabling data sharing can improve the quality of service delivery in the field.
- Consolidate the main focus areas of the FFC:
  - Family
  - Communication
  - Coordination between front line workers
- Details on the FFC intervention will be further explained in Module 4 of the Tool Kit, 'Communication and Collaborative Skills for Front Line Health Workers'.

SESSION 3: THE AROGYA MANTAP- PROVIDING SPACE FOR COLLABORATION AND DISCUSSIONS

Objective

- To let participants know about Arogya Mantap's role and activities in providing a collaborative forum for FLWs

Methodology

Brainstorming and discussion

Duration

30 minutes

Training Materials

Markers and brown sheets/ card sheets

Tips for facilitators

The *Arogya Mantap* is an activity of the Sukshema project to build a collaborative forum at the SC level. It offers space for all the FLWs and the VHSNC members to come together to discuss common issues and generate solutions. Engage the participants in brainstorming and discussions so that they will understand the concept of the *Arogya Mantap*, the need for this platform, and its importance.

Process

- Ask the FLW participants (ASHAs, JHAs or AWWs) to imagine they are working in a SC area.
- Ask them to think of one important thing they wish they had to work better and be more effective. For example, for a teacher might say, I wish I had the support of parents to ensure that all children come to school.
- Note their responses on a flip chart.
- Tell the group that in the field they need a space or a platform where they can meet together to share and discuss their work, as well as their personal lives so they can understand each other's issues and concerns.
- Tell them that in order to fill this gap, a forum called the Arogya Mantap has been developed where all the ASHAs, JHAs and AWWs, as well as VHSNC members in each of the SCs where there is an Arogya Mantap, can meet once a month. They can discuss the challenges they face in their work as well as enjoy a time of fellowship, perhaps planning entertainment activities.
- Meeting regularly in this forum will help them stay motivated and connected so they can function more effectively as a group.

SESSION 4:
BRIDGING GAPS IN THE MNCH CONTINUUM OF CARE THROUGH ENUMERATION AND TRACKING

Objective

- To help participants understand the usefulness and importance of enumeration and tracking using the Community Demand List (CDL) Tool in outreach work

Methodology

Case study, small group discussion, plenary presentation and discussion

Duration

1 hour and 30 minutes

Process

- Give one of the case studies to each of the five groups.

Training Materials

Copy of case studies, markers and brown sheets/ chart paper

Tips for facilitators

This session does not deal with the details of the Community Demand List (CDL) Tool, but helps the participants understand the concept of why the tool was developed and how it will help the ASHAs in the field to help all women access the MNCH continuum of care services.

Case 1:
The population of Herur village of Gangavati Taluk is around 1000, including 15 pregnant women. Nine of them work under a contractor. The contractor took these nine pregnant women to Rampura village for 15 days for some work. Five out of them are due for the first dose of Tetanus Toxoid (TT) injection and four of them are due for a booster dose of TT. In this situation, how should ASHA from Herur village ensure that all the pregnant women receive the TT injections as per the schedule?

Case 2:
A group of five to six migrant families returned to Mallapur from Mangalore. Three pregnant women are part of this group. One of them is in the first trimester and the other two are in the third trimester. One of them has a 10 year old child. None of these women are registered. What can the ASHA do to ensure that these three women receive the care that needs to be given at this period?

Case 3:
There are a total of 10 pregnant women in Bennur village. Four of them are due for delivery this month. While two of these four have registered in private hospitals, the other two have registered in the government hospital. All four have gone to hospital without any birth preparedness. What can the ASHA do to ensure they receive PNC services?

Case 4:
The findings of a survey conducted in Alvandi village on immunization found that out of the 16 children who had completed their first year, only 10 had received a complete package of immunizations. How will the ASHA ensure that all the children from Alvandi village are completely immunized?

Case 5:
In Mahalingpura village 10 women have recently delivered. How will ASHA ensure that all of them get complete PNC services?

- Ask group members to read the case study in the group, discuss and answer the question in each case study.
- Allow 15 minutes for discussion, then ask a representative from each group to take 5 minutes to read out their case study and share their responses to the case study's question.
- Ask other groups to share any other key information about the case study.
- Continue with the next 4 case studies in the same manner.
- Highlight that the ASHA is the main point of reference and link between women and the service providing facility.
- Ask the participants if a village had 1000 people with an ASHA in place and there were 25 pregnant women would all the pregnant women receive all MNCH services in the continuum of care?
- Note their responses on a flip chart.
- Ask them to share and discuss from their own experiences of working in the field.
- Consolidate the discussion by pointing out:
  - Pregnancy and delivery are very normal events.
  - Most of the women deliver normally without any problems, but other women and newborns are at risk for morbidity and mortality because they don't know about or have access to all MNCH services in the continuum of care.
  - If a pregnant woman misses even one service in the MNCH continuum of care, the continuum is broken.
  - Many times ANC registration is done so late that more than 50 % of MNCH services are not provided.
  - It is crucial that 100 % of ANC registration is done and continuum of care is given to all pregnant women without any gap.
  - Every woman needs information about services and access to ALL services on time and that the ASHA is responsible for this.
- Tell the participants that the following gaps have been noted in the field:
  - Some of the ASHAs don't recognize the importance of the "MNCH continuum of care" concept.
  - Some are unaware of all the MNCH continuum of care services and the timing of the services.
  - Some have no effective tools to support them in their outreach. Though they have many registers they do not have a means of identifying where the gaps exist and following up all the women in their area.
- Ask participants what the solution could be to fill in the gaps in the continuum of care?
- Note their responses on a flip chart.
- Ask them to share and discuss from their own experiences of working in the field.
- Consolidate the discussion:
  - ASHAs should be supported to build their capacity in knowing about the MNCH continuum of care services
  - ASHAs should be provided with tools that can help them plan their outreach in her area to ensure 100 % registration and 100 % continuity in MNCH care services to avoid any gaps.
- Tell the participants that the Community Demand List (CDL) Tool has been developed to plan and monitor their outreach. The tool:
  - Provides an overall picture of all women in a specific area to allow the ASHAs to enumerate and track them.
  - Shows who should be given what services and when the next service is due.
  - Maintains a record that shows the percentage of coverage.
  - Identifies gaps, analyses reasons for gaps and suggests solutions.
- The ASHAs will be trained to use the CDL Tool by the RPs.
- The CDL Tool will be explained in detail in Module 5 of this Tool Kit.

SESSION 5:
IMPROVING THE QUALITY OF INTERACTION IN PROVIDING HOME BASED MATERNAL, NEONATAL AND CHILD CARE

Objective

- To help the participants understand the concept, importance and usefulness of the Home Based Maternal, Neonatal and Care (HBMNC) Tool in monitoring the mother and newborn.

Methodology

Small group discussion and presentation

Duration

1 hour

Training Materials

Markers and brown sheets/ card sheets

Tips for facilitators

ASHAs have the important task of visiting women throughout the perinatal and post-natal period to seek information from the mother and the newborn that can help her screen them for any complications. The HBMNC Tool is an important tool to help the ASHA monitor them and to communicate the right messages at the right time.

Process

- Ask the participants what is the main responsibility of the ASHAs?
- Note their responses on a flip chart.
- Ask them to share and discuss the reasons and responsibility of visiting homes from their own experiences of working in the field.
- Note their responses on a flip chart.
- Consolidate the discussion by pointing out:
  - Doing home visits is the ASHAs key responsibility.
  - It is a crucial platform for communicating with the woman and her family during the MNCH continuum of care
  - One of the main aspects of a home visit is to check the condition of the woman during ANC and her child during PNC and suggest appropriate services and practices and steps to ensure that they are healthy.
- Ask the participants how home visits are conducted currently in the field and what the gaps are?
- Note their responses on a flip chart.
- Ask them to share and discuss the identified gaps.
- Highlight the gap of communication: either what to communicate or how to communicate.
- Tell the participants that for ASHAs to communicate well, they need to first understand all the aspects of the MNCH continuum of care thoroughly and to know the right messages at the right stage:
  - **Antenatal care** – care during pregnancy
  - **Intra-natal care** – care during the delivery and first two hours after the delivery
  - **Postnatal care** (Mother and newborn) – care during the first 42 days
  - **Child care** – care of the child up to 5 years of age.
- Tell them that the HBMNC Tool has been designed to address gaps in communication to help the ASHAs improve the quality of their interactions during home visits and help them plan interventions in cases where the health of the mother or newborn is at risk.
- Consolidate that the HBMNC Tool is essential in maintaining a detailed record of every woman and newborn across the MNCH continuum of care. It can guide the ASHAs on what to be looking for during each stage and helps them develop the right message at the right time: informing women and their families about high risk pregnancies, danger signs during ANC, delivery and PNC periods, and healthy practices in newborn care.
- The ASHAs will be trained to use the HBMNC Tool by the RPs.
- The HBMNC Tool will be explained in detail in Module 6 of this Tool Kit.

SESSION 6:
ENHANCING ACCOUNTABILITY THROUGH SUPPORTIVE COMMUNITY MONITORING

Objective

- To help the participants understand the concept of Supportive Community Monitoring (SCM)
- To help the participants understand the responsibility of the community to ensure the adoption of healthy behaviours and improve access to available services by women and family members and the community's responsibility to support the FLWs to be effective in the field.
- To inform the participants about the Supportive Community Monitoring (SCM) Tool.

Methodology

Discussion and group work

Duration

2 hours

Training Materials

Brown sheets and markers

Tips for facilitators

The focus of the session is to enable the participants to critically think about the concept of supportive community monitoring and its relevance to improving MNCH and general health status of the village. Some of the participants may not have worked with grass root community structures and might find this concept new. Take time to discuss and help them understand the role of the community to enhance health outcomes at the village level.

Process

- Give one of the case studies to each of the four groups.

Case 1:
Repeated efforts by the ASHA and JFA have not been successful in convincing Ramappa to register and bring his wife for check-ups at the PHC despite it being her first pregnancy and she being underweight. Every possible attempt was made using communication materials, discussions with family members and even bringing the Medical Officer to their house. He refuses and accuses the FLWs that they force women only 'to fill their pockets'. What can be done?

Case 2:
In Mudhol village, 3 maternal deaths have happened recently. This village is known for child marriage, which is believed to be a traditional practice. FLWs have failed to convince families about the dangers of marrying a girl before she is 18. Early marriage leads to early pregnancy and delivery related complications. What can be done?

Case 3:
The Girinagar PHC has not received any Madilu kits for the past 6 months from the GoK and the women are demanding that they receive the kits. The villages are blaming the ASHA for this. What can be done?

Case 4:
An SC/ST woman in Kavalur village is highly anaemic. She is pregnant with her first child and her husband has alienated her. Her family has refused to accept her back into the house and she lives alone in a hut with no means to feed herself. Her earning as a daily wage labourer is very low. She needs a blood transfusion to save the life of the baby. It will cost her 1500 Rs. What can be done?

- Ask group members to read the case study in the group, discuss and answer the question in each case study.
- Allow 15 minutes for discussion, and then ask a representative from each group to take 5 minutes to read out their case study and share their responses to the case study's question.
- Ask other groups to share any other key information about the case study.
- Continue with the next 3 case studies in the same manner.
- Highlight any solutions that involve the villagers/ village heads/ Gram Panchayat members to resolve the case study problems.
- Tell them that the larger community has a very crucial role to play in ensuring the general health status of a village, but that very often this role is undermined.
- Ask the participants that if they agree that the community plays a crucial role in reducing maternal and child morbidity and mortality in rural villages and how this source of help can be improved?
- Note their responses on a flip chart.
- Ask them to share and discuss their own experiences of working in the field.
- Highlight any answers that involve the Village Health Sanitation and Nutrition Committee (VHSNC). Make sure all participants know about the committee and its role.
- Tell them that the NRHM has recognized the importance of community participation and involvement in maintaining the health of the village and have constituted the VHSNC to be in charge of offering support to all health related activities at the village level.
- One of the crucial roles of VHSNC is to support the efforts in reducing maternal and infant morbidity and mortality at the village levels.
- They can do this by supporting the efforts of the FLWs using supportive monitoring of MNCH continuum of care activities in the field.
- Divide the participants into two groups. Give each group one of the following questions to discuss:
  - What does supportive monitoring mean? What activities could it involve?
  - How can the VHSNC do supportive monitoring?
- Allow 15 minutes for discussion. Ask a representative from each group to take 5 minutes to share their answers.
- Ask the other group to contribute any other key information about that question.
- Consolidate the session saying that the key to effective community monitoring is "supportive" monitoring, not supervising. The spirit behind the intervention is 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'. Community feedback on the status of functioning of the healthcare system and service providers can facilitate corrective action and enhance accountability to the community among health care providers and community structures.
- Tell the participants that the SCM Tool has been designed to help the VHSNC members to assess the gaps in the field regarding access to and delivery of MNCH services across the continuum of care. It will then help them to strategize on what steps should be taken locally to address the gaps. Monthly use of the SCM Tool will help them understand the areas where they need to support the FLWs.
- The VHSNC members will be trained to use the SCM Tool by the RPs.
- The SCMT will be explained in detail in Module 7 of this Tool Kit.

SESSION 7: STAFF STRUCTURE, ROLES AND RESPONSIBILITIES AND DRAWING-UP AN ACTION PLAN

Process

7.1 STAFF STRUCTURE

- Divide participants into three groups. Give them each the following situations to role play:

  – *Seema is pregnant for the second time and is in her seventh month. During the first delivery Seema had obstructed labour. The ASHA and JFA from Seema's village are discussing how they would be able to ensure that Seema goes to the PHC for her delivery. What will the RP do to help?*

  – *Geetha is pregnant for the sixth time and has five daughters. Her mother-in-law thinks that since she has delivered for five times before there is no need for her to register so early. Geetha gets tired very quickly, but cannot take rest as she is the eldest daughter-in-law of the house. What are different issues that Geetha needs guidance on and how will the RP help?*

  – *In a village, eight girls below 18 were married off over the last three years. Three of them are pregnant now. The ASHA of the village is very concerned about them. What will the RP do to help?*

- Allow 15 minutes to prepare their role play.
- After each group has performed their role play, ask all participants to discuss the role of the RP.
- Display the 'Overview of MNCH staff' flowchart at the front of the training room.
- Explain the existing MNCH staff structure roles.
- Ask the participants to return to their role play group and to write down the roles of the FLWs based on the role play and their experiences in the field on a flip chart.
- Allow 15 minutes for group work then ask a representative from each group to display their flip chart on the walls of the training room and to take 5 minutes to share their answers.
- Consolidate by stating that every level/staff has clearly defined roles and responsibilities. Clarify that the ASHA, JHA and VHSNC will directly work with the community and it is their responsibility to create awareness, give the right message at the right time, and ensure that all services reach the women across the continuum of care.

Objective

- To help the participants understand the roles of the project staff at different functional levels.
- Help the draw up an action plan for the Sukshema project's activities.

Methodology

Group discussion

Duration

1 hour

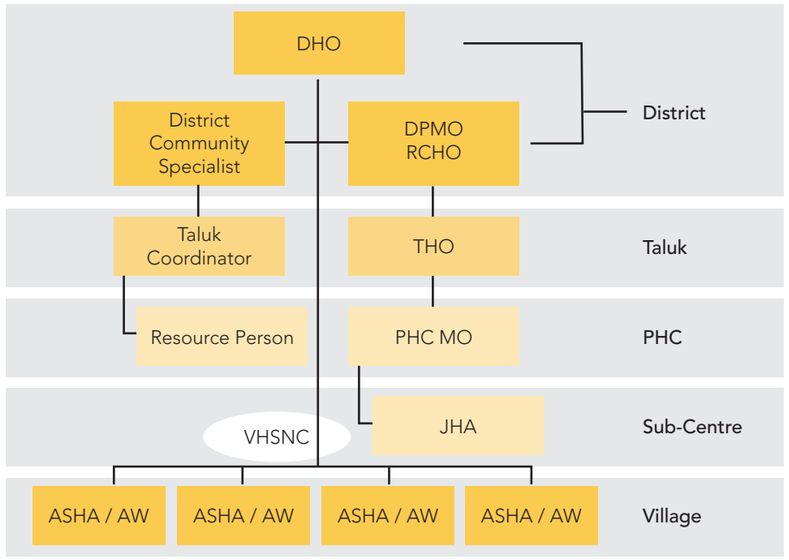
Training Materials

Briefs for the role-play, brown sheets, pen, pencils and sketch pens; Background material 9: Staff structure and responsibilities for under project Sukshema, format 5: Profile of PHC/ SC

Tips for facilitators

Note that the staff structure presented in this session is based on Sukshema's experience in the field. This session can be modified by users according to availability of resources, scale of project, funder support and the roll out plan. It is important to build role clarity so that the roles do not overlap. The RPs need to understand that they are not here to replace any existing position, but to motivate and support the ASHAs to do their work responsibly and efficiently. Their role is not supervisory, but supportive.

OVERVIEW OF THE KOPPAL MNCH 'SYSTEM'



- Emphasize that the RPs role is to support them with information, tools and providing guidance in planning and NOT direct implementation. RPs should not do a policing job, but support the FLWs with affection, trust and team work.
- RPs will conduct trainings for them on the following community level interventions and support them to roll out:
  - Family focused Communication (FFC) Tool
  - Community Demand List (CDL) Tool
  - Home Based Maternal Neonatal and Care (HBMNC) Tool
  - Supportive Community Monitoring (SCM) Tool
- The RPs also have a responsibility to follow up with the FLWs and analyse the outcome of the use of these tools, the interventions on MNCH outcomes, and ASHA tasks. This includes:
  - Analysing the CDL Tool outcome through gap analysis and problem solving tools
  - Analysing the HBMNC Tool outcome and the manner in which it is helping the ASHA do home visits more effectively.
  - Analysing the SCM Tool outcome and supporting VHSNCs to implement the tool and take appropriate action steps to work more effectively with the FLWs.
- RPs will use checklists that have been developed to help them do these duties.

7.2 DRAWING ACTION PLANS

- Ask the participants to return to their role play group and to develop and write down on a flip chart their action plan based on their specific roles for the next three months in their respective areas.
- Allow 20 minutes for group work then ask a representative from each group to display their flip chart on the walls of the training room and to take 5 minutes to share their answers.
- If the training has a Taluk coordinator or a District coordinator let them sit with the groups and plan how they will initiate this process in the field.
- Their action plan can start with profiling their PHC areas, gathering information about all FLWs working in that area, rapport building with VHSNCs, PHC staff and FLWs, preparing for ToT, briefing health department officials about the project and its interventions, etc.
- Give inputs on their presentations and help them finalize their plans based on the stage that the project is in and the scale at which the activities are going to be launched.

SESSION 8: TRAINING EVALUATION AND FEEDBACK

Objective

- To assess what affect the module had on the participants' attitudes, knowledge and practice levels.
- To obtain feedback from the participants on the usefulness of the training and suggestions for enhancing future effectiveness.

Methodology

Reflection

Duration

30 minutes

Training Materials

Training evaluation and feedback form

Tips for facilitators

The training evaluation and feedback form will assess what affect the module had on the participants' attitudes, knowledge and practice levels and obtain feedback on the usefulness of the training and suggestions for enhancing future effectiveness.

Process

- Distribute the training evaluation and feedback form. Go over all the areas that the participants will need to think about while filling it in.
- Allow 20 minutes to complete it.
- Collect the training evaluation and feedback forms from the participants.
- Before the closing ceremony begins, ask the participants to share their feelings about the training: encourage anyone who is keen to orally share two positive aspects and two areas that need improvement.
- At the closing ceremony thank all the participants for their enthusiastic participation, congratulate them and wish them the best as they go back to their own field areas and begin to initiate the intervention on ground.
- Thank everyone else who contributed to the training program. This might have included administrative staff, venue owners, facilitators, guest speakers and the organizers.

TRAINING EVALUATION AND FEEDBACK FORM:

KARNATAKA HEALTH PROMOTION TRUST
Training Evaluation and Feedback Form

Name: _____ Designation: _____ Place of training: _____
Training dates: _____ Name of the PHC: _____

S.No.	Subject	Excellent	Good	Poor
1	Training content and sessions			
2	Training methodology and activities used			
3	Training skills of the facilitators			
4	Logistics at the training (Food, stay and comfort)			
5	Relevance and usefulness of training			

List the three aspects of the training that you found most useful.

1.
2.
3.

Name any session during the training that you did not understand properly/ or that was not communicated well.

1.
2.
3.

What are the three most important lessons that you can take back to your work place from this training?

1.
2.
3.

Please list suggestions for improved facilitation in future trainings.

1.
2.
3.

ANNEXURE 1 - Reading material on village health and sanitation nutrition committee (VHSNC)

On the 12th of April 2005 the Indian government started the "National rural health mission" (NRHM) to safeguard and improve the health of all its citizens especially the poor and those living in rural areas. Under the aegis of this mission the government has started several programs to improve the health of its citizens. The government has put local community members in charge of health services and has encouraged them to formulate and oversee them in order to give the people an opportunity to take decisions regarding their health and to play a pivotal role in safe guarding it. The supervision and planning of government's health plans have been handed over to the community so that their response to people's needs and also their effectiveness can be ensured. In this way the goal is to engender a sense of ownership in stakeholders including the government, community and NGOs.

PURPOSES:

1. For the government, Panchayat Raj institutions, and the community to work together to achieve the goal of ensuring equal partnership of the community in improvement of health services.
2. Create an atmosphere where it is clear that it is the community's right to access health services and it is the responsibility of the government and concerned departments to extend such services.
3. Identify the reasons why health services and various health benefits are not effectively reaching the community and importantly to women, children and the weaker sections of the society.
4. Ensure that there is transparency and accountability in the delivery system of health services and to encourage them to effectively use the constitutionally sanctioned platform of Grama Sabhas.
5. Clearly understand the intentions, goals, organizational structure and best practices of the mission and help the members with the knowledge, skills and methods necessary to adapt it.

A1. VHSNC/VILLAGE HEALTH PLAN AND MONITORING COMMITTEE:

- At the village level, the VHSNC will also function as the village health plan and monitoring committee.

Formation and selection of general members

- The VHSNC/Village health plan and monitoring committee will comprise of 15 Grama Sabha members. Out of this there should be a minimum of 8 women members and among the women members 3 of them should belong to SC/ST and 2 SHG members. Among the remaining 7 members, a minimum of 2 should be belonging to SC/ST.

Ex officio members

- The Junior Female Health Assistant (JHA), the Junior Male Health Assistant (JHA), the primary school teacher (preferably women), all Anganwadi workers (AWWs) and the Accredited Social Health Activists (ASHAs) of that particular village will be the ex officio members.

"Committee President"

- Only the local Gram Panchayat member can become the ex officio President of the Village health and sanitation committee/Village health plan and monitoring committee.
- If that member is already the President of the local Gram Panchayat, only he can become the ex officio President of the Village health and sanitation committee/Village health plan and monitoring committee.
- If the Gram Panchayat President is not a resident of the village, then a Gram Panchayat member who is a resident of the village can become the ex officio President of the VHSNC/Village health plan and monitoring committee.
- In case there are more than one Gram Panchayat member in the village, then the Gram Panchayat has to nominate one of them to be the ex officio President of the VHSNC/Village health plan and monitoring committee.
- If the Gram Panchayat is unable to decide on whom to nominate, the chief executive of the local Taluk Panchayat can select a suitable member from among the concerned Gram Panchayat members to be the ex officio President of the VHSNC/Village health plan and monitoring committee.
- In such a situation, the decision of the chief executive of the Taluk Panchayat will be final.

A2.4 COMMITTEE SECRETARY

A local ASHA worker who is the member of the committee will be the secretary of the VHSNC/Village health plan and monitoring committee. If there are no ASHAs in the village the Anganwadi member will be the member secretary. If there are more than one ASHA or Anganwadi Worker, than the VHSNC/Village health plan and monitoring committee is authorized to select the senior most and able among them to be the member secretary.

A2.5 MEMBERSHIP TENURE:

Among the 15 Gram Sabha members elected to the committee, 1/3rd of them will retire after the first year and will be decided by a lottery. 5 new members from the Gram Sabha will then be elected to take their place. Similarly the remaining 5+5 members will retire after the 2nd and 3rd years decided by the lottery and their places will be taken similarly by other Gram Sabha members. If the retiring member is from a reserved category then the incoming member will also have to be from the same category. The Gram Sabha will have the discretion of re-electing a retired member. But the members of the Gram Sabha should be aware of the purpose and that is to give every capable member of the village a chance to become the member of the committee. The retiring and re- electing of 1/3rd of its members should be repeated annually. The supervision of the retirement and re-election of the members must be jointly done by the secretary of the local Gram Panchayat and the doctor of the primary health centre

A3. RESPONSIBILITIES OF THE VHSNC VILLAGE HEALTH PLAN AND MONITORING COMMITTEE

- The VHSNC/Village health plan and monitoring committee should every year prepare an annual village health plan and a monthly report card and submit it to the concerned PHC's health plan and monitoring committee. In addition the committee will also have the following responsibilities:
  - Establish meaningful community monitoring systems as per the directions of the Indian government
  - Arrange a quarterly health related people contact program where there is a dialogue with the community about health department services and short comings if any, local solutions andsuggestions on how to further improve the services.
  - Engender an understanding in the community about health services and health related rights.
  - Prepare a village health plan to suit local realities and necessities.
  - Analyse current village health and care activities and supply information to its concerned workers/officers on how to make it better.
  - Submit the annual village health report to the Gram Sabha
  - Submit the authentic and qualitative information about the state of the health of the village to the health plan and monitoring committee of the PHC.
  - The management of the index numbers of the village health records and the health information board should be done regularly. The records and the board should not only carry information about services like pregnant women care and post natal services, care for new born babies, vaccinations, nutrition, etc., but also services aimed at people suffering from contagious diseases and life style related diseases and Madilu, birth protection scheme, post-natal care, mother's care, etc., and complete information about similar people oriented programs, which then should be regularly updated. Information regarding the visit dates of health workers to the village, venue, etc., should also be provided to the people.
  - Oversee the visit of health workers to the village on the specified date and ensure complete health care to the villagers.
  - Organize people awareness campaigns about the societal boundaries leading to forced abortions of female foetus.
  - Use of open funds: According to the periodic directions given to the state government, the open funds can be used and the monthly accounts have to be submitted to the doctor at the primary health centre and a copy of the accounts to the Gram Panchayat.
  - For the sake of village health related works every Gram health and sanitation/gram health plan and monitoring committee can accept help in the way of money or in kind from institutions, Panchayat and donors.

A.4 COMMITTEE MEETING:

- In the afternoon of the first Monday of every month the committee should compulsorily meet and conduct a meeting at any convenient place, for example the Gram Panchayat office building/sub centre/ Anganwadi Centre/school building/community hall. In an emergency, an extraordinary meeting can also be called.
- The committee secretary has to send a notice along with an agenda 3 full days before the date of an ordinary meeting. An extraordinary meeting can be called 24 hours after the notice has been sent.
- To conduct a meeting the quorum/members present should be 1/3rd the total number of members. Among the members present, at least 1/3rd should be women.
- If there isn't a quorum, the president should wait for

30 minutes. If there is still no quorum, the meeting should be postponed to a date convenient to everyone in the same month and a fresh notice sent intimating the new date.

- On the day of the meeting if the president is absent and if there is a quorum, then a unanimous choice from among the members present can function as the president and conduct the meeting.
- The proceedings and decisions of the meeting have to be recorded in an authentic book and the signatures of the members present has to be affixed in it and the copies of it have to be given to the PHC.
- The health plan and monitoring committee and the secretary will have the responsibility of properly maintaining the documents.
- The bank account of the VHSNC should jointly in the names of the president and the secretary.
- Every three months the VHSNC/village health plan and monitoring committee should submit a financial and program report to the Gram Panchayat standing committee.
- The village health and sanitation/village health plan and monitoring committee should be the successor to the Gram Sabha of the Gram Panchayat.
- According to the Karnataka Panchayat Raj order 1993 61-A, the VHSNC/village health plan and monitoring committee will have the position of a subcommittee to the gram Panchayat standing committee.

ANNEXURE 2 - Reading material on Government infrastructure related to healthcare

In the rural areas, the health care needs are primarily looked after by the outreach services which are available at the basic unit of 1000 people by ASHAs and AWWs. But the proper infra-structure of healthcare in rural areas has been developed as a three tier structure based on predetermined population norms which are as follows:

HEALTH CENTRE NORMS		
	Population Norms	
Centre	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5,000	3,000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Source: MHFW (2005), Population Norms (Census 2001), http://www.mohfw.nic.in

Sub-Centres (SCs)
The Sub-Centre (SC) is the most peripheral and first contact point between the primary health care system and the community. Each SC is required to be manned by at least one JHA and one Male Health Worker. The SCs are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children.

Primary Health Centres (PHCs)
PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. As per minimum requirement, a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 SCs. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services.

Community Health Centres (CHCs)
CHCs are being established and maintained by the State Government under Minimum Needs Programme (MNP) / /Basic Minimum Services Programme (BMS). As per minimum norms, a CHC is required to be manned by four medical specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

First Referral Units (FRUs)
An existing facility (district hospital, sub-divisional hospital, community health centre etc.), in addition to all emergencies that any such healthy facility is required to provide, can only be declared a fully operational First Referral Unit (FRU) if it is equipped to provide round-the-clock services for:

- Emergency Obstetric Care including surgical interventions like Caesarean Sections
- Newborn Care
- Blood Storage Facility on a 24-hour basis.

For 2,50,000 to 3,00,000 people a Taluk hospital would provide the health service infrastructure, while for average of 20,00,000 people, this would be the District Hospital where specialists and emergency care and caesarean section services are available.

ANNEXURE 3 - Reading material on Government schemes for mothers and children

Under the National Rural Health Mission (NRHM) several programmes/schemes have been introduced to reduce the incidence of maternal and child morbidity and mortality. Several important programmes/schemes are:

1. *Janani Suraksha Yojane*
2. *Madilu Yojane*
3. *Prasuthi Araike Yojane*
4. *Universal Immunization programme*
5. *Thayi card*
6. *Thayi Bhagya Scheme and Thayi Bhaya plus scheme*
7. *Janani Shishu Suraksha Karyakrama*

1. JANANI SURAKSHA YOJANE

Objective:
To provide financial support for families living below the poverty line (BPL) and belonging to SC/ ST groups.

Primary programme components include:

- Early registration
- Micro / birth planning
- Referral transport (Home to Health Institution)
- Institutional birth
- Post-delivery visit and reporting
- Family planning and counselling

Eligibility of beneficiaries:

- Low Performing States (LPS): All pregnant women. Above Poverty Line women delivering in general wards of Government / Accredited Private Hospitals
- High Performing States (HPS): All BPL pregnant women, 19 years and above, up to 2 live births.
- LPS & HPS states: SC and ST women 19 years and above, 2 live births delivering in general

wards of Government or Accredited Private institutions.
- Home Deliveries: All BPL women of 19 years of age or above, up to 2 live births.

ASSISTANCE PACKAGE IN RUPEES:				
Category	Rural		Urban	
	Mothers	ASHA	Mothers	ASHA
LPS states	1,400	600	1,000	200
HPS states	700	-	600	-
	For two live births only			

In both LPS and HPS states provisions for caesarean section:
- Up to Rs. 1500/- per case for hiring services of experts from private sector
- If private doctors are not available, utilization permitted for providing honorarium/TA to Government specialists, if available in another Government facility provided s/he has the time to spare and empanelled.

Other relevant information:
- The scheme is supported by ASHAs or any other linked worker.
- Pregnant women have to register with the health worker to avail these services. If not, they have to have at least undergone three check-ups. They should have also had 2 Tetanus injections and the prescribed course of iron tablets.

2. MADILU YOJANE

Objective:
- To enable pregnant women with very low income, especially from BPL families, to access Government Hospitals for delivery

Eligibility of beneficiaries:
- Women from BPL families
- Women who have delivered in a Government Institution
- Women with only two children

Assistance package:
- Under this scheme, a post-natal medical kit containing 19 items for the safety and use of the mother and child up to 3 months after the delivery, is given as a 'Tavarige udugore' or gift from the mother. The kit includes bedspreads, bathing soap, detergent, etc. Mosquito nets are also supplied in malaria endemic districts.

Other relevant information:
- Mothers who deliver in a private hospital are not eligible for this service
- Pregnant women have to register at the SC and in the local Health Centre well in advance
- BPL families that do not possess the BPL card have to get authorization letter from the Revenue Department Officer to avail of this service

3. PRASUTHI ARAIKE YOJANE

Objective:
- This scheme aims to address the nutrition deficiency in SC and ST families by giving financial assistance to encourage rest, provide access to nutritious food and medical care during first and second live births for BPL mothers.

Assistance package:
- Financial assistance of Rs.2000/- during Antenatal period for BPL women that is given in two instalments. The first instalment of Rs.1000/- is given during third trimester, and second instalment is given immediately after delivery.
- An information booklet is given to all pregnant women focused on the necessity of nutritious food.

Eligibility criteria:
- Pregnant women from SC and ST, BPL families, living in the districts already identified by the State Government are eligible, up to 2 live births.

Other relevant information:
- During every ANC visit, the women should get the signature, date and seal of the PHC/Government Hospital Medical Officer.
- The Junior Health Assistant (Female) has to provide

a document ascertaining the beneficiary's registration (ANC) and if it is the 1st or the 2nd delivery.
- The delivery has to be compulsorily conducted at the PHC/Government Hospital.
- The beneficiary has to provide the doctor with a photocopy of the caste certificate or a copy of the BPL card.

ANC REGISTRATION BOOKLET (THAYI CARD)

The Thayi card is a comprehensive ANC registration booklet. It encompasses all the mother and child health parameters from early ANC registration to post natal follow up, immunization records of the child, weight gain record, etc. These cards help in pregnancy tracking and the immunization and growth of the child and record the disbursement of the money for JSY/Prasuthi Araike Yojane as well as the disbursement of Madilu kits.

THAYI BHAGYA YOJANE

Objectives:
- Despite in-sourcing/hiring of obstetrics, anesthesia and pediatric specialists at FRUs, Karnataka is experiencing shortage. However, the private medical sector expertise is available and this scheme proposes to tap this valuable resource. Private providers are empanelled in identified districts to provide the delivery care package. The private providers must be screened by District Health Society. This scheme enables cashless transactions for rural BPL families to access delivery at recognized private hospitals.

Eligibility criteria:
- BPL women more than 19 years of age, for first two live births, who have regular ANC check-ups.

Package:
- Private providers are reimbursed Rs.3,00,000 for every 100 deliveries on a capitation basis i.e.RS.3000/- per delivery, out of which Rs.250 + Rs.75/- will go to transportation charges of the beneficiary and accompanying person.
- This scheme is extended to Government institutions up to FRU level. For Government institutions a threshold is fixed on the basis of number of deliveries conducted. This package is only applicable for deliveries above the threshold level. Rs.1,50,000 for 100 deliveries will be paid as a package for Government hospital i.e. Rs.1500/- per delivery.

JANANI SHISHU SURAKSHA KARYAKRAMA

Objective:
- This scheme is commonly known as JSSK and was introduced by the Government in September, 2011. It covers all women, with no difference linked to BPL or APL.

Package:
- Access to ANC services and newborn services up to 30 days.
- Consumables /drugs (normal delivery or C-Section), i.e., bandages, gloves, etc.
- Lab testing (ANC and newborn) i.e., X-Ray, blood check, scanning, etc.
- Hospitalisation if required during ANC with food when normal delivery for 2 days and C-Section for 7 days)
- Free vehicle support for transfer to higher facility
- No user charge in any Government institution.

ANNEXURE 4 - Checklists for Sukshema's project field staff

1) CDL RP ANALYSIS FORMAT

CDL RP ANALYSIS FORMAT 1 MONTH: MATERNAL, NEWBORN AND CHILD INDICATORS

S.No	PHC name	Sub Centre name	ANC reg	TT	IFA	ANC	Home delivery	PNC visits	Deaths		
									Maternal	Neonatal (0-28 day)	Post neonatal (29th day - 1 yr)

Formula to denote red, yellow or green mark across each of the indicator

Formula: Sum of Ach (Fulfilled)/Sum of Target (Client needs) * 100
If the percentage obtained is less than 50% in that sub centre mark red, if the percentage obtained is between 50%-75% in that sub centre mark yellow and if the percentage obtained is more than 50% then mark green. In case of home deliveries reported in that sub centre area mark red even if there was one home delivery reported. Mark green if there were no home deliveries reported. Similarly mark red even if there was one maternal death reported in that sub centre. Mark green if there were no deaths reported in that sub centre.

Red: Less than 50%	Yellow: 50-75%	Green: More than 75%

2) CDL RP ANALYSIS FORMAT

CDL RP ANALYSIS FORMAT 2

SUB CENTRE NAME:

Reasons for gaps in services	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1. ASHA workers visiting pregnant women and newborn												
2. Ineffective communication between frontline workers & beneficiaries												
3. Unavailability of ASHA/ANM/AWW workers in the area												
4. Incomplete ANC services - IFA/TT injections												
5. Cultural practices and beliefs												
6. Families negatively influencing the pregnant women and mothers												
7. Poor health seeking behavior												
8. Male preference												
9. Inability to pay the delivery cost owing to poverty												
10. Others												

Instructions: Sub centres listed in the RP Analysis format 1 having 3 or more than 3 indicators with poor performing indicators (less than 50%) marked red are selected for further analysis in this format. The probable reasons for gaps in services are listed in this format which should be identified every month and marked (√) or else marked (×) if no reasons were identified. The issues identified should be discussed in the Arogya Mantapa meeting and the group should arrive at problem solving approaches.

3) HBMNC TOOL HANDHOLDING CHECKLIST

Name of the RP: _____ PHC: _____ Taluk: _____

ASHA Name	Sub centre Area name	Rapport established with the women	Interacted without looking at the tool word by word	Examined the Women/ newborn as required	Appropriate messages were identified through open ended questions	Suitable tool was used for effective communication	Message was focused on women & her family	Appropriate communication skills were used (Active listening, observatio, open ended questions, paraphrasing & other) skills have been used	Informed about the further follow up needed	Collected information & has been recorded in the prescribed tool	Color Green/ Yellow/ Red
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Scoring: If score is 8 & above (Green): Good, 5-7(Yellow): Average, 4 & < 4(Red): Needs further support

4) SCM TOOL HANDHOLDING CHECKLIST

Name of the RP: _____ PHC: _____ Taluk: _____

Name of the village	Members participation was open & free mind	Members sat in different groups & discussed freely	Discussion was conducted on the activity planned in the previous meeting	Microplanning was done after the meeting	Mutual cooperation was observed	All the columns are filled & abstract prepared	Members are discussion without the help of RPs	Discussion points are brought to the notice of the panchayat & followed up	SCMT meetings are conducted regularly	Tools are filled only after the discussion	Color Green/ Yellow/ Red

Scoring: If score is 8 & above (Green): Good, 5-7(Yellow): Average, 4 & < 4(Red): Needs further support

5) AROGYA MANTAPA HANDHOLDING CHECKLIST

Name of the RP: _____ PHC: _____ Taluk: _____

Name of the Subcentre	All the FLWs (subcentre level) were participated	All the members taking part freely	AM meting are being convened on rotation	Follow up discussions were held on the resolution of the previous meeting	Gap analysis was done by FLWs after updating & discussion	Prepared Action plan for the coming month	Innovative & interesting Activities conducted	Proceedings documented on rotation basis	Members are discussing without the help of RPs	VHSNC supporting this meeting	Color Green/ Yellow/ Red

Scoring: If score is 8 & above (Green): Good, 5-7(Yellow): Average, 4 & < 4(Red): Needs further support