Improving Management and Delivery of Outreach Services, Shaping Demand and Strengthening Accountability: AN OVERVIEW OF SUKSHEMA'S COMMUNITY INTERVENTION

ಸುಕ್ಷೇಮ sukshema
Improved Maternal, Newborn & Child Health

KHPT
Karnataka Health Promotion Trust

NATIONAL HEALTH MISSION
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UNIVERSITY OF MANITOBA

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Improving Management and Delivery of Outreach Services, Shaping Demand and Strengthening Accountability: An Overview of Sukshema's Community Intervention is a detailed account of the implementation experiences and recommendations of the project aimed at improving MNCH outcomes in Karnataka state

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The photographs are by N P Jayan and they have been used with consent from the community.

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCG	Bacillus Calmette-Guerin
CC	Community Coordinator
DCM	District Community Mentor
DCS	District Community Specialist
DPC	District Program Coordinators
DPS	District Program Specialist
EDD	Expected Date of Delivery
ETT/CDL	Enumeration and Tracking Tool/Community Demands List
FFC	Family focused Communication
FLWs	Frontline Health Workers
GoI	Government of India
GoK	Government of Karnataka
HB-FFC	Home-based- Family Focused Communication
HBMNC	Home-based Maternal and Newborn Care
HBNC	Home-based Newborn Care
IFA	Iron and Folic Acid
IIT	Intimate Interactive Theatre
JE	Japanese Encephalitis
JHA	Junior Health Assistant
KHPT	Karnataka Health Promotion Trust
LMP	Last Menstrual Period
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
MO	Medical Officer
NRHM	National Rural Health Mission
OPV	Oral Polio Vaccine
PHC	Primary Health Centre
PNC	Postnatal Care
RCHO	Reproductive and Child Health Officer
RP	Resource Person
SCF/AM	Subcentre Forum/Arogya Mantapa
SCMT	Supportive Community Monitoring Tool
TB	Tuberculosis
TC	Taluk Coordinator
THO	Taluk Health Officer
VHND	Village Health and Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committee

CONTENTS

ABOUT THE DOCUMENT

This document is a detailed account of a package of community centric interventions aimed at enhancing MNCH outcomes in eight northern districts of Karnataka. It presents the process and experiences of implementing the community interventions, shares intervention results, showcases innovations, captures field experiences and concludes with lessons learned and recommendations. The information used in the document is derived from qualitative sources including extensive interviews, site visits and observations over a 2-year period. We hope that this document serves as a guide for program managers and policy makers and others interested in learning from the experience to develop or replicate similar approaches in India or elsewhere to improve maternal and newborn care.

ABOUT PROJECT SUKSHEMA

Funded by the Bill & Melinda Gates Foundation, the Sukshema project supports the Government of Karnataka to develop and implement strategies to improve maternal, newborn, and child health (MNCH) in alignment with the Government of India National Rural Health Mission (NRHM). The project is implemented by Karnataka Health Promotion Trust in collaboration with University of Manitoba, St John's Medical College, IntraHealth International, and Karuna Trust. The six-year project started in September 2011.

The goal of Sukshema is to: *Develop and adopt effective operational and health system approaches within the NRHM to support the state of Karnataka and India to improve maternal, newborn, and child health outcomes in rural populations.*

To achieve this goal, the project integrated and aligned key aspects of the Foundation's MNCH strategy with the NRHM in eight districts in northern Karnataka, with the following four key objectives:

1. Enable expanded availability and accessibility of critical MNCH interventions for rural populations.
2. Enable improvement in the quality of MNCH services for rural populations.
3. Enable expanded utilization and population coverage of critical MNCH services for rural populations.
4. Facilitate identification and consistent adoption of best practices and innovations arising from the project at the state and national levels.

Improving Management and Delivery of Outreach Services, Shaping Demand and Strengthening Accountability:

AN OVERVIEW OF SUKSHEMA'S COMMUNITY INTERVENTION

This report contributes to Objective 4 of the Sukshema project - to facilitate identification and consistent adoption of best practices and innovations arising from the project at the state and national levels - by documenting the activities to date in implementing the maternal newborn and child health (MNCH) community-level interventions.

01 RATIONALE

In designing the interventions, the project drew on the latest evidence on community engagement and community accountability in MNCH, findings from a qualitative assessment of utilization of MNCH services in three districts representative of Northern Karnataka. In addition, a review of several community level approaches in other contexts helped identify critical gaps in coverage, awareness and utilization of MNCH services.

1.1 Focus on community engagement and community accountability in MNCH

Evidence shows that to improve MNCH and reduce morbidity and mortality, efforts should focus on building capacities at individual, family, and community levels to ensure appropriate self-care, prevention, and care-seeking behaviour [1]. In limited resource settings, community-level interventions can address this, since care-seeking behaviour is strongly influenced by the socio-cultural environment. [2]

The community interventions are designed specifically to enhance participation of community-level structures in supporting and monitoring the utilization and coverage of MNCH services using a continuum-of-care approach. This approach is globally viewed as a core principle for MNCH programs as a means to reduce the burden of maternal, neonatal and child deaths. [1] It promotes care for mothers and children from pregnancy to delivery, the immediate postnatal period and childhood.It recognizes that safe childbirth is critical to both maternal and newborn health and that a healthy start in life is an essential step towards a sound childhood and productive life. However, for such an approach to be successful it needs to be linked to enhancing demand creation at community-level, improving outreach services to promote good family care and care-seeking practices, and strengthening linkages with primary health care services. [3]

This is in line with the Government of India's (GoI) National Health Mission (NHM) whose main objectives are to reduce maternal and infant mortality rates through community-based strategies such as improving community access to key MNCH services and building the capacity of community-based health workers called ASHAs (Accredited Social Health Activists) who provide community outreach services and who serve as the first point of contact between communities and health facilities. The Government of Karnataka, last year, also identified RMNCH+A districts which have been identified as priority regions

1 Kerber Kate, Graft-Johnson Joseph, Bhutta Zulfi, Okong Pius, Starrs Ann, Lawn Joy. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet. 2007; 370(9595):1358-1369.

2 Elder John, Ayala Guadalupe, Harris Stewart. Theories and intervention approaches to health-behaviour change in primary care. American Journal of Preventive Medicine. 1999; 17(4):275-284.

3 Bhutta ZA, Ahmed T, Black RE et al What works? Interventions for maternal and child under nutrition and survival. Lancet 2008;371(9610):417-40.

for improving MNCH outcomes. These districts are the same as the Sukshema project districts. The focus of the project has, therefore, been in sync with the government priorities for improving MNCH.

However, there needs to be a shift in viewing communities not just as "recipients of services designed for their benefit" but as "being active makers and shapers of services, exercising their preferences as consumers and their rights as citizens' [4]. As stated above, communities are often passive recipients of government programmes and are not active in advocating for their rights to quality services or even know what to expect from government programmes. For example, one of the gaps identified by the NRHM is that communities are not aware of the role of ASHAs and do not know what to expect from this community based volunteer. On the flip side, ASHAs report that they sometimes struggle to find acceptance in the community and to be seen as a credible source of information and support. Strengthening community accountability is promoted as a right in itself, and to enhance quality of care, appropriateness of health service delivery for users, and patient satisfaction and utilization [5]. Engaging the community in planning and monitoring health service delivery is central to enhancing the availability, accessibility, quality and use of the public health system.

The NRHM has positioned community ownership as central to its strategy, primarily through the Village Health, Sanitation and Nutrition Committee (VHSNC). VHSNCs are village-level bodies comprised of key stakeholders in a village and serve as a forum for village planning and monitoring. VHSNCs were formed to ensure that no section of the village community is excluded from services; to prepare a village health plan to suit local realities and necessities; to provide monitoring and oversight to all village health activities; and to ensure that untied funds are appropriately used for improving maternal and neonatal health in the village.

1.2 Findings from a qualitative assessment of utilization of MNCH services in Bellary, Gulbarga and Bagalkot

Dr. Sharon Bruce and associates carried out a qualitative inquiry to explore participants' understandings and health care practices surrounding pregnancy, the birthing process and care of the newborn (i.e., first month of life) in Bellary, Gulbarga and Bagalkot [6].This qualitative inquiry was carried out as a part of situation assessments by the project Sukshema in the first year. The study aimed to determine participants' understandings of a healthy pregnancy, including delivery, and ill health in a newborn; to determine the actions or behaviours undertaken by participants to facilitate a healthy pregnancy and delivery, and to promote good health in the newborn; to determine the available and preferred health care alternatives for pregnancy, delivery and care of the newborn; and to determine the decision-making processes involved in pregnancy, delivery and newborn care.

It revealed several deep-seated cultural beliefs around pregnancy and childbirth, women's lack of decision-making authority in key decisions around pregnancy and childbirth, low awareness/knowledge around immediate and exclusive breastfeeding and limited utilization of government schemes.

Women's lack of decision-making authority.

The study revealed that the woman's family (her husband, her mother/grandmother and her in-laws) was the key decision maker in issues surrounding pregnancy and childbirth. Decisions around place of delivery, care of a newborn and even nutrition during pregnancy and lactation were either made or heavily influenced by a pregnant woman's family.

Cultural beliefs around pregnancy and childbirth

The study identified several cultural beliefs around pregnancy and childbirth that could adversely affect the pregnant woman and her newborn. A number of cultural beliefs exist around nutrition during pregnancy such as avoiding iron-rich non-vegetarian foods (meat, chicken and eggs) during pregnancy because they are 'hot foods'; avoiding sour and salty foods because they may cause excessive phlegm production; using particular herbs or foods to prevent infections and to reduce 'expansion of stomach' etc.

"Pregnant women should take caution during solar and lunar eclipse and not do any work. Otherwise the baby will be born with birth defects"
"Cold foods causes the mother's teeth to become loose and also increase bleeding after delivery"- Bagalkot

4 Bhutta ZA, Ahmed T, Black RE et al What works? Interventions for maternal and child under nutrition and survival. Lancet 2008;371(9610):417-40.

5 Standing H, London: DFID Health Systems Resource Centre; 2004. Understanding the 'demand side' in service delivery: definitions, frameworks and tools from the health sector.

6 Bruce et al.: A qualitative exploration of factors influencing site of delivery (home, public or private hospital) in three North Karnataka districts as described by pregnant women, mothers of neonates, husbands and grandmothers. BMC Proceedings 2012 6(Suppl 5):P7.

Lack of knowledge on immediate and exclusive breastfeeding.

The study showed that several beliefs and practices existed about breastfeeding in all three districts. Many believed that colostrum was 'bad' for a newborn and a mother had to wait for a day or two until her milk 'comes in' before breastfeeding her baby. Some even reported that their doctors advised them to do so. Among those that believed that colostrum was bad for newborns, many reported feeding newborns several pre-lacteal supplements such as cow's milk, herbal drinks, sugar water etc.

"Bad milk comes out the first day of birth if it is given to babies, it causes lumps in their stomach and causes them to vomit"- Gulbarga

Limited Utilization of Government Schemes

The study showed that while most respondents were aware of the Government incentives and schemes around pregnancy and childcare, many reported not receiving any because of a number of reasons. An important reason for this was that they did not deliver at a Government health facility or delivered at home and thus could not avail of the incentives associated with public institutional delivery. Although many reported that cost was a major prohibitive factor in delivering at private hospitals, respondents felt that the additional costs were worth it since they perceived quality of care and the perceived quality of care and the facilities themselves to be superior at private versus government hospitals. Another drawback to choosing to deliver at home or at private hospitals could be that ASHAs and Anganwadi Workers (AWW) are unable to assist those families who are eligible to receive incentives, but do not access government health care services, since all Front Line Workers are linked to government facilities.

"We submitted papers, but no result; we did not bother applying for second child"- Bagalkot

The study stresses the importance of designing community interventions that address these gaps in knowledge and shape demand for facility delivery. It also emphasizes on the need for communication messages that are family-centric vs woman-centric.

1.3 Findings from community-based interventions to improve MNCH outcomes

In designing the community interventions, the Sukshema project reviewed findings from similar interventions across a variety of settings in India and other countries. Highlights of published findings related to community-based interventions and their effects on MNCH outcomes are summarized below:

Home-based care of newborns – Indian Studies

There are several publications on the SEARCH, Gadchiroli field trials [7],[8] that assessed the effects of a home-based newborn care (HBNC) package on neonatal and perinatal mortality in rural Gadchiroli in India. The package of interventions had a combination of both primary and secondary prevention interventions. The primary intervention focused on influencing mothers' and caretakers' behaviours and the secondary intervention directly addressed management of sick newborn babies. The interventions were delivered to the communities through a cadre of village health workers trained in neonatal care who made home visits and managed birth asphyxia, pneumonia, premature birth or low birthweight, hypothermia, and breast-feeding problems. They diagnosed and treated neonatal sepsis and pneumonia. Assistance by trained traditional birth attendants, health education, and regular supervisory visits were also provided. The trials showed large reductions in neonatal and perinatal mortality rates and sustained gains at the end of the 7 year-trial that carried forward to the first year of life. Similar reductions in neonatal mortality rates were observed in the rural communities of Shivgarh, Uttar Pradesh in those homes receiving postnatal home visits along with a preventive package of interventions for essential newborn care. [9],[10]

Other Community-based interventions

Studies in Guatemala [11], Bangladesh [12],

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7 Bang AT, et al., Effect of home-based neonatal care and management of sepsis on neonatal mortality: field trial in rural India. *Lancet* 1999; 354: 1955-61

8 Bang AT, et al., Neonatal and infant mortality in the ten years (1993 to 2003) of the Gadchiroli field trial: effect of home-based neonatal care. *J Perinatol* 2005; 25: S92-107

9 Kumar V, et al., et al. Effect of community-based behaviour change management on neonatal mortality in Shivgarh, Uttar Pradesh, India: a cluster-randomised controlled trial. *Lancet* 2008; 372: 1151-62

10 Baqui AH, et al., Impact of an integrated nutrition and health programme on neonatal mortality in rural northern India. *Bull World Health Organ* 2008; 86: 796-804

11 Bartlett A, et al., Neonatal and early postneonatal morbidity and mortality in a rural Guatemalan community: the importance of infectious diseases and their management. Pediatr Infect Dis J. 1991 Oct;10(10):752-7.

12 Baqui AH, et al., Effect of community-based newborn-care intervention package implemented through two service-delivery strategies in Sylhet district, Bangladesh: a cluster-randomised controlled trial. Lancet 2008; 371: 1936-44

Pakistan [13] and Kenya [14] confirm that community based intervention studies can positively influence maternal, newborn and child health outcomes, particularly with accompanied referral to nearby health facilities.

The Kenyan study evaluated the effectiveness of the community health strategy in delivering community-based maternal and newborn care interventions as a means of influencing the adoption of essential maternal and newborn care practices among mothers with children aged 0-23 months. The results showed significant changes in ANC attendance, skilled deliveries and exclusive breastfeeding.

In summary, the findings from the evidence review suggest that the community interventions should include components that focus on delivering maternal and newborn care interventions using community outreach techniques. It also suggests that trained community health workers are used for outreach and timely referrals to available health services.

1.4 Critical gaps in coverage, awareness and utilization of MNCH services

Coverage: Available data indicates that the coverage of target populations for MNCH services is poor and inequitable – there are unreached populations for many services, and those who are reached do not receive a complete package of services through the continuum of care from antenatal to newborn care. For instance, as per the DLHS (District Level Household Survey) for northern Karnataka, while 74% of currently married women (15-44) received tetanus toxoid injections, fewer than 27% received the full set of ANC visits. Similarly, only 52% of currently married women (15-44) received postnatal care visit within 48 hours of delivery [15]. Vulnerable populations, such as those belonging to scheduled castes and tribes as well as migrants seem to be left out of the registers maintained at the Sub Centres. While the proportion of institutional deliveries has risen in recent years, only a small proportion of mothers stay for 48 hours after delivery in facilities. State Health Management Information System (HMIS) data showed that only 38% of women delivering in institutions during August 2010-July 2011 stayed for at least 48 hours after delivery.

Awareness: Currently, there is a lack of awareness in the community on healthy practices and available services for the mothers and newborns through the continuum of care. Often, existing cultural practices and beliefs, and poorly informed decisions, become barriers to access MNCH services. The findings from Sukshema's assessment of community facilitators and barriers for utilization of MNCH services have reaffirmed that practices related to pregnancy, delivery, and post-natal care, as well as the decisions to seek care, are strongly influenced by the family [16]. The elders in the family, particularly the mothers-in-law and the mothers, as well as the husband, play an important role in decisions on seeking care, as well as in perpetuating unhealthy practices.

The ASHAs being members from the neighbourhood, are the community resources to facilitate a positive change in awareness and practices around maternal and child health through the continuum of care. Although ASHAs undergo a fairly comprehensive initial training on roles and responsibilities, in practice, the training focus has been on referrals, or bringing people to services – particularly for institutional delivery. There has been very little emphasis and expectation from them as "change agents" – in influencing awareness and practices related to critical MNCH services. There are no user-friendly interpersonal communication materials and job-aids to facilitate ASHAs in functioning as change agents. There also is a need to focus on key MNCH issues that the ASHAs need to emphasize while working with the community to improve their awareness and practices. In addition to this, identifying key target groups is important. Similarly, Anganwadi Workers (AWWs) have been working on components related to nutrition during pregnancy (anaemia) and childhood (exclusive breastfeeding and timely complementary feeding). However, they lack effective communication skills, tools and job-aids to effectively bring about positive changes in the awareness and practices around nutrition issues.

Postnatal care (PNC) gaps: The first days following delivery are when women and newborns are at greatest risk, yet it is often during this time that the system breaks down. Due to constraints of workload and travel, Junior Health Assistants (JHAs) are not

13 Bhutta ZA, et al., Implementing community-based perinatal care: results from a pilot study in rural Pakistan. *Bull World Health Organ* 2008; 86: 452-9

14 Wangalwa G, et al., Effectiveness of Kenya's Community Health Strategy in delivering community-based maternal and newborn health care in Busia County, Kenya: non-randomized pre-test post test study. Pan Afr Med J. 2012;13(Supp 1):12

15 District Level Household and Facility Survery-3, 2007-08

16 Community Assessments & In-Depth interviews, MNCH Situational Assessments, "Sukshema", KHPT, 2010-11

able to make timely PNC visits in the community. One of ASHAs' roles is to visit mothers and newborns in their homes, yet many ASHAs do not know what they are supposed to do during post-natal visits. According to the Government of Karnataka (GoK) guidelines, the ASHA is supposed to weigh the newborn as well as conduct a health check-up during each of these visits, and counsel on danger signs for mothers and newborns [17]. Despite PNC visits being incentivized for ASHAs, many recently delivered women do not receive PNC visits from ASHAs and the quality of those visits is often lacking.

1.5 Consultations with front line workers to explore their challenges and solutions to address the gaps.

Several gaps were identified during consultations with frontline health workers.
They are:

- Limited knowledge among women and their families on healthy MNCH practices and available services
- Cultural practices and beliefs that act as barriers for positive health seeking behaviour
- Poor community engagement in supporting and monitoring MNCH service uptake
- Poor coverage of target populations by frontline workers for MNCH services– unreached target populations and reached by incomplete package of services Currently there are no tools and methods available for FLWs to map and track pregnant women and children to enable them to monitor and plan coverage out for services through the continuum of care.
- The current tools for the FLWs do not present an integrated approach to the health of the mother and the baby, nor help her be a change agent to encourage improved MNCH practices in the community.
- There is a need for innovative tools that can aid FLWs in screening for danger signs among mothers and newborns and be able to quickly link them to skilled care when needed.
- Lack of capacities among the FLWs to counsel and engage family members of the pregnant women to change attitudes/ behaviours as well as support them in accessing care services
- Lack of uniformity in planning by ASHAs
- Poor coordination and communication between the ASHAs and the JHAs
- Lack of job aids/ checklists to help ASHA workers in making their home visits effective, particularly for screening for danger signs among pregnant, postpartum mothers and newborns so that they are able to quickly link them to skilled care when needed
- Lack of tools to help ASHA identify specific counseling needs
- Lack of community platforms for planning and monitoring village health programs.
- The perception of monitoring very authoritative, probing and supervisory rather than supportive and participatory
- Lack of ownership and accountability of the village health programs in general and MNCH issues in particular in the community
- Widening gap between the needy community and the health service system
- Poor awareness and hence lack of participation of VHSNC members in supporting the frontline health workers at the village level to improve MNCH outcomes

17 Guidelines for incentives to ASHAs, Directorate of Health and Family Welfare Services, Government of Karnataka, July 2011

02 OVERVIEW OF SUKSHEMA'S COMMUNITY INTERVENTION

In order to address the above gaps, Sukshema's package of community interventions was envisioned after joint deliberations at the field level. All the community interventions are linked to one another and aim at addressing gaps at the level of the Front line health worker and community structures such as the VHSNC. The package of interventions comprise of both **Tools** and **Processes** that address the felt needs on the field.

The community interventions are designed on the premise of the principle of decentralization. It has been an effort to develop scalable and effective strategies evolved by the community members themselves. In the Karnataka context, as in other regions of India, communities have commonalities as well as diversities. Addressing both these are critical while designing and implementing interventions. The community intervention package has drawn from the cultural principle of people leading people and communities changing communities. Through the CI package efforts were to integrate all interventions rather implement the programs in a parallel fashion. Since the larger community is the envisioned beneficiary, the receiver's involvement at every stage of the interventions' plan, design and implementation has been elicited and provided scope for.

2.1 Objectives of Sukshema's Community Intervention

The Sukshema community interventions have been designed and implemented with the following objectives:

1. To increase the ***frequency and quality of interactions*** between beneficiaries and frontline health workers (FLWs).
2. To ensure that **all** pregnant and postpartum women, newborns and infants ***enter*** into MNCH care continuum.
3. To ensure that **all** pregnant and postpartum women, newborns and infants ***continue*** in MNCH care continuum.
4. Enhance participation of community-level structures in ***supporting and monitoring*** the utilization and coverage of MNCH services.

2.2 Focus of Sukshema's Community Interventions

Sukshema's community interventions have three main areas of focus:

- Maternal health care of pregnant women and mothers of newborns (antenatal and upto 42 days postpartum)
- Health care of infants (upto one year of age) including newborns (upto 28 days)
- Health care of children (upto 18 months)

The main strategy for Sukshema's community interventions is to empower the FLWS (ASHA, AWW & JHA) and community representatives to sustain a supportive community monitoring environment through tools-and-processes based facilitation and a mentoring approach.

The project's core target groups for the community interventions are the FLWs (ASHAs, AWWs and JHAs) and the Supportive Community Monitoring Team comprised of 6 VHSNC members.

Sukshema's MNCH community intervention integrates elements of improving tracking of pregnant women and children; management and delivery of outreach services with components that strengthen accountability and shape demand (refer to text box).

Components of Sukshema's Community Intervention

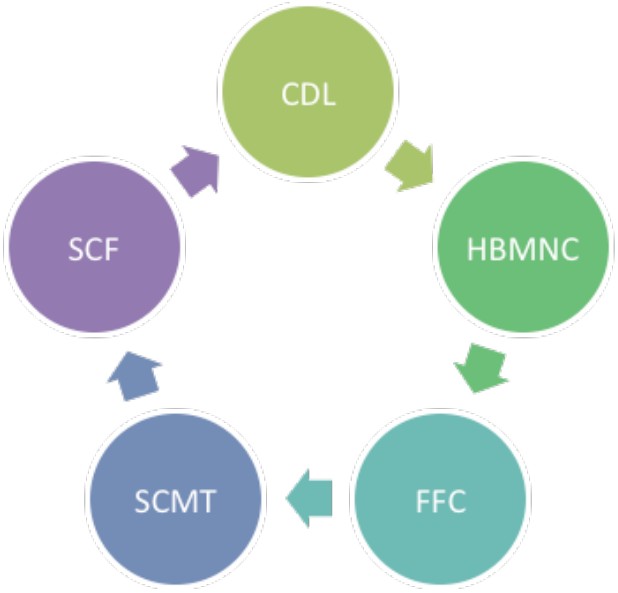
There are 5 main components of Sukshema's community intervention that aim to improve management and delivery of outreach services, shape demand and strengthen accountability.

Improving management and delivery of outreach services and shaping demand

1. Community Demand List to help in enumeration and tracking for ASHAs to improve coverage (CDL)
2. Integrated maternal and newborn management tool for ASHAs to improve identification and actions for postnatal danger signs (HBMNC)
3. Family focussed communication tools and materials for ASHAs to use with families to influence awareness and practices (FFC)

Strengthening accountability

1. Supportive Community Monitoring tools (SCMT) for Village Health Sanitation and Nutrition Committees (VHSNCs) to strengthen accountability
2. Sub centre forum (SCF – Arogya Mantapa)

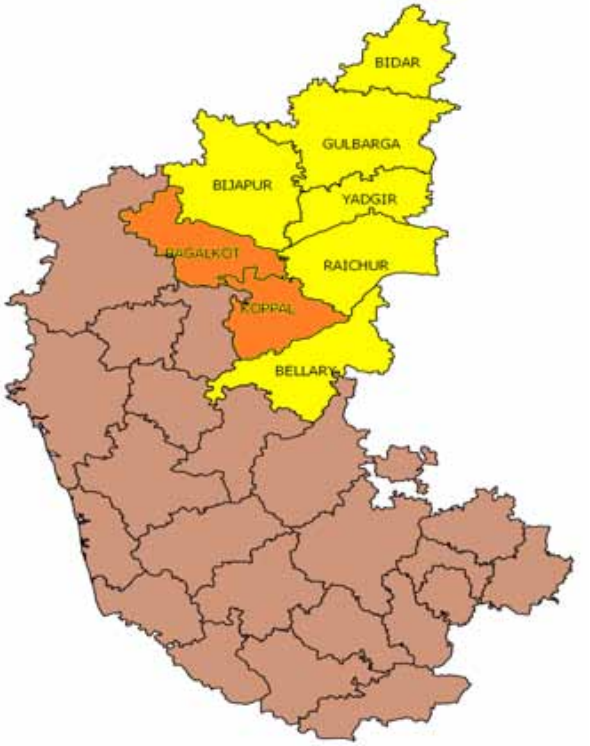


ASHAs facilitated the implementation of the community intervention, in tandem with their supervisors, the Junior Health Assistants (JHAs). During the pilot phase of the implementation, the project also employed a new cadre of full time Resource Persons (RPs) who mentored and supported ASHAs; they were integrally involved in all project implementation activities. The Sukshema project trained RPs (Resource Persons) in all components of the community intervention, starting with FFC training.

ASHAs use CDL to track gaps in coverage across essential MNCH services and HBMNC to guide ASHA in her home visits helping her recognize danger signs to facilitate timely referral of the pregnant women and the new born. These tools help manage gaps in knowledge, awareness and access to MNCH services within their communities. The FFC trainings also help enhance the coordination and coordination of among the frontline workers as well as guide them with necessary skills to adopt a family centric approach in their outreach and interactions during counselling. ASHAs also enhance community knowledge and awareness and influence practices on key MNCH issues through FFC-based communication tools and materials during their home visits. The use of these tools and aids has helped ASHAs and JHAs improve referral processes and ensure continuity of care for referred cases.

In addition to mentoring and supporting ASHAs, RPs will also facilitate the formation of SCMT committees within VHSNCs that will be trained in the SCMT tool, which is geared towards strengthening community ownership of and engagement in planning and monitoring availability, accessibility, quality, utilization and coverage of MNCH services. In an on-going effort to create an opportunity for FLWs and VHSC members to collectively identify issues in their individual areas of work, shape appropriate solutions jointly and support each other to implement it, RPs will also facilitate formation of Arogya Mantaps (AMs) or Sub-centre forums whose members will be ASHAs, JHAs, Anganwadi workers and VHSC presidents within a given sub centre's limits.

The implementation strategy of the community interventions occurred in two phases. In Phase 1, all 5 components of the community intervention were launched in two pilot districts – Koppal and Bagalkot. A total of 106 RPs - 53 for Koppal and 53 for Bagalkot were recruited and trained to provide support to 8270 ASHAs and 2007 JHAs in the two districts. Support the FLWs (ASHAs, AWWs and ANMs) through a cadre of Resource Persons. Support was leveraged from the government departments for rolling out the trainings.



In phase 2, the project scaled up the community intervention in the other 6 project districts after certain modifications and adaptations based on the experience in the pilot districts and in consideration of other administrative/ management implications in Phase 2.

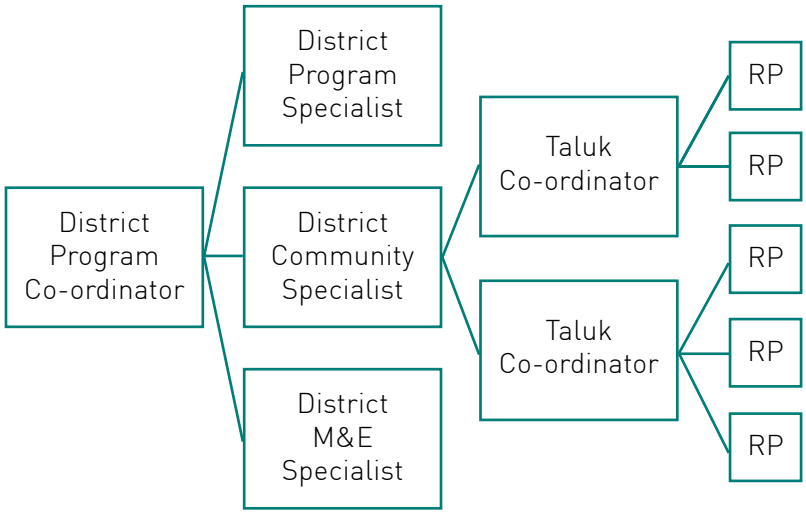
The community interventions package is intentionally being implemented across all districts to derive lessons about implementing the intervention at scale. It is anticipated that if this intervention proves successful, the GoK would adopt the processes, tools and job-aids to replicate this intervention in other districts in the state.

03 MANAGING SUKSHEMA'S COMMUNITY INTERVENTION IN THE PILOT DISTRICTS

Context

The Sukshema project developed a management structure and management processes to oversee implementation of the community intervention. A core technical managers' team, which handles both technical and administrative matters based in Bangalore, provides guidance and support to the field teams. Every member from the central core team also played the additional role of the district program coordinators (DPC) who acted as the point persons for the three interventions at each of the districts. The core team at the district level consists of District Community specialist (DCS), District Program Specialist (DPS) and District M & E Specialist, who are the Technical Leads for the different components of the Sukshema project such as community interventions, mentoring interventions and M & E, respectively. This team has a mandate to support the taluk level teams headed by taluk community coordinators and supported by 8-12 Resource persons (RPs) each. Each of these resource persons are in charge of 1-2 PHC areas.

Figure 1: Management Structure of the Community Interventions in Pilot Districts



District Program Coordinator
As mentioned above, DPCs are based centrally n Bangalore. They routinely visit the project districts to provide supportive supervision to the DCS, DPS and M&E specialists, TCs and RPs, advise on management processes and anticipate and troubleshoot issues as needed.

District Community Specialist
At the district level, a District Community Specialist (DCS) based in each district is responsible for implementation, follow up and monitoring of the community interventions in the district. The District Community Specialists are expected to:

- Assist in the recruitment of RPs and TCs
- Build rapport with the FLWs
- Provide handholding support to TCs and RPs in their routine field activities
- Conflict resolution
- Hold district level review meetings
- Review and summarize RP reports along with TCs
- Hand hold TCs in identifying gaps using CDL output every month
- Prioritize PHCs for greater focus and also follow-up on CBTS outcome
- Coordinate field visits for staff, trainers, consultants and other visitors
- Interface and liaison with government district officials
- Regularly update the central team (DPCs) about the implementation activities in their districts.
- Coordinate with the DPS and M & E specialists on ground.
- Convergence/ integration of CI and mentoring initiatives

Taluk Coordinators (TC)
TCs are based at the Taluk level in each of the pilot districts. They are responsible for:

- Mentoring and handholding RPs in their respective taluks.
- Interfacing with taluk health officials
- Having more of an advocacy role with the Health Department and DWCD (dept of women and Child Development) at the taluk level
- Training, handholding and supportive supervision of RPs
- Assist RPs with FLW trainings and handholding
- Hand hold RPs in identifying gaps using CDL output every month
- Prioritize sub centres for greater focus and also follow-up on CBTS outcomes
- Regularly update the DCSs about implementation activities in their Taluks

04 PLANNING AND IMPLEMENTATION OF THE COMMUNITY INTERVENTION IN THE PILOT DISTRICTS

Preparation and implementation of the various components has been a step-wise process as noted below:

Implementation Step 1: Development of job-aids, tools, processes and mechanisms to support FLWs with community and FLW consultation
Implementation Step 2: Recruitment and Training of RPs
Implementation Step 3: Baseline CBTS surveys (refer to the Monitoring Section)
Implementation Step 4: Training Frontline Workers
a. FFC Roll-outs
b. CDL Roll-out
c. HBMNC Roll-out
d. Arogya Mantapa Roll-out
e. SCMT roll-out

The timeline for these activities in the Pilot districts is presented below:

Implementation Steps in Pilot districts	Dates
1. Development of job-aids and tools	April, 2012
2. Recruitment and Training of RPs	March 2012
2a. FFC Training of Trainers (ToT) for RPs	May, 2012
2b. ETT Training of Trainers (ToT) for RPs	Sep 2012
2c. HBMNC Training of Trainers (ToT) for RPs	Jan 2013
3. Baseline CBTS surveys	June, 2012
4 .Training Front-line Workers (ASHAs and JHAs)	Aug, 2012
a. FFC Roll-outs b. CDL Roll-out c. HBMNC Roll-out d. Arogya Mantapa Roll-out e. SCMT roll-out	July, Aug & Sep 2012 Oct , Nov & Dec 2012 Jan, Feb 2013 Sep 2012 May 2013

Implementation Strategy
The implementation strategy adopted by Sukshema includes:

- Field test the methods and tools in 2 districts – Bagalkot and Koppal
- Support the FLWs through a new cadre of Resource Persons (RPs)
- Leverage the support from the government departments for rolling out the trainings in tools and methods
- Timely and regular review of the interventions' impact on key indicators towards improvement of MNCH
- Scale up the tools and methods to other districts based on the learning in two districts

4.1 IMPLEMENTATION STEP 1: Development of job-aids and tools (FFC materials, ETT, HBMNC and SCMT)

Context

Currently there are no tools and methods available for ASHAs to map and track pregnant women and children; to help them monitor and plan outreach services through the continuum of care. Also, the existing tools do not present an integrated and comprehensive approach to the health of the mother and the baby, and do not help ASHAs to tailor their behaviour change messages to encourage improved MNCH practices in the community(do you also want to add that there are no user friendly tools for community monitoring or platforms/ process for coordination). There was also lack of adequate supportive supervision for FLWs(good to add this in the gaps – one ASHA mentor per taluka of 200 ASHAs was hardly sufficient for supporting or reviewing ASHA work).

The project has developed, field tested and implemented a set of tools and job-aids that equip ASHAs with competencies in improving the coverage for routine MNCH services, help in better communication with families about the importance of availing MNCH services and adopting healthy practices for pregnant women and newborns, and help them screen, identify and refer danger signs, especially during the critical postnatal period.

For the development and pretesting of tools and training modules and the required processes for implementation, the following activities were carried out prior to finalizing tools and job-aids:

STEP 1a: A tool development consultation workshop was organized. The participants in this workshop included a selected group of ASHAs (28), ANMs (8), AWWs (5), ASHA mentors (2), VHSC/Panchayat members (6), RPs (4), Taluk Coordinators (2) and district coordinators (2), the project technical leads and managers, district program specialists and district M & E specialists.

The objectives of the workshop were to:

i. draft the tools for FLWs and community structures
ii. draft the guidelines in the use of these tools
iii. draft the training module
iv. draft the training roll out plan.

The involvement of the target groups (FLWs and community structures) in the drafting of tools and training methods helped the project to achieve a set of tools that are relevant in the field, that are more likely to be helpful to the FLWs and community structures. This workshop was a three day long intensive sessions where the project staff and the FLWs discussed and critically evaluated the relevance, applicability and usefulness of the interventions and the tools. After the workshop, the tools and the intervention processes came closer to the reality on the ground.

STEP 1b: The draft tools and training modules developed in the workshop were pretested and finalized. The finalized Community Demand List (CDL), Home-based Maternal and Newborn Care Tool (HBMNC), Family-Focussed Communication (FFC) tools and Supportive Community Monitoring tools (SCMT) were ready for the ground following this process.

4.1.1 Family Focused Communication (FFC)

Purpose

FFC intervention was planned strategically to address the gaps seen among the front line workers in the field. ASHAs, AWWs and JHAs lacked motivation, skills and perspective on the causes of and the solution to high maternal and infant mortality and morbidity in Koppal and Bagalkot. Another key gap that FFC aimed to address was that the women failed to engage with family members while trying to communicate healthy practices and accessing services during the pregnancy and child birth. In addition to this, the ASHA, JHA and AWW seldom met together to discuss challenges and work together for a common objective.

Thus, a need was identified for an intensive training that brings these three key workers together and takes them through a process of critical thinking, reflection and evaluation of issues around MNCH the gender-social perspectives. It is also primarily intended to put into perspective how realities of gender roles, power structures and inequalities shape a woman's behaviours and practices. FFC training also emphasises the coordination between all the three front line workers, ASHA, AWW and JHA, to avoid duplication of efforts and build an enabling environment where all three of them can work effectively through mutual support towards improving the health of mothers and infants.

Results: Development of FFC

FFC was chosen as the key tenet of Sukshema's community intervention in order to address the following gaps in order to improve outreach and communication:

- Poor or no focus on significant family members in the communication process.
- Existing materials were information- oriented rather than behaviour- oriented. They were not user friendly.
- Tools and job aids were neither ASHA- friendly or beneficiary-friendly.
- Birth preparedness was not the focus in any of the materials
- None of the materials addressed the male folk
- Lack of focussed communication messages across the MNCH care continuum.

VOICES FROM FFC TRAINING

"In my 30 years of experience I have not attended a training of this kind." – JHA, Bagalkot

"This is the first time that all the FLWs were brought under the same roof for a trainings. It was an excellent thing to do"

"While I did home visits earlier my concentration was only on pregnant women/mother/child, but at the end of this training I realised that family members also should be considered as they have greater influence on women" – ASHA, Bagalkot

"First of all, our perceptions need to change. We need to understand that we are working for WOMEN and not just for any dept." – AWW, Koppal

"We need to think beyond just medical causes into deeper social causes to bring about holistic well bring of women"

The evolution of FFC comprised of activities to ensure that communication is effective and desired messages are transferred to the beneficiaries. Under this component of the intervention, behaviour change communication materials, keeping the woman and her family as focus, were developed and introduced to the FLWs. The following activities were carried out as part of FFC:

1. FFC training for ASHA, AWW and JHA

This training first establishes an understanding among women about the social and gender contexts around the issue of MNCH through its initial sessions and moves on to build their communication skills and coordination functions not just as individual workers but as a team that has a common goal- to improve MNCH. The FFC training was structured in such a way as to facilitate attitudinal changes and dispel individual misconceptions and roadblocks. It was so designed that the FFC training was the first training that all three FLWs attended; in order to provide a good foundation for the project to start work. It has a three day training module in place which addresses socio-cultural and gender issues.

FLWs are taken through 8 main topics areas over the course of 3 days. These are:

- FFC concept and the need to focus on families
- How to communicate- Assessing and building communication skills
- Status of women in society
- Analysis of gender issues and impact on MNCH
- Health services for improving maternal and child health
- The need for coordination among FLW
- Roles and responsibilities of FLW
- Attitudes of FLW

The very last session gives the FLWs an opportunity to provide feedback and the general consensus is that all the FLWs appreciate the content and the training methods (refer to box below).

2. FFC materials

FFC material focuses on enhancing the ASHA's skill of communicating with the woman as well as her family members and trains her to plan her communication messages based on the need and the context within each family. The 2 key FFC materials developed by Sukshema are FLW reminder cards and a birth-preparedness calendar for pregnant women.

2a. Reminder cards for FLWs – a set of cards that can easily be carried and referred by the FLWs during the home visits, to remind them about the key messages that need to be conveyed to the woman and her family members during home visits.

FLW reminder cards are a set of 30 rotatable, business or visiting card-sized cards strung together on a key ring. Each card has messages and corresponding pictures on both sides. Therefore, there are about 60 messages based on eight communication objectives listed below:

1. Birth preparedness
2. Danger signs during pregnancy
3. Danger signs during delivery
4. Danger signs in women during the PNC period
5. Danger signs in the newborn
6. Anaemia
7. Newborn care
8. Family planning

This material is linked to the HBMNC Tool which is intended to help ASHAs counsel women.

Figure 2: Image of the Index of the ASHA Reminder Cards

Advantages of the cards

- The cards are very handy because of their size and can be easily carried by ASHAs in their bags wherever they go.
- Each of the 8 thematic areas have been colour coded and cards with messages under each area follow the same code, making it convenient for ASHAs to easily choose the right card with the relevant message.
- Each card has either a green or a red symbol in the corner. The cards with the red symbol indicate danger signs that need immediate referral to facilities. The green symbol directs ASHA for onsite counselling.
- Every card is dominated by a visual that conveys the message and has minimal text. This makes it easily understandable for the ASHA. These images are black and white with colour being used only in aspects that need to capture the attention of the ASHA.

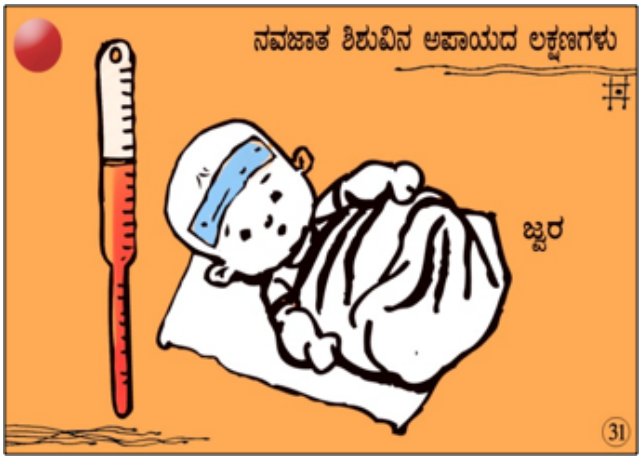
- All cards are attached to a key ring which makes them rotatable.
- The cards are printed on thick, laminated paper that protects them from water and routine wear-and-tear.
- They easily replace bulky reference material since they have the same information in a more minimalistic fashion serving the ASHA's purpose.

Use of cards

ASHA will use these cards as reminders to ensure that their communication messages are focussed, complete and timely. She could also use these cards during her one-on-one interaction with women during ANC, INC and PNC periods.

2b. Birth Preparedness calendar - The purpose of the calendar is to help pregnant women and their families orient themselves on pregnancy and birth preparedness. The birth preparedness calendar is designed in the form of a table calendar with 15 pages. It has messages that focus on the aspect of birth preparedness, printed on both sides of a page.

Figure 3: Image of a danger sign in Newborns

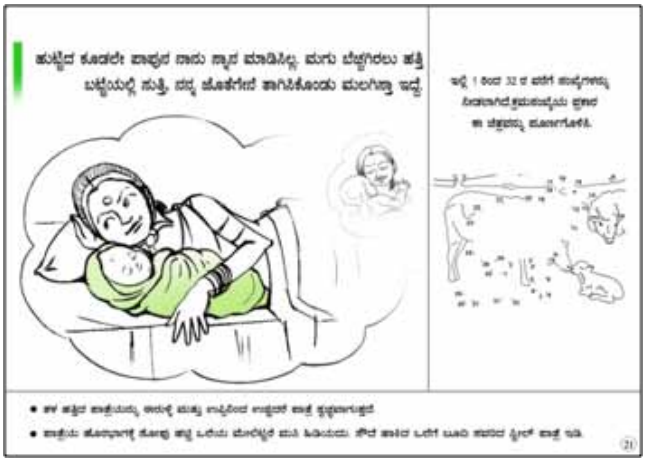


The messages are communicated throughout the calendar using a simple storyline contextualised to the women's local realities.

Every page in the calendar has three parts:
1. The storyline with a picture, related to the key communication message.
2. Creative ideas on cooking, mehndi and rangoli/ games/ riddles/ puzzles that are usually of interest to women in rural areas. This helps women stay involved and interested.
3. Home and beauty tips for women to use in their daily life to motivate women to keep reading the calendar and not discard it.

All the messages in the calendar are sequential and direct the women to prioritize their actions with respect to birth preparedness. Some of the messages communicated are:
1. Importance of registration and testing
2. Iron tablets- Myths and misconceptions
3. Nutrition and vaccinations
4. Lifestyle during pregnancy
5. Danger signs during pregnancy
6. Government Schemes and how to avail them
7. Institutional delivery
8. Savings
9. Preparedness with respect to transportation to the health facility, labour partners, finances, babies' clothes
10. Breast feeding and new born care

Figure 4 : A page from the Birth Preparedness Calendar



Advantages of the calendar

- It is handy and can be placed anywhere in the woman's house and does not need to be hung.
- Its design ensures that it is visible to people viewing it from either side.
- Each page has either a green or red symbol in its corner. The pages with the red symbol indicate danger signs and alert women to seek immediate care at the nearest health facility. The green symbol indicates healthy practices during pregnancy.
- The storyline keeps the interest of the reader. The story line is communicated through drawings which are rustic keeping the local context in mind. The drawings are black and white with colour being used only in aspects that need to capture the attention of the woman or her family.
- Though it is intended as a birth preparedness calendar, it has information across ANC, INC and PNC stages so that that the woman and her

family are well informed and prepared right from the beginning.

- The last page of the calendar has a list of questions which either the ASHA can ask the woman during her home visits or the woman can use to check how well she has internalised these messages.

Use of calendar

This calendar will be provided to every beneficiary. She will use it to orient herself and be well informed about her pregnancy. This can also be used to keep the other family members involved with the woman's pregnancy. This will also help the ASHA to build a rapport with the women during her initial visits.

Lessons learned: FFC training and material development

- The FFC training paves the way for the other interventions to be launched. All the interventions need to be viewed holistically as a package rather than as individual activities at every stage of implementation.
- The training sessions need to be linked ensuring that the messages of one session are connected to the session that follows. It is crucial to provide a sense of continuity since otherwise, the focus may shift and the outcome may be watered down.
- Training needs to be followed immediately by handholding support so that the learning is immediately translated into actual action on the field.
- FFC training needs to focus more on changing attitudes and perspectives rather than building FLW skills. Gender and social issues should dominate the content of the trainings.
- Training methodology is critical for FFC. Participatory approaches and involvement of all the FLWs is essential for its success.
- All FLWs appreciated the pictorial nature of the ASHA reminder cards. It was particularly useful for ASHAs with low literacy skills.
- Linking the reminder cards to the HBMNC tool is useful in supporting the ASHAs improve the effectiveness of carrying out home visits.

4.1.2 Community Demand List (CDL)

Purpose

CDL 1 is a visual tool that will help ASHAs list their target population (pregnant women, women who have recently delivered and newborns) in their allotted geographic area in a particular month, and track this population throughout the continuum of care, i.e. pregnancy, delivery, 42 days post delivery and 18 months of immunization of a child. It allows ASHAs to organize outreach information into 6 broad categories: identification details, antenatal care details, delivery details, post natal care details and immunization details. Additionally the tool has information on the identification details of the ASHA herself – the district, taluka, PHC, Sub centre and village names as well as the estimated number of pregnant women in her area, as per the Community needs assessment carried out by GoK.

This tool attempts to address the following gaps at the frontline worker level:

- Confusion on who is responsible for planning
- Lack of uniformity in planning
- Communication gap between JHAs and ASHAs
- Lack of clarity on the purpose of planning
- Lack of a common format/register for data entry
- Using multiple registers for entry
- Lack of ability to track a registered mother across the care continuum
- No provision to track migrant women

Components of CDL 1

The CDL 1 has the following components:

a. Tracking tool for ASHA in her area (CDL 1)
b. Community Demand List (CDL 2) which is a self reflection and planning and consolidation tool for the ASHA
c. CDL 3 which is a self-reporting tool
d. Guidelines for the use of both the tools that has standard definitions for every indicator

a. Tracking tool (CDL 1)

The following information is collected in this tool by the ASHA for every given pregnant woman in her area. There are a total of 59 indicators in this tool, some of which are listed below.

Section 1: Identification details

(1) Serial number
(2) names of the woman and her husband as well as her blood group
(3) ASHA registration- Registration of the name of pregnant woman, new mothers and children also includes the date of registration
(4) Thayi card number and date issued
(5) contact number of the woman
(6) current age of the woman
(7) Caste group-whether the woman belongs to a scheduled caste or a scheduled tribe
(8) whether the woman has a BPL card or not (9) current gravida and para of the woman
(10) and (11) number of male and female living children
(12) age of the youngest child
(13) Complications experienced during the previous pregnancy/delivery

All this information is collected during the first time the ASHA meets a woman and is used to determine whether there is a need to prioritize services.

Section 2: Antenatal care (ANC) and delivery details

In this section the ASHA records details of ANC services utilized by the woman – either directly through the ASHA or through the JHA, AWW or at a private facility. The details include
(14) Date of last menstrual period – LMP,
(15) expected date of delivery – EDD
(16) gestational month at the time of registration
(17), (18), (19) and (20) dates of first, second, third and fourth ANC checkups before delivery
(21), (22) and (23) dates of receiving the first, second and booster doses of Tetatus Toxoid (TT) injection
(24), (25) and (26) dates and number of Iron-Folic Acid (IFA) tablets received – in three separate visits, and
(27) Complications associated with the current pregnancy.
(28) Serial Number given to Pregnant Woman

The delivery details in ETT include:
(29) date and place of delivery
(30) type of delivery – caesarean, assisted or normal
(31) Name and sex of the newborn, and
(32) Birth weight of newborn

Section 3: Postnatal care (PNC) details

The post-natal care details include
(33), (34), (35), (36), (37) and (38) dates of post-natal care visits on the 3rd, 7th, 14th, 21st, 28th and 42nd day after the delivery and whether the woman is currently using family planning

Section 4: Child immunization details

The immunization details include
(41) Date of BCG vaccination
(42), (43) 0 dose immunization dates for OPV and Hepatitis 0
(44), (45) First dose (OPV and Pentavalent) immunization dates
(46), (47) Second dose (OPV and Pentavalent) immunization dates

(48) , (49) Third dose (OPV and Pentavalent) immunization dates
(50) Date of Measles vaccination
(51) Date of receiving Vitamin A
(52) Date of Japanese Encephalitis (JE) vaccination
(53), (54) Date of Booster dose (DPT, OPV) -
(55) Date of Second Dose of Measles vaccination
(56) Date of second dose of JE vaccination

Section 5: Information on Migration
(57) and (58) Outbound Migration (date on which the pregnant woman left the village) and inbound migration (date on which pregnant enteredvillage).

Section 6: Reasons for mother and child mortality
(59) The date along with reasons for the death of the mother or child as recognized by the ASHA

b. Community Demand List 2 (CDL2)

The CDL 2 serves as a self-reflection and review tool. It has a list of 16 indicators derived from the CDL 1. It helps the ASHA to identify and list only those indicators that are very critical to MNCH care such as registration of the pregnant woman, TT injection, PNC visits, family planning and so forth. This tool is designed to help the ASHA carry out self assessment of the progress she has made on these critical indicators, develop a plan to effectively address the gaps seen, evolve her monthly action plan and reinforce her personal targets as well as engage in constructive reflection of her performance and challenges.

One additional indicator on Family planning has been included in CDL2 which is exclusive (not a part of CDL 1). FP guidelines require that information is captured about those eligible for family planning but are not yet pregnant; and thus is outside the scope of CDL1. Information for this indicator would be taken from EC register.

The Community Demand List 2 provides the ASHA with information of beneficiaries due for services during the month as well as tracks those who have received services during that month. CDL 1 has the list of the names of the beneficiaries. However, CDL 2 will only have their corresponding serial numbers. Therefore the ASHA does not need to write the names of the beneficiaries each time that she identifies their service due in this format. The CDL 2 is expected to be filled by the ASHA the 21st of every month as her reporting period is from the 21st to the 20th of the next month.

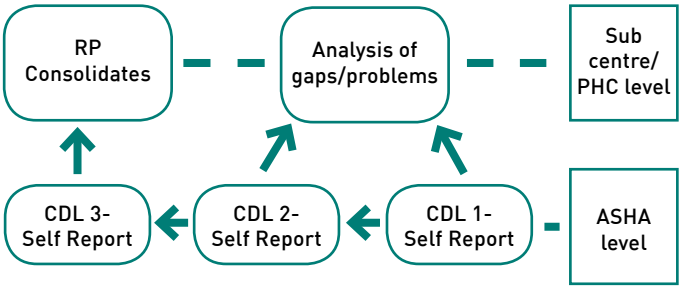
c. Community Demands List 3 (CDL 3)

Similar to CDL2, CDL 3 has two components-

1. Reporting of the previous month's progress which enables the ASHA to record total demand and review her performance on the specific 16 tasks outlined by GoI.
2. Planning - Capture the planning for the next month in terms of her targets. This is an extract of the following month's CDL 2. She copies her CDL-2 data as is, in this section.

On the 21st of every month, after she completes CDL 2 of the reporting month and planning (CDL2) for the next month, then she abstracts her CDL2 data in to CDL3. CDL 3 is to be submitted to the RP/ ASHA facilitator during the ASHA meeting that will be conducted on the 21st of every month.

Figure 5: Flow of information across levels for gap analysis



d. Guidelines

Guidelines for both the tracking tool and the CDL are provided to each ASHA. The guideline for the tracking tool (CDL 1) has definitions of all the 58 indicators while that of CDL 2 has information on how to define targets and achievements. The purpose of the guidelines is to maintain uniformity and have a common standard definition for all indicators used in the tools. This ensures that there is a shared common understanding among ASHAs while using the tool for planning and tracking.

The entire CDL package has been piloted in Koppal and Bagalkot for a period of one year and the tools have now attained a final stage. The key learning from the pilot is that the trainings for CDL should not focus on individual tools rather on the CDL as one entire package with the three tools.

Use of tool

ASHA will record the names of all the women in her area who are either currently pregnant, or have a child under age 18 months, irrespective of whether she is a usual resident of her area or a visitor to her area (for pregnancy/delivery purposes). One row is allocated for one woman.

Thus she will have, at any given point of time, about 60 women who are her current target groups (about 20 currently pregnant women, about 20 recently delivered women and about 20 women who have delivered in the previous year).

Every month, ASHAs with the help of JHAs and RPs, will use CDL to plan their outreach services. This planning will be done by identifying, from the CDL, who is due for what type of service during a given month, based on (1) whether a woman is due for a service as per the prescribed schedule for MNCH service delivery and (2) whether the woman has already received a service due for her in that month. Based on the target as well as the number of women receiving services, the ASHA will fill tool CDL 2 at the end of every month to carry out an assessment of her own performance on key indicators. ASHAs then fill out CDL 3, which is a abstract of CDL-2 and will submit it to the RP during the ASHA meeting that will be conducted on the 21st of every month.

Results: CDL development

It is expected that frontline workers will find value in using the tool to help them better serve their communities.

Several considerations guided the design of the new tool to enhance its appeal to frontline workers including that it:

- Serves a handy tool for the ASHA to carry with her wherever she goes and update information regarding all services she delivers, irrespective of what they are and where they are given.
- Enables her to keep track of her daily progress and guides her follow- up.
- Reduces duplication of documentation.
- Is a systematic approach to simplify and organizes ASHA's work.
- Helps consolidate data even at the JHA level.
- Is a simple tool that can be used by all ASHAs irrespective of their literacy levels.
- Enables tracking of migrant women.
- Provides all beneficiary information in one tool rather than having to refer to multiple registers.
- Enables ASHAs to assess their performance and review their own work

The Sukshema technical team led the development of this tool in consultation with other Sukshema staff, several frontline workers, and the University of Manitoba. The iterative development process took place over a 10 - month period. Developers referred to existing GoK tools, GoI tools and ASHA guidelines to prepare the content of the tool.

After obtaining approval from the NRHM Mission Director, the tool was field tested in the pilot districts of Koppal and Bagalkot.

Lessons learned: CDL development

- **Iterative changes:** The tool/job aid, which was designed initially as a chart for listing down pregnant woman details in a village by an ASHA worker, was later customized to ease operations at the field level. The tool had to go through several changes after testing on the field.
- **Hardbound tool:** The tool had to be provided in a hard bound book or a Diary for retention rather than a separate hand out which used to be lost easily.
- **Practical training:** FLW training strategy for the tool should involve practical field exercises which should be facilitated by an experienced JHA/ ASHA mentor/ASHA Facilitator in the field.
- **Rigorous handholding:** Information such as Gravida, Parity and Abortion status and EDD of pregnant women included in the tool will require rigorous handholding of ASHA workers to ensure its effective usage. The importance of estimating expected date of delivery (EDD) in the tool should be reinforced to the ASHA workers in the consecutive review meetings. EDD would not only help effective planning of ANC/Delivery/ PNC services but would also aid in informed decision making of the family to avail free government MNCH schemes
- **Grading ASHAs:** Grading of the tool's users based on their ability to write and understand the tool is essential for planning the frequency of handholding by facilitator/trainer for each of the poor graded ASHA worker.
- **ASHA advocacy:** Advocating with the Health department for absorption of tool within the system is critical but the advocacy role is the ASHAs' and not Sukshema staff. The users of the tool should advocate for its inclusion. ASHAs' acceptance of ETT/CDL would eventually lead to system acceptance.
- **Simplicity:** Tools need to address ASHA needs. They need to be simple and easy to use rather than be a means of data generation for the project or the government.
- **Meet community demands:** The main purpose of the tool should be to meet community demands and help ASHAs plan better on how to meet these demands.

4.1.3 ASHA Diary

Purpose

The ASHA DIARY was developed in order to provide a comprehensive record for ASHAs that would encompass the ETT/CDL tools in addition to other relevant job aids and tools. It encompasses a daily activity record, monthly calendar with important days marked, a set of pictures for communicating key messages regarding care during ANC, delivery and PNC periods, contact numbers of key officials, tools for planning and tracking beneficiaries, tools for self review and reflection, MNCH messages that serve as reminders, ASHA incentive list for her claims, EDD calculation calendar as well as tools to record other services she provides such as HIV, TB. The diary serves as a job aid that has proven to successfully provide a one stop solution for most of the issues that the ASHA has been facing on the field. The Diary makes available all related formats for MNCH service delivery and follow up, local ASHA area level data for reporting and planning, communication material for home visits, monthly calendar for planning activities and other essential information for ASHA both within and outside the MNCH context in a single record.

Components of the Diary

1. Preface - this introduces NRHM and its key objectives, ASHAs role, the MNCH community intervention designed to support her work in the field and the purpose of the diary.
2. Personal information - this provides space for the ASHAs to record her personal information such as Name, area of work, address, contact number, birthdays, anniversaries and so on.
3. ASHA Information - space for filling details about other ASHAs in her sub centre area. This will help her know whom to contact if the need arises, especially for referrals.

Figure 6: Image of front cover of ASHA Diary

4. PHC and Sub centre information - details about PHC and sub centre such as address, names and contacts of staff. Sub-centre wise Anganwadi worker details are also included. This will help ASHAs in referrals and for when she needs to contact these health workers.
5. Important contact numbers - space to fill contact numbers of Gram Panchayat President, PDO (Panchayat Development officer), VHSNC president, TH and DH, SHGs (Self help Groups) is provided.
6. Yearly calendar with holiday list is provided in the diary.
7. Space for daily notes - This will help ASHA record her daily activities.
8. Important local festivals - information and dates of festivals and cultural events which also include full moon (hunnime) and newmoon (Amavasya) days. This is important to know because very few women in rural settings remember significant dates. Instead, they keep track of days using dates of local festivals and hunnime and amavasya. This also helps in the calculation of EDD and LMP.
9. Motivational and health related tips/ sayings provided at the bottom of every page to help ASHAs in their communication.
10. Monthly non MNCH data sheet - At the end of every month, the diary also has a page allotted for ASHAs to collect non MNCH data in her area. She will update this data at the end of every month, since she is needs to report this data to the department every month. This space will help her accomplish this task as well, in addition to her prominent role in MNCH.
11. LMP-EDD calendar - This is a tool that readily suggests the possible EDD for pregnant women based on her known LMP. ASHA will find it useful to plan her service cycle.
12. HBMNC (Home Based Maternal and Newborn Care) tool and guidelines are enclosed in the diary. The tool is a sample copy. This tool can be used by ASHAs to improve quality of interaction with women and their families.
13. Communication material - ASHA reminder cards are reproduced in the diary. These pictorially depict important practices during ANC, delivery and PNC periods. ASHAs can use this in their communication with women and families during home visits.
14. Guidelines for conducting Arogya Mantapa - the diary also has guidelines for ASHAs to conduct monthly sub-centre forums (Arogya Mantapa). This will help ASHAs support the process along with the JHAs, AWWs and the VHSNC president.
15. SCMT (Supportive Community Monitoring Tool) - A sample of this tool and guidelines to use it is enclosed in the diary. This tool guides the

ASHA to be involved with the VHSNC members in their supportive monitoring processes.

16. Notes - Space has been provided in the diary for ASHA to make notes on any important subject or issue. That space can be used by her at her own discretion.
17. ETT (Enumeration and Tracking Tool) - This tool has been included in the diary with guidelines to use it. ASHAs will use this tool to identify gaps and effectively address them. ASHAs and JHAs will also be able to prioritize at the sub centre and PHC levels based on ETT.
18. ASHA incentives checklist - the diary also has enclosed the incentive checklist for ASHA which will help her to keep track of the payments that she has received every month for all the 26 suggested line items.

Results: ASHA Diary Development

The ASHA diary evolved based on the feedback gained from the experiences of ASHA using it on the field, department officials in PHCs as well as district and state offices and from the field level staff who have been closely supporting the use of this diary on ground. One ASHA diary is to be used by ASHA for each ASHA area. Therefore, each ASHA will maintain as many diaries as the number of ASHA areas that she covers. **Example:** Ratnamma looks after two ASHA areas since there has been a drop out in her neighbouring village. Ratnamma therefore, will maintain two ASHA diaries for both Mudhol village and the neighbouring Amlapura village. This will help to have area-wise information readily available which, in case of new ASHA recruits, can be passed on to them for follow up.

Over 2000 ASHAs have been trained in the use of this tool. The Goverment of Karnataka has adopted this DIARY as is, as part of its commitment to enhancing the skills of and supporting ASHAs through a systematic, user friendly, simple and contextual job aid that will empower and equip her to meet her daily challenges on the ground.

Advantages of the diary

It helps the ASHA to do the following:

- Record her daily work including personal details
- Record non-MNCH data such as TB, blood smear, VHND and VHSNC related data in her area.
- Record individual and area-wise service delivery data in the enclosed ETT.
- Calculate LMP and EDD of the pregnant women in her area.
- Use the pictorial information to communicate MNCH related messages with pregnant women, new mothers and family members during home visits.
- Use HBMNC tool to collect information during home visits.
- Conduct VHSNC and Sub centre level forum (Arogya Mantap) meetings based on guidelines enclosed.

Comparison of project monitoring data in areas where ASHA Diaries were available and not available

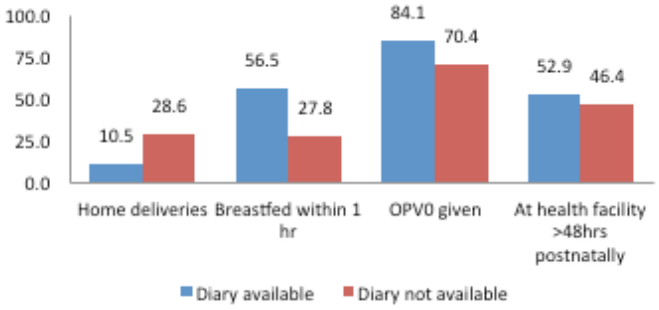
Data collected indicates that availability of ASHA diaries has a positive impact on several MNCH outcomes in an area. On comparing the results in Koppal based on the availability of ASHA diaries

Table 1: Number of ASHAS who received Diaries in Koppal and Bagalkot during Pilot

SL#	District	Sanc-tioned ASHA positions	Working ASHAs	ASHAs who received Diaries with one-day training and orientation
1	BAGAL-KOT	1227	1019	1019
2	KOPPAL	1086	806	806
	TOTAL	**2313**	**1825**	**1825**

(Fig. 7), fewer women delivered at home and a higher percentage of women breastfed within one hour of birth in the 52 areas where ASHA diaries were available, compared to the 12 areas where ASHA diaries were not available. An increased percentage of women also stayed at a health facility for > 48 hours after birth and more newborns received Oral Polio Vaccine at birth (OPV0) in areas where ASHA diaries were available compared to areas where diaries were not available.

Fig.7 Monitoring data in areas where ASHA diaries were available and not available in Koppal



Lessons learned: ASHA Diary development

- **Multiple registers merged in to one:** ASHAs are now able to access all the necessary information in a single place (the diary), compared to earlier when they would refer to multiple registers and information sources. The ASHAs treat the diary more like a handbook that provides a one stop solution for most of the issues that ASHA faces in her daily work.
- **Include non-MNCH topics:** ASHA Diary should also cover non MNCH aspects such as TB status etc.
- **Comprehensive:** It should be comprehensive with visuals, guidelines, and information about all the interventions.
- **ASHA advocacy in all districts:** It is important that the Diary is accepted and promoted by the department and by the ASHAs in all districts of the Karnataka, and not just the project areas. This would ensure uniformity in ASHA reporting processes.

4.1.4 Home-based Maternal and Neonatal Care Tool (HBMNC)

Purpose

The purpose of tool is to improve quality of interactions between front line workers and pregnant and postpartum women. It works as checklist of relevant messages that need to be communicated during ANC and PNC visits by the ASHA. The tool also has information about danger signs and quick referrals. The tool helps ASHAs focus more on communication while making home visits rather than mere information gathering.

The tool is meant to be used by an ASHA during each home visit to a pregnant woman or a woman in the post-natal period (42 days after delivery) and to use as a checklist for screening and linking them to appropriate services. The key objective of the HBMNC is to guide an ASHA to provide comprehensive home based care and enhance effectiveness in her routine outreach services.

This tool attempts to address the following gaps at the frontline worker level:

- ASHAs did not know the purpose of a home visit, despite being trained in home-based care by GoI.
- Their interactions during home visits lacked focus and quality.
- Existing home-based care tools were lengthy, were not user-friendly and hardly anyone was using these existing tools.

Components of HBMNC

The HBMNC tool has the following components:

Section 1: Identification

This has identification details of the ASHA and the pregnant woman/ nursing mother's background information. The ASHA collects this information during the first home visit which is usually in the ANC period. During the course of her informal discussion, she will gather this information which will serve as the starting point of establishing rapport with the pregnant woman and her family.

The beneficiary's social and economic background, previous pregnancies and other personal details are gathered at this stage, to enable an ASHA to discern or assess the kind of family environment that the

woman is in. Based on this information, the ASHA can plan her communication strategy with the family. A key indicator in this section is the LMP and the EDD of the woman. This will help the ASHA plan for ensuring timely services for the woman.

In cases where the ASHA is meeting the woman for the first time only after the delivery is completed, she will still need to fill out the basic personal details of the woman in this section.

Section 2: Antenatal Home Visits

This section focuses on visit details, complaints, tests, and ANC checkups, risks during pregnancy, counselling and referral. Though the crucial period for safeguarding mothers and newborn lies in how effectively the PNC services are given, discussions with the frontline workers revealed that the need to include information on ANC which in the long run would contribute to the health of the mother and child.

This section therefore, aims at supporting the ASHA in delivering all ANC services during the ANC home visits.

This section has three sequential parts:

a) Screening of pregnant women for danger signs
b) Identifying which of the pregnancies is high risk
c) Counselling
d) Referrals and follow up

The tool lists all the danger signs as well as all the symptoms of high risk pregnancies. This helps ASHAs screen the women and suggest appropriate action in terms of tests, referrals through follow up ANC checkups and counselling. A list of issues that need to be addressed through counselling is also included in the tool to help ASHAs.

The tool also records the facility to which the woman has been referred and the reasons for the referral. The ASHA is expected to plan a date for the follow up of the case in her tool.

Section 3: Delivery details

This section has details such as delivery date, place of delivery, name of institution, type of delivery and basic information of the baby such as sex and weight. An important part of this section is a record of complications that the woman may have had during her delivery (whether institutional or elsewhere). All the information in this section is collected by the ASHA during her first PNC visit. This section helps the ASHA to plan her PNC visits and her communication strategy with the woman and her family, which is the next section of the tool.

Section 4: Post Natal Home Visits

This section has information on maternal and newborn complaints, behaviours, counselling and referral.

There are four sequential aspects in this section:

a) Maternal and new born danger signs
b) Behaviour and practices followed by the woman
c) Counselling
d) Referral and follow up

Assessing a woman's behaviours and practices will help the ASHA plan her communication messages, including those on 'safe motherhood practices'. This section helps the ASHA identify danger signs and accordingly refer the woman and newborn to a facility.

A list of issues that need to be addressed through counselling is also provided.
ASHAs can also use this section to record the facility to which the woman has been referred to and reasons for the referral. The ASHA is expected to plan a date for the follow up of the beneficiary in her tool.

Use of tool

The tool will help the ASHA identify the problem and customize her communication messages based on the needs identified. She can effectively utilize the communication materials that go along with the HBMNC i.e. pictures and visual cards given to her. This will simplify the message for the woman, help her better recollect the message.

The ASHA will fill out the tool only after completing her home visit rather than during her interaction with the women, so as to not distract from the interaction and seem disrespectful to the woman.

NOTE: There is an ongoing process to convert the entire tool into a pictorial one to make it more user-friendly.

Results: HBMNC development

In order to improve the quality of interactions between the ASHA and the pregnant/recently delivered woman and the newborn during the antenatal and post-natal periods, Sukshema introduced the HBMNC tool as a job-aid to help ASHAs remember to seek certain information from the mother about herself or her newborn, so that she can screen for any complications during pregnancy or post-delivery. The HBMNC tool is intended

to be used by ASHA in her every home visit to a pregnant woman or a woman in the post-natal period (42 days after delivery),to guide ASHAs to provide comprehensive home based care and help them effectively discharge their duties is the key objective of this format.

Several considerations guided the design of the new tool to enhance its appeal to ASHAs including that it should:

- Help ASHAs observe the health status of pregnant or nursing mothers while at home and suggest suitable remedial measures
- Make the mothers' health information available in a standard format. This can be called a mirror image of the case record of pregnant/ nursing mother available at the health centre
- Contain the details about the 'must observe' components while caring for the pregnant/ nursing mothers. For ex. It provides a list of danger signs, that could be used for timely identification of problems and to provide appropriate services by the ASHA
- Highlight situations that may require counseling or referral for higher care
- Help ASHA track important services (like Thayi Card, Pregnancy check-ups and follow up) availed by the pregnant/ nursing mother
- Help ASHAs develop and conduct village level health activity plans
- Serve as a reminder to ASHAs to go through all the key components during a home visit
- Help ASHAs counsel on social and behavioural around MNCH practices
- Help ASHAs prioritize communication messages during home visits and identify 'influencers' within the family with whom she needs to communicate
- Help ASHAs provide comprehensive and quality home based care to every woman and newborn

Lessons learned: HBMNC development

- It is important to assess existing tools on the ground before developing new tools. The HBMNC tool developed by the government was only simplified by Sukshema. Involvement of the users of the tool, i.e.FLWs, in this process is critical.
- It is crucial to ensure that the training content of Sukshema trainings do not overlap with the Government's trainings. The ASHAs were already trained on technical MNCH concepts and HBNC by the Health department. In Sukshema, the focus was more on orienting them to the simplified tool and on communication skills.
- A key strategy is to use resource persons within the health department to conduct the orientations. Based on experiences in the pilot districts, the combination of Sukshema RPs and government RPs in the HBMNC roll out training worked well. The government RPs had a wealth of technical knowledge while the Sukshema RPs excelled in communication.
- Linking the reminder cards with the HBMNC tool worked well. As a result, ASHAs with low literacy skills found the tool more effective and useful in conducting the home visits rather than filling the HBMNC tool itself. Developing supportive materials to simplify FLW tasks is important.
- Adapting the usage of the tool to what suits the FLWs best is important. The tool's original purpose was to help ASHAs create case records of every beneficiary based on their home visits. However, based on its usage in the field, FLWs seem to value it more as a checklist that helps them screen pregnant woman, make referrals and counsel without missing any important messages.
- Handholding support post-training is essential to ensure appropriate use of tool. Some of the project RPs found it difficult to handhold ASHA for HBMNC tool usage owing to its highly technical nature. Therefore, equipping the RPs to effectively handhold should be a project priority.

4.1.5 Supportive Community Monitoring Tool (SCMT)

Purpose

SCMT attempts to involve the community through Village Health Sanitation and Nutrition Committees (VHSNC) in planning and monitoring village health service delivery to realize the community participation and ownership of village health programs as envisaged in the goals of NHM, strengthen community accountability towards village health in general and improved MNCH outcomes in particular and provide opportunity for FLWs to be supported by the community in their efforts to improve MNCH outcomes.

Its main aims are:

- to provide space for VHSNC members to understand, assess and monitor health situations
- to help communities come up with local and joint solutions for issues around MNCH and support efforts of front line workers in this area
- to enhance accountability and sustainability of health activities at a village level
- Promote supportive community monitoring

The tool tries to address the following gaps:

- Ineffective and inefficient VHSNC committees
- Lack of supportive monitoring and participatory facilitation
- Lack of ownership and accountability of village health programs in general and MNCH issues in particular in the community.
- Widening gap between communities' health needs and the health service system.
- Lack of tools/mechanisms that help VHSNC members identify specific issues that can guide their actions.
- Lack of accountability towards the health status of mothers and children in the village by the Panchayat.
- Lack of opportunity for engagement at the community level to assess health situations and develop local and joint solutions for them.

This tool is intended to help the community realize its right to these services while also being accountable to ensure that their responsibility to enforce this right is also ensured. This tool will be used by six chosen members which includes the ASHA worker, President of the VHSNC, member secretary, SC/ST representative, SG rep, youth rep, elderly village opinion creator with social concern at the village level. Within every VHSNC who will be called the Supportive Community Monitoring Team (SCMT team).

Components of the tool

The Supportive Community Monitoring Tool has the following 4 sections-

Section 1: Services across ANC, delivery and PNC periods

In this section, SCMT members carry out discussions with ASHAs in the village regarding eight specific services namely:

1. ANC registration and distribution of Thai card
2. TT injections
3. Distribution IFA tablets
4. ANC visits
5. Institutional and assisted deliveries
6. PNC visits
7. Full immunization of infants
8. Family Planning
9. DOT service for TB
10. IFA tablet distribution to school going adolescent girls

The SCMT members record the outcome of this discussion as the current status of the village under these indicators and also record existing gaps.

Section 2: Nutrition

In this section, the SCMT members will conduct discussions with Anganwadi workers (AWWs) in their village to gather information on the following:

1. Thayandira sabhe (monthly mothers' meeting)
2. Observation of Village Health and Nutrition Day(VHND)
3. Distribution of supplementary food
4. Regular weighing of all children
5. Supplementary food for children with low birth weight
6. Ensuring that all eligible children are referred for Balasanjeevani scheme
7. Ensuring that all eligible children are referred for Bhagyalakshmi scheme
8. Maintaining cleanliness in Anganwadi

The SCMT members record the outcome of this discussion as the current status of the village under these indicators and record existing gaps.

Section 3: Key health aspects to be observed by VHSNC

In this section, the SCMT members have a discussion with the VHSNC members of the village to understand the status of the following:

1. Chlorination of drinking water
2. Ensuring if all ASHA and AWW are recruited
3. Ensuring that the JHA regularly visits the village
4. Support for anaemic pregnant women, mothers of new born and malnourished infants

from VHSNCs (in the form of medicines or supplementary food)
5. Monitoring of immunization programme
6. Ensuring that Madilu kit scheme is availed by all BPL mothers
7. Ensuring that all children are availing the mid day meal scheme.
8. Ensuring that anaemic pregnant women and mothers of new born have received all the necessary care/ services

Section 4: Village's health status

1. Instances of child marriage
2. Instances of infant deaths
3. Instances of maternal deaths
4. Death due to communicable diseases

The SCMT members record the outcome of this discussion as the current status of the village under these indicators and record existing gaps.

Format of the tool

This tool is a very simple pictorial format that can be filled even by SCMT members with low literacy levels. There are two symbols- a smiley face and a sad face- next to all indicators. SCMT members will tick either of these two symbols against every indicator. If the achievement is above, then it would mean a smiley face. If it is below it would mean a sad face.

Under each section, once the indicators are ticked, SCMT members will count the total number of smiley faces and sad faces which will be consolidated in the last page of the tool for every month.

Consolidation table

The total number of counts of the two faces provides a snapshot of the village using three categories:
1) Good (smiley face): If the total number of smiley faces across all indicators is 25 and above, it indicates that the status of the village is good.
2) Average (neutral face): If the total number of smiley faces is between 15 and 24, it indicates that the status of the village is average.
3) Poor (sad face): If the total number of smiley faces is 14 or less, it indicates that the status of the village is poor.

Under section 4, if the village shows a single sad face, it affects the overall consolidation measure greatly. This is to ensure that the seriousness of the four indicators in this section is understood by the community.

There is scope to use a copy of the tool for a period of one year after which new copies of the tool will be provided to the SCMT members. Specific guidelines have been provided to fill this tool.

Figure 8: Image of smiley, Neutral and Sad Faces in SCMT

Use of tool

The six-member SCMT team will comprise of the VHSNC president, ASHA, AWW, representatives of women's groups, youth groups, and the SC/ ST community. The gaps identified will be classified as those that need to be addressed at the individual/family level, those that need to be addressed at the community level and those that need to be addressed at the systems level. The gaps are discussed and solutions are identified at the Panchayat level and at the sub centre platform (Arogya Mantapa) level.

Community's gain

If this tool is adopted by the community/ VHSNC, then it has the scope to bring about collective responsibility among community members in supporting FLWs and ensuring that socio-cultural practices that directly and indirectly affect the village health and more specifically MNCH are curbed and well managed.

Lessons learned: SCMT development

- Though the SCMT Tool has been developed for the purpose of monitoring MNCH indicators, it should also monitor indicators that are outside the purview of MNCH since the VHSNCs under the NRHM have a larger mandate of the overall village health status and sanitation
- The VHSNC members need to also be trained on using the outcome of this monitoring process for advocacy towards long term changes at the decision making levels within the department
- Using the available state training resources and centres such as the satellite training centres would help the purpose of creating greater ownership of this programme
- Important to guide the VHSNC/ SCMT members initially through a review and reflection and follow up processes
- Strengthening and handholding the SCMT committee within the VHSNC is critical in order to ensure sustainability of this effort

4.1.6 Arogya Mantapa (AM)

Purpose

Arogya Mantapa is a sub centre level collaborative forum of front line health workers. Its members are all the ASHAs, JHAs, AWWs and the VHSNC president falling under that given sub center limits. The JHA plays the role of coordinating the activities of the Arogya Mantapa and the project RP assists their efforts when requested for and also be special invitees occasionally. AM's purpose is to create an opportunity for FLWs and VHSC members to meet, identify issues in their individual work fields, shape appropriate solutions jointly and support each other to implement it.

AM also aims to create the space for building stronger team relationships by understanding each other's struggles, and safeguarding each other's self respect.

The Arogya Mantapa is guided by the following principles and values:

- Gender equality and respect for women
- Respect for individual differences and heterogeneity
- Strong belief in the common vision for reducing IMR and MMR
- Mutual respect and trust
- Transparency and democratic values
- Valuing local realities and context for planning strategies
- Non hierarchical in field relationships
- Team work and respect for every individual member's sensibilities
- Value for community participation and involvement
- Inclusiveness and respect for marginalized groups

Process of starting an Arogya Mantapa at a Sub-Centre

The formal process to begin the Arogya Mantap will comprise of the following activities:

1. Project field staff has one-on-one discussions with FLWs, the VHSC presidents in their area about this concept .
2. These discussions are documented in order to elicit if such an effort is a felt need and accordingly take it forward in their areas. The belief is to implement activities only in response to the felt needs of either the community or the front line workers.

On assessing the field situation, the project implementation team will proceed with the Arogya Mantapa formation.

Arogya Mantapa's monthly meeting process

The duration of the meeting usually does not exceed 2 hours. The meetings are conducted at different sites in the villages such as the Panchayat offices, Sub centre offices, Anganwadi centres, Community halls and sometimes even at FLWs homes.

During the first hour of the meeting the FLWs usually update everyone on the status of their work with regard to the Sukshema's community interventions (please see table below). The second half of the meeting generally focuses on team building activities and entertainment such as craft and cooking demonstrations, home remedies for illnesses, potlucks, rangoli competitions etc. The proceedings of the meeting are recorded.

Table 2: A model AM meeting plan

Sl. No.	Issue	Duration
1	Prayer, Welcome	5 minutes
2	Monthly announcements	5 minutes
3	Experience sharing- a. Pregnant woman count from the previous month b. Child deliveries in the current month in my area (Institution/Home) c. Details regarding successful distribution of services among pregnant/ new mothers d. Specific problems stopping the distribution of services	25 minutes
4	Expected Support from the VHSNC	15 minutes
5	Preparation of nutritious food (This can also be utilized to celebrate birthdays of members, anniversaries, etc)	15 minutes
6	Entertainment (Songs, jokes, funny moments during work, etc)	15 minutes
7	Indoor games/ competitions (Musical chairs, etc)	25 minutes
8	Details regarding the next meeting & vote of thanks	5 minutes

Role of resource persons/ Project field staff

The RP coordinates the first meeting of the Arogya Mantapa almost entirely. They assist the JHAs in planning future meetings. They attend subsequent AM meetings to ensure that participants are aware of the purpose of AM. They assist in resolving conflicts during meetings. They track participation during meetings and support JHAs to ensure that all the members including the VHSC presidents are regular. They help review meeting documents prepared by FLWs. They ensure that the issues and decisions made at the meeting regarding the community interventions are followed up in the field.

Indicators to check results

The following indicators reflect the current status of Arogya Mantaps in the districts:

- Total number of Arogya Mantapas formed in the district
- Total number of active Arogya Mantapas in the state
- Total number of Arogya Mantapa meetings conducted
- Total number of members present at Arogya Mantapa meetings
- List of issues discussed at Arogya Mantapa meetings- ETT, HBMNC, communication hurdles.
- Percentage categorization of issues discussed and followed up.
- Type of activities conducted by the Arogya Mantapa.
- Number and type of services extended and problems solved by health temples during emergencies
- Instances where Arogya Mantapas have given able support to ASHA workers

Results: Arogya Mantapa development

In the FFC training program (the first of our community interventions) conducted for more than 3000 FLWs in Koppal and Bagalkot districts, the overall feedback was that "there is a continued need for all of us to work together and we have to motivate ourselves to fan the flame in us to move forward for achieving our goal of improving maternal and child health". There was also a suggestion that expounded the idea of some sort of a platform in close proximity to their respective homes where they could assemble, share their experiences, their struggles, and listen and support each other. Many expressed the need to involve the community often and seek their support in addressing health concerns of mothers and children. Therefore, the AM concept was born with the intent to bring them together as a team, streamline their joint discussions into something concrete, and to give their discussions structure, purpose and a set of operational guidelines. Through the AM, the FLWs not only benefit from each other's experiences, but are also able to review the progress of the community interventions, understand the areas of support that the FLWs need, assist any FLWs who need additional support in their field work.

4.1.7 PHC level Convergence Meeting

Purpose

In addition to the five core Community interventions, the PHC level convergence meeting has also been supported by the team on the field. This is a monthly ASHA review and planning meeting. This is a Medical Officer (MO)-led meeting at the PHC level that was intended to be a forum where the MO-PHC, JHAs and the RPs can review the ASHAs' work, collect and compile reports and provide incentive payments to ASHAs. Although this meeting is not a new component of the health system that was introduced by Sukshema, it can still be considered an important component of the project because Sukshema helped strengthen the functionality and effectiveness of this meeting. It is one of the three important forums on which the project's handholding strategy for ASHAs is based.

PHC level convergence meeting process

Each RP is mandated to handhold (i.e. build capacity through on job training approach) around 20 ASHAs.

The PHC level ASHA convergence meeting is used by the RPs to handhold ASHAs, since an ASHA's reporting period is the 21st of the current month to 20th of the following month. Since it is MO-led, it is the only scheduled contact meeting between the MO-PHC and the ASHAs. Therefore, it is an ideal forum for ASHA diary verification, the assessment of CDL usage as a self-planning, self-review and self-reflection tool, grading of ASHAs based on their handholding needs, submitting the listed community demands/needs to the concerned JHA and MO, and receiving incentives for the services rendered during the previous month. Based on their assessment of the handholding needs of different ASHAs, the RPs and ASHAs make a combined handholding action plan.

4.2 IMPLEMENTATION STEP 2: Recruitment and Training of Resource Persons (RPs) in Koppal and Bagalkot

In designing the community interventions, a key decision was to determine the profile of resource persons. At a minimum, RPs had to be at least secondary school graduates and had to be from Koppal or Bagalkot. A hiring committee was created with respective team leaders from Sukshema's Community Intervention team.

The hiring committee crafted a 3-tier hiring strategy to identify the best candidates. Because of the varied skills that RPs need to possess, it was thought that a conventional hiring process of screening CVs and interviewing candidates might not be sufficient to fully assess a candidate's capacities for the position. Also the project's need to hire many candidates at once offered opportunities for more creative group based assessment processes. This process is important owing to its priority on appointing local candidates, female candidates, persons from backward caste. Identifying local capacity helps in sustainability as well as reducing turnover and drop out.

Information on each level of the hiring process is presented below.

First level of screening

The project placed local advertisements in local Kannada newspapers at the taluk and district level and posted position openings in Dec, 2012. The project received around 400 applications. Interested male and female candidates with the above listed qualifications were asked to submit self-written applications.

The applicants were asked to mandatorily provide the following information.
1. Name: 2. Sex: 3. Date of birth: (Age) 4. Educational qualifications: 5. Residence, postal address: 6. Permanent address: (Village, Town, Taluk, etc has to be clearly stated) 7. Marital details: 8.Experience of serving in a rural area: (In a minimum of 10 lines) 9. Opinion of the candidate about the personal qualities and capacity he or she possesses to work as a resource person: (In a minimum of 10 lines) 10. Signature

Additional desired information to be included was:
1. Telephone number: 2. Present occupation/ Unemployed: 3. If employed, monthly income: 4. Interests/Hobbies: 5. Training programs attended: (E.g. Health, Leadership, Development, etc) 6. Information about interests in drama, music, arts, oratory, report writing, photography, etc

RP Qualifications

- RPs should be above 18 years and below 35 years (For suitable scheduled caste/tribe candidates)
- The candidate should have a minimum educational qualification of SSLC and candidates who have studied above this will be given preference. (If suitable candidates with this educational qualification are not available, the qualification limit can be relaxed to the 7th standard level)
- Should be a resident of a village in Koppal or Bagalkot district for the last five years. (A proof of residence stating the above mentioned qualification should be submitted during the interview)
- Should be committed to work in all villages as per program specifications

Of the 441 applicants in each district, the hiring team selected about 250 candidates in each district based on their applications.

Second level of screening

The selected candidates from the first round of screening were sent a questionnaire which they had to fill out and mail back to the project offices by a stipulated date. The questionnaire comprised of questions related to a range of topics including linguistic abilities, personal socioeconomic details, emotional details, MNCH topics. Also, information on their participation in social activities within their communities was asked. Of the 250 questionnaires received, about 100 applicants were invited to attend a 2-day workshop in each district.

Third level of screening

The project team organized a 2 day workshop for candidates that included discussions on rural health management, an exercise involving a group discussion, emotional creative expression tests, oratorical tests, and teambuilding and communication tests.

Checklists were used by the assessors to aid in objective scoring of the candidates across different competencies. After the 2 day session, about half of the candidates (about 50 of the 100 candidates) were offered positions.

Pre-induction and Induction Training

A total of 106 RPs (about 1 per PHC) in the two districts were recruited during the month of March 2012. The newly recruited RPs engaged in a one

An RP success story from Koppal district

Kumar, an RP in Koppal, faced a number of challenges in the project and his first hurdle was getting buy-in from the ASHAs, MO and JHAs for the ASHA diary. FLWs felt that filling out the ASHA diary was a duplication of effort since they were already filling out the RCHO diary. Kumar's supervisor asked him to fill the diaries for the ASHAs. After filling out 3 diaries, he realized that this was not a sustainable solution and would possibly have a negative impact on the project. He was disheartened and came very close to resigning his RP position. Meanwhile, Kumar was alerted about a maternal death at a village nearby. He visited the village along with the MO, during which he briefed the MO about the purpose of the ASHA diary and convinced him that this death could have been averted if the ASHA diary had been used properly. Also, Kumar reasoned that since Sukshema was providing free diaries, it was in the PHC's best interest to save printing costs and use their untied funds for other activities and services. After some deliberation, the MO recommended that ASHAs at that PHC use only the ASHA diary.

When Kumar heard that the PHC needed more Sukshema case sheets, he contacted their Nurse Mentor who did not respond to him in a timely manner. He immediately contacted the Koppal office and carried 40 case sheets back to the MO. When asked what the urgency was he replied "If there is no case sheet, they don't record and refer the case. And if this continues, then dealing with a number of case sheets becomes difficult and this may lead to maternal death."

During the RP assessment process, project team leaders found that Kumar was very systematic and organized. He had documented all issues and actions taken at that PHC, with signatures from the MO so that the MO was made aware of everything which would make it easier for Kumar to follow-up. Kumar's dedication and effort was appreciated in front the entire district team and the KHPT project leads gifted him a book. Kumar got very emotional and told one of the project leads that this was the first time that he had got any appreciation for his work.

month pre-induction profiling of their respective PHCs (1 RP: 1 PHC). RPs collected information on the number of sub-centres and ASHAs and engaged in other activities such as planning for training activities, sensitization and relationship building with the Medical Officers, Taluk Health Officers etc. There were several dropouts, both initially and once roll-out had started. However, since there were 2 RPs who were shortlisted per cluster there was always an RP available to fill in vacant positions due to dropouts. Three-day induction training was conducted in three rolling batches during 12-17 March 2012 at Kudalasangama in Bagalkot district. The training covered the following topics (a) introduction to project Sukshema – goals, objectives, technical interventions and solution levers (b) maternal, newborn and infant care services during ANC, intra-partum, post-partum and postnatal periods (c) service delivery mechanisms (d) proposed interventions at the community level for the FLWs and community structures. The resource persons included the technical leads and managers at the central office, district program specialists, and district M & E specialists. The training method included lectures, group works and role plays.

On the last day of the induction training, all RPs had to plan for taluk-wise FFC trainings. There were about 20 drop-outs in total in both pilot districts.

Role of RPs in Sukshema- Handholding Support

The major role of RPs in the project was to supervise and provide handholding support to ASHAs. RPs are provided with a number of supportive supervision and monitoring tools to guide their work. A list of the tools is given below (refer to annexures for complete tools).

- **RP analysis format:** This is a sub-centre level tool that RPs fill out each month. The tool has several key Maternal and Newborn/Child health indicators that RPs track each month, as well a section for gap analyses.
- **SCMT handholding checklist:** This is a checklist for RPs to follow when SCMT meetings/ VHSNC meetings are conducted. RPs grade the meetings based on performance, using indicators such as adequately filling SCMT tool, member participation, functioning effectively without RP assistance etc
- **AM handholding checklist:** This checklist helps RPs assess AM meetings using indicators such as attendance by all members, gap analyses carried out at AM meeting, preparing monthly action plans etc
- **HBMNC checklist:** This checklist helps RPs assess the quality of interaction between an ASHA and her client (in this case, a pregnant

or postpartum woman) using indicators such as using appropriate counseling messages and tools, effective communication skills, scheduling follow-up visits etc.

- **RP reporting format:** This is a consolidated reporting tool for the RP to refer to as needed. It has 5 forms that need to be filled out by RPs
  - Day-to-Day Handholding reporting format
  - Monthly ASHA Grading Format
  - RP monthly handholding reporting format (Abstracted verson)
  - Sub-centre wise monthly progress format
  - PHC convergence meeting report

As mentioned above, providing handholding support to ASHAs is the main role of the RPs. RPs help build the capacity of ASHAs with on-the-job training. RPs use the checklists as guides to help them grade ASHAs based on their ability to adequately fill out the tools and to know what and who to focus on during the handholding process (Please refer to the Scale-up for more information on Handholding and ASHA Grading).

Lessons learned: Hiring RPs

What worked well:

- The process followed for identifying and recruiting RPs worked well. The candidates that were ultimately selected were the best performers on various assessments and evaluations.
- The pre-induction profiling of their respective PHCs and their 5 day induction training proved valuable as candidates had additional time to learn about the job responsibilities. (Any drop outs?)
- The hiring process was effective in identifying strong candidates but the process itself required a substantial level of engagement of senior project staff that may be difficult to replicate in a government system at scale.

Challenges:

- Initially, the transition from a community mobilization approach in the VHSNC project to a technical support task of MNCH project took time.
- RPs had poor grasp of key MNCH content and were still in the VHSNC and HIV mind-set from previous projects.
- There was a need for extensive handholding support of RPs in the initial couple of months
- Acceptance of RPs among the department officials took time initially.
- Taluk Co-coordinators and CMOs had to translate all abbreviations into Kannada and refreshers were provided at each contact period.
- RPs youthfulness and lack of experience, in some cases, might pose a challenge to their ability to establish credibility with the FLWs and more experienced PHC staff.

4.3 IMPLEMENTATION STEP 3: Conducting The Baseline Community-Based Tracking Survey (CBTS)

Purpose

CBTS is a simple and rapid sample survey of target populations to measure intended outcomes in the population. The survey is conducted once every 4 months in a representative sample of women who have delivered in the past 2 months to collect data on

- Knowledge of mothers on key MNCH issues
- Utilization of MNCH services from the front line workers and health facilities
- Practices regarding maternal and newborn care

CBTS provides information on short-term changes and relatively more real-time data that are required for program monitoring. It is short, more frequent, and better focused to track short-term changes in indicators at smaller geographic areas. Results from the CBTS helps the central project team and field staff tweak program implementation strategies in order to stay focused on outcomes. Data from CBTS is used by ASHAs to prioritize outreach activities. **NOTE:** For further information, please refer to the section titled "Monitoring and Evaluating the Community Intervention".

For Round 1(Baseline) of CBTS, RPs collected baseline CBTS information and conducted household surveys over a period of 2 months. However, subsequent rounds of CBTS were conducted by trained enumerators.

4.4 IMPLEMENTATION STEP 4: Training Front Line Workers on all five community interventions

The FFC and ETT ToT for the RPs and a few selected FLWs, was a 3 day residential training. Both FFC and ETT were combined into one ToT because of lack of time. The topics covered included:

- perspectives on community outreach
- improving basic communication skills among FLWs
- achieving coordination among AWWs, ASHAs, JHAs and VHSNCs at the village level
- skills to facilitate sub centre level meetings and coordination among functionaries.

This was similar to the FFC roll-outs for the FLWs which is detailed below.

4.4.1 Training Front-line Workers (ASHAs and JHAs): Family Focussed Communication (FFC) Roll-outs

Context

FFC roll-outs were the first in the set of training workshops. FFC is designed to train all three FLWs (namely ASHAs, JHAs and AWWs) in a given sub-centre. Training of the FLWS in FFC was carried out in two stages:

1) Stage 1: Pilot or 'Soft' Roll-out
2) Stage 2: Full-Fledged FFC Roll-out Training

Pilot or 'Soft' roll-out: Two pilots of FFC were conducted at each Taluk. Resource teams of 4-5 RPs per team were assembled, with at least 2 RPs per team being more experienced. Although, only 2 FFC 'soft' pilots were conducted at each Taluk, all RPs were encouraged to observe the roll-out trainings.

Lessons learned: FFC Pilot or 'Soft' roll-out

What worked well:

- FLWs were organized and received the trainings with much interest

Challenges:

- RPs lacked co-ordination and there was poor transfer of content and loss of key messages initially. TCs and CMOs had to provide intensive handholding support
- FLWs were already trained in key MNCH topics as part of the GoI guidelines, so it was difficult for RPs to keep them engaged and 'tuned-in' during trainings
- RPs youthfulness and lack of experience, in some cases, posed a challenge to their ability to establish credibility with the FLWs.
- Hierarchical differences were apparent during interactions among ASHAs, AWWs and JHAs.

Full-fledged FFC roll-out training: Based on the learnings from the 'soft' roll-out, the full fledged FFC roll-out training was planned in all Taluks of Koppal and Bagalkot. This was a three day residential training guided by participatory methodology and use of activities in all Taluks of Koppal and Bagalkot. RPs were the primary facilitators of this training, with occasional assistance from already trained ASHAs and JHAs

Training agenda and schedule

Day 1: After the personal introductions and a preview to Family-centric communication, the rest of the day focused on enhancing communication skills- verbal and listening skills, individual and group communication skills.

Day 2: After a few sessions on enhancing communication skills, the rest of the day focused on women's issues, dealing with societal biases, understanding power dynamics between men and women.

Day 3: The last day focused entirely on co-ordination of the 3 FLWs using concepts like Three sisters and the discussion of roles and responsibilities of AWWs, JHAs and ASHAs.

Lessons learned: Full-fledged FFC roll-out training

What worked well:

- The experience of rolling out FFC trainings was very encouraging. The FLWs were very appreciative of the methodology followed in the training.
- The project team found it extremely beneficial to start with FFC training during the initial stages of the project's work. It set the stage for project staff to launch all other components of Sukshema's community intervention.
- It brought all the FLWs together for the first time and this served as an opportunity for them to understand each other's roles, challenges and helped them mutually support each other both professionally and personally.
- FLWs learnt to work as a team. According to one AWW from Gangavathi , "Hair will be disorganised if it is not tied properly. ASHA, JHA and AWW are like three strands of hair. It looks beautiful if all three are tied properly. To make our work more smart, all three of us should be tied together".
- The training also dealt with socio-cultural issues around MNCH which helped build perspective of the team. FLWs shifted their focus to include families as well and not just areas such as ANC, immunizations etc
- FLWs acceptance of RPs was markedly increased after the FFC trainings. For eg. FLWs invited RPs to participate in non-Sukshema activities such as immunization days

Challenges:

- Residential aspect of training was challenging both logistically as well as in terms of convincing FLWs and health officers
- Travel allowances were an issue (since only ASHAs get TA/DA)
- Bringing FLWs from 2 different departments (ASHAs and JHAs from Health and AWWs from Woman and Child departments) was a challenge
- Some Taluks had a large number of ASHAs and AWWs to train, so there had to be parallel trainings with several RPs.
- Training venues and providing refreshments were challenging

4.4.2 Training Front-line Workers (ASHAs and JHAs): CDL Roll-outs

Context

This was a non-residential training conducted in stages. Community Demands List (CDL) is for training ASHAs. The trainers for CDL trainings were selected from a pool of ASHAs or JHFAs with good communication skills, understanding of the field and the subject with high confidence levels in their respective sub-centres. RPs provided them with handholding support through the process.

Training agenda

Similar to the FFC trainings, training of ASHAs in ETT was carried out in two stages:

1) Stage 1: Pilot or 'Soft' CDL Roll-out
2) Stage 2: Full-Fledged CDL Roll-out Training

Both Pilot CDL roll-out trainings and full-fledged CDL roll-out trainings had similar formats with various levels to the trainings:

- Level 1- ToT for facilitators at PHC level for 1 day
- Level 2- Training ASHAs at sub centre levels for 1 day
- Level 3- Use of tool on field by ASHAs for 2-3 days
- Level 4- Consolidation and conclusion of training with ASHAs at sub centre level for 1 day.

Lessons learned: CDL roll-out and usage of tool

What worked well:

- Feedback on the CDL training was positive.
- The tool was well received by ASHAs and is beginning to bring positive results with improved planning and outreach at the ASHA level.
- One ASHA from Bagalkot found CDL to be " the most simple tool that we have ever used and it has drastically simplified our recording process and the burden of referring to many registers has been reduced through this".
- A major success of the tool is the fact that the CDL tool helps ASHAs track every single pregnant woman in their area all through her continuum-of-care course.
- CDL was designed to replace at least 13 different registers that previously housed MNCH data and therefore general acceptance and buy-in among FLWs is very high. ASHAs and other FLWs prefer the ASHA diaries and CDL over existing GOI/ GOK tools.
- FLWs feel that the ASHA diaries enable effective sharing of data since all the information is in 'one spot'. An entire year's data is on a single form and this makes it easier to access data whenever there is a request or query. In one taluk, the ASHAs were so relieved that they could share CDL data with their supervisors/nurses even by phone as opposed to having to physically carry all their registers. One ASHA pointed out that there has been a role reversal because after the introduction of the CDL, the JHAs now depend on ASHAs for information on child immunization, ANC etc.
- FLWs find it easier to know what their targets are and also to identify gaps in target achievement. In particular, ASHAs feel a sense of empowerment because they can calculate their targets and achievements themselves as opposed to the earlier way of getting JHAs doing it for them.
- ETT targets and target achievements help FLWs in planning their monthly activities a few months in advance, where previously they were only told what to do for one month at a time.
- ASHAs are able to calculate EDD which helps in referrals to facilities for delivery
- JHAs find great benefit in CDL because reporting has now become more streamlined and less inconsistent as a result of similar data formats.
- FLWS are able to quickly problem solve around gaps in services and health care access
- ASHAs feel that the CDL has improved their interactions with JHAs with respect to
  - ease of generating monthly reports
  - consistent targets and achievements for both ASHAs and JHAs
  - sharing of responsibilities for data reporting since data is now consistent and clear
  - monitoring and supervising ASHAs by JHAs

Challenges:

- ETT abstracts were a big challenge (and still are) with some RPs doing the abstracts for the FLWs.
- Some areas where there were no ASHAs, JHAs did not find value in the tool and its abstracts
- Achieving uniformity of consolidated information was difficult, with respect to targets and achievements. RPs found this challenging in the beginning.
- ASHAs were unhappy about referring back to old registers since even older cases had to be included in CDL
- JHAs did not know how to calculate EDD and GPA prior to training
- CDL indicators and their linkages had to be stressed
- ASHAs were categorized as A and B based on ability to calculate LMP and EDD, with B category ASHAs requiring more intensive handholding support from RPs

4.4.3 Training FLWs: HBMNC Roll-out

Context

Sukshema's HBMNC training did not focus on clinical skills, since ASHAs are already trained by the GoK Health Department on home-based care. The training focused on improving the quality of home visits through improved communication skills and prioritizing messages by ASHA.

Since the HBMNC roll-out followed the baseline CBTS, results from the baseline CBTS in each Taluk were used to orient ASHAs on gaps identified in the community's health seeking behaviour (For eg. In one Taluk, birth planning & preparedness was an identified gap along with poor knowledge of danger signs in pregnant women, mothers & newborns) in that particular Taluk. These gaps then serve as focus areas for the ASHA during their home visits.

In order to generate more ownership of the tool and its implementation in the Department of Health, TOTs were conducted not only for Sukshema RPs but also for staff from GoK's Department of Health including senior JHAs, active ASHAs, ASHA mentors etc. In each Taluk, GoK Health Department staffs were identified based on their earlier exposure as resource persons for the Home-Based Neonatal Care (HBNC) training of the department, as mandated by GoI. In addition to that, the Health Department staff had very strong clinical/technical knowledge about home based care which needed to be tapped into for Sukshema's HBMNC training roll out. The roll out trainings were conducted at the PHC level by GoK department staff and facilitated by the Sukshema RPs, with GoK staff handling a major part of all the technical aspects of HBMNC.

Also, in order for the RPs to identify whether ASHAs can prioritize messages based on results from CBTS to ensure correct usage of communication material and tool based on the needs of the individual and family, a Checklist for supportive supervision and handholding was developed for the RPs.

Training agenda

It was a one day training and it was conducted at the PHC level with about 20-25 ASHAs in every batch. The trainings mainly focused on enhancing communication skills and tool orientation and not on building clinical skills since all ASHAs had already been trained on HBNC by the health department.

A sample training agenda from the HBMNC training is given below.

Time	Session
10-10.45	Sharing experiences on previous HBNC training conducted by the Health department
10.45-11.15	Sharing results of Community behavior Tracking Survey: An Overview, The need for home based care for mother & newborn
11.15-11.30	Tea break
11.30-01.30	Uses of HBNC tool, Introducing the revised HBMNC tool
1.30-2.00	Lunch break
2.00-3.30	Using Communication skills & IEC materials in home based care
3.30-3.45	Tea break
3.45-4.00	Wrap-up

Lessons learned: HBMNC roll-outs and usage of the tool

What worked well- Roll-outs:

- Having the training content not focus on clinical skills and focus more on communicating key messages during home visits was a good strategy, since all ASHAs had already been trained in GoI's home based care.
- Since all ASHAs had been trained in HBNC, they were already familiar with the format of Sukshema's HBMNC tool.
- Involving the Department of Health staff in the trainings and roll-out as the actual trainers, in contrast to the ETT roll-outs where Sukshema RPs were the trainers, created a sense of ownership in the GoK staff and helped make HBMNC implementation less challenging.
- Both the health system staff (JHA, LHV) and Sukshema RPs conducted the trainings together and this worked well because tapping into the GoK staff's technical skills with respect to home-

based care also helped in a smoother roll-out of HBMNC.
- FLWs appreciated the simple tool and found it easier to use than one used by the department.

What worked well- usage of tool:
- Overall, the ASHAs find the HBMNC tool easy to use and fill, even for those ASHAs with low literacy levels and the following are their comments:
  - They are able to identify high risk women and counsel all women using the communication materials appropriately and are able to immediately refer if needed
  - The previous (GOI and GOK) tools focused only on the newborn while the current Sukshema tool focuses on both mother and child and is more of a checklist
  - It helps them plan the timing of their home visits and what to do/look for at each home visit. The GOK tool does not guide them clearly around what to look for/when to provide counselling/when to refer.
  - The tool encourages them to streamline their counseling and also focus certain messages to other family members of the pregnant woman, and not just the pregnant woman herself. GOK tool does not help them to identify behavioural & cultural practices, where as the HBMNC helps in identifying and acknowledging these practices.
  - They like that the tool focuses on one individual so that the ASHA can refer to what was done during previous visits
  - It helps them track whether the woman's health has improved since the last visit, for instance, whether the woman's bleeding has stopped.
- JHAs and RPs used the HBMNC tool as an entry point when planning their interactions with women that choose home delivery
- Acceptance of tool in implemented districts is high. Sukshema staff and FLWS felt that overall the HBMNC tool and roll-out was the least challenging of all the other tools/interventions.
- There has been no negative feedback yet from Dept of Health. The earlier GOI HBNC tool has been phased out and the acceptance of HBMNC state-wide is high. Despite initial hesitation, Reproductive and Child Health Officers (RCHOs) of Koppal and Bagalkot are advocating for HBMNC since they see value in using it.

Challenges:
- **Ineffective handholding:** During the follow-up period after the roll-outs, Sukshema RPs were unable to adequately provide handholding support to ASHAs on HBMNC. This is because although RPs were knowledgeable about the tool and communication skills, they were not sufficiently trained in the clinical skills aspects of HBMNC to be effective in handholding. Therefore, involving health department personnel to handhold would likely have worked better.
- **Inability to assess decision-making:** HBMNC helps ASHAs provide information to families but does not enable them to assess the pregnant women's decision making ability. For instance, while the tool helps ASHAs screen danger signs in a pregnant woman, it does not help them assess whether this woman was motivated enough to visit a facility to address the danger sign(s).
- **Visuals in HBMNC:** Despite the tool being a simplified version of GoI's HBNC, many ASHAs still find it difficult to use because of all the documentation needed. Based on feedback from the FLWs, the central team is considering other pictorial alternatives as well
- **Need for Incentive attached to filling HBMNC:** ASHAs feel that there should be an incentive attached to filling out tool since they see it as extra work. However subsequent trainings on tool will focus on using the tool for improved interactions and not merely a tool-filling exercise
- **Shift from tool-filling to using it as a job-aid:** Some ASHAS still see it as a reporting tool for Sukshema and not as a job-aid want to know what to report from the HBMNC tool. RPs have to routinely convince them that the HBMNC is meant to be a job-aid and there is no reporting expectation based on the tool. This reinforces the previous point that ASHAs see this as a tool-filling exercise.

4.4.4 Training Frontline Workers: Arogya Mantapa Roll-out

Context

Arogya Mantapa (AM) introductory training for the RPs was a 1 day district level training in Koppal and Bagalkot. However, ASHAs were not formally trained in the AM concept.

AM Training

AM trainings for FLWs (ASHAs, JHAs and AWWs) occurred alongside of the ETT roll-outs with the intent that this would help in gap analyses. For example, any gaps identified by the ETT in immunizations or ANCs could be addressed immediately in the monthly AM meetings, by all 3 FLWs. At the PHC level RPs advocated with the Medical Officer and at the sub centre level they worked with the JHAS to initiate this process. JHAs were appointed as the point persons for conducting AM meetings, with Sukshema RPs providing handholding support throughout the process.

Lessons learned: AM roll out

What worked well:

- In the majority of AMs formed, no travel allowance was demanded by the FLWs attending the AMs. There was ownership of the forum and the process, which is quite rare.
- Some issues got resolved jointly by jha, asha, aww- community level n system level issues. these were discussed and resolved. Saving lives of mother n child,
- MO has used this platform on many occasions, especially to stress on specific needs of the sub centre. He would plan his field visit days on AM days. He would get everyone together.
- Representation from VHSNC helped since they (FLWs) could put forward their recommendations/ support needed in the Am forum.
- Capacity building sessions were also undertaken in the AM (FFC skills// CDL etc) need based by the rps based on the need.

Challenges:

- Initially, JHAs were dependant on the RPS to organize AMs and there was no real ownership of this initiative. This led the team to include the recreation aspect in the AMs and discussion around their sub centres to better engage the FLWs in the concept.
- But initially we started off AM with the idea of the FLWs discussing ETT/ CDL targets n achievements in the AM That created a gap. We should have focussed rather on building their perspectives first.
- It was not very effective to build their perspectives which would be critical for sustaining such a process as the AM.
- Very little scope for personality development.
- Important to be an informal process rather than a formal structured process. RPs not to control the AM.
- Purpose of AM is also to bring the two department workers together (JHA, AWW). But since the JHA was supposed to be leading the AM, the AWW seemed to take a back seat. Work related rivalry/ work plan clashes/ departmental divides interfered with this purpose. We therefore changed our strategy to ensure participation from both by scheduling the AM during the VHND or thayiandara sabhe days when both parties were anyways present.
- Based on our pilot experience, include the staff nurse in the AM is essential especially in the context of enhancing convergence. The 3 sisters represent the community, the staff nurse could be the 4th sister who represents the system. Their mutual coordination would be critical to ensure that issues are resolved at both the community level and the health systems level.

Arogya Mantapa – A Case Study

In Bagalkot, a pregnant mother of 4 female children regularly missed her ANC check-ups. Her family refused to send her for ANC services since "all her older kids were girls anyway". ASHAs and AWWs visited the family and tried to convince them to let her attend ANC clinic but that still did not help. The FLWs then alerted the VHSNC president at an Arogya Mantapa meeting and the issue was discussed at length. After this, the VHSNC president personally approached the family and managed to convince her family that attending regular ANC check-ups was important.

4.4.5 Training Frontline Workers: SCMT Roll-out

Context

The SCMT roll-out initially started with RPs being the primary facilitators. However soon after, there was general consensus between the central team and the field teams that this was an additional burden on RPs and that for the roll-out to be more successful it needed to be outsourced. Thus, in order to roll-out SCMT trainings, KHPT partnered with Janani Suraksha Abhiyan – Karnataka (JSAK), a campaign promoted by SAMUHA to promote zero-tolerance to maternal and infant deaths in Karnataka. This alliance was aimed at developing a clear implementation plan to achieve the following objectives:

- Build capacities of the VHSNC to take on supportive monitoring roles in a systematic and consistent fashion using the SCMT
- Develop a mechanism where the outcome of these monitoring experiences are channelized towards:
  - Building the collective vision of VHSNC members in ensuring long term sustainability of supportive health monitoring and its impact on the community's well being
  - Strengthening accountability in MNCH service delivery
  - Enhancing demand for MNCH services within the community

Thus, the SCMT roll-out was a two-day training where a central team of external facilitators was created to lead the trainings. The RPs provided support only where required. A 3-day ToT was conducted for RP Teams of Bagalkot and Koppal districts.

The SCMT members' were carried through a 2-day residential training. However, though the roll-out started with a 2-day residential training for the SCMT members, the central facilitator team developed three versions of the training module to use based on the diverse needs of certain taluks or districts. The different versions of the training process were:

- Version 1: Two-day residential training
- Version 2: Two-day non-residential training
- Version 3: Three hour village level SCMT/ VHSNC training

Around 181 two-day SCMT trainings were conducted and about 5770 SCMT members were reached from 1212 villages across the two districts. Around 121 village level SCMT/VHSNC hand holding trainings were conducted.

Training agenda

A sample agenda from the 2-day SCMT training is given below.

Day 1: The first day focused on Sukshema and the objectives of the project, the SCMT tool and its purpose, awareness on maternal and infant morbidity and mortality and how the entire village is responsible for the health of its community, particularly mothers and children, the role of SCMT and how it fits in to NRHM and Sukshema.

Day 2: The second day focused on creating an SCMT action plan and the processes involved, how to bring about societal change, further discussion about the responsibility of the SCMT team and how to utilize resources.

A Case study -SCMT training

An SCMT training program had been organized in Belur, with participants from 6 villages. When the issue of postnatal home visits was discussed, representatives from Nagarala, Shivapura and Banashankari got into a heated argument about missed home visits by the ASHAs. In reality, there was only one ASHA for Cholachagudda, Banashankari, Nagarala and Shivapura and due to her extra work load, she could not visit all the new mothers. All the participants felt that it was pointless trying to conduct a training program when there was a serious lack of ASHAs in their villages. Then the local Karnataka Municipal Administrative Service Officer, who was also present at the training, called the District Health Officer (DHO) and conveyed the issues faced by the three villages. Understanding the gravity of the situation, the DHO promised to appoint extra ASHAs in these villages.

There are currently 2 new ASHAs in these villages and one more has been recruited. As a result, all the village representatives are very cooperative towards Sukshema activities.

Lessons learned: SCMT training roll-outs and usage of tool

What worked well:

- **External and internal trainers:** Some Sukshema RPs felt that the external teams were more effective trainers for SCMT and felt that there would have been gaps if Sukshema RPs had conducted all SCMT trainings. Also, having training teams comprise of external facilitators and RPs was a bonus since each group had their own strengths.
- **Tool Simplicity:** Some VHSNC members were able to describe the purpose of the tool and the information it provided. They found the smiley and frowny faces easy to follow and they noted that it helped them assess their community's health. One VHSNC member described the tool as the lifeline of their work "This is the heart of life".
- **Increased awareness:** Some VHSNC members said that they gained knowledge from the trainings. They learned about anemia counseling, community 'seemantha' (a traditional South Indian ritual carried out usually in the 7th month of pregnancy to invoke blessings for a safe delivery and a healthy baby), regular check-ups, myths and misconceptions around pregnancy and child birth etc. Since the SCMT enables the VHSNC to identify high-risk women and children, they are able to contact/alert their PHC as a precaution
- **Effective training methods:** Training was very simple and even members with low literacy levels could understand the content. Most VHSNC members liked the role-play activities during training
- **Increased ability to focus on MNCH issues:** A VHSNC president from Bagalkot felt that even though they met regularly before the introduction of the SCMT, the tool helped them focus on MNCH issues, immunizations, IFA tablets etc and provided a clear way forward. The tool helped them identify health gaps in their village on a monthly basis, assess where their village was on a number of MNCH indicators (based on the number of smiley and frowny faces), and to chart a course of action.
- **Advocacy:** Some VHSNC members expressed a desire for the entire village to be trained on the SCMT and not just VHSNC members. At Koppal, one VHSNC decided to share the tool with the rest of the village and was successful in doing so. One of the greatest successes of the SCMT is that based on their own experiences, some VHSNC members have been advocating for SCMT in neighbouring villages to increase adoption of the tool. SCMT training in one region helped advocate for and get more ASHAs from the Dept of Health
- **Improved Accountability of ASHAs and AWWS:** A VHSNC president stated that using the SCMT improves accountability of ASHAs and AWWs back to their VHSNCs and ensures that they are doing their jobs 'properly'. Health gaps are discussed at the SCMT team meetings and the team works together to meet targets. ASHAs also find the tool very useful. An ASHA in Koppal claimed that before SCMT, there was nobody to question the ASHAs work. But after the introduction of SCMT, the ASHAs feel a greater sense of responsibility towards their communities since they are accountable to the VHSNC.
- **Community empowerment:** Following the SCMT introduction, one village in Koppal decided to mobilize Gram Panchayat funds to improve their MNCH status. Another village dealt with their IFA stockouts, as identified by the tool, by contacting the District Health Officer in person and making him aware of the situation.
- **Identified need:** When asked if SCMT should not be introduced in villages that already have processes of tracking health, the unanimous answer was that every village needs SCMT since other processes do not provide the specifics that this tool provides.
- **ASHA-centric approach:** The training teams realized that using an ASHA (VHSNC member secretary)-centric approach for the SCMT is key. For instance, one RP was not allowed into a village by the VHSNC members but the ASHA assisted in getting her to their village.
- **Improved Interactions with PHCs and other health department staff:** Earlier, VHSNCs did not have meaningful interactions with JHAs, AWWs and PHC staff. However, SCMT provides them with the knowledge and opportunity to discuss their communities' health with PHC staff and a relationship has been built. One member stated trustworthy relationships have been built between VHSNC members and PHC staff since they see each other "like a chain".

Challenges:

- **Outsourcing trainings:** Initially, Sukshema RPs felt territorial about external facilitators conducting the SCMT roll-outs and trainings. However, acceptance of external teams by Sukshema RPs was high after they realized that RPs would also be involved in the roll-out process.
- **Mobilizing SCMT teams:** Encouraging all 6 SCMT members to attend the SCMT trainings was a major challenge. It happened only in 21% of the total number of the targeted villages. The

average number of participants per village was 4.7. VHSNC presidents and youth representation was poor (62 & 54% respectively) and only 29% of male participation.

- **Residential training:** The residential aspect of the trainings was another major challenge. Less than 30% of trainings ended up being residential due to various constraints.
- **Training process:** The training teams felt that the SCMT trainings should be a 4 day process , and the training modules should be a combination of the 3 different versions that the teams developed. They felt that this would not only help better understanding of the SCMT tool and the responsibility of the SCMT members but would also foster greater cohesion among SCMT team members. They also felt the need for on-going process documentation and dissemination so that the whole process becomes iterative and the training process can be refined as needed.
- **Ineffective follow-up and handholding support:** RPs found handholding support for SCMT (after the SCMT trainings) at the actual VHSNC meetings to be very challenging due to inability of VHSNC members to attend trainings. Project team leaders believe that effective handholding support will be a problem in scale-up districts as well. Some districts teams proposed that organizing trainings and providing handholding support should occur simultaneously but be handled by separate teams, a training team and a handholding team.
- **Lack of capacity in Scale-up districts with respect to VHSNCs:** Project team leaders felt that scale-up of SCMT was going to be particularly challenging because villages in the scale-up districts lack VHSNCs. To compound this challenge, VHSNCs seem to require a lot of initial facilitation to reach a level of useful engagement. Thus, returns may be low compared to the effort required keeping in mind human resource and time constraints in scale-up districts.
- **Monitoring and Evaluation of SCMT data:** One VHSNC member told us that they do not discuss those health issues that have a smiley face. This could be the result of having a rating scale where good=Smiley face and bad=frowny face. Also, the SCMT data is not being used for health planning in terms of setting timelines for action points so that there is a commitment to actually following through on the action points.

05 IMPLEMENTATION OF THE COMMUNITY INTERVENTION IN THE SCALE-UP DISTRICTS

5.1 Overall Lessons Learned from Pilot Districts

- The three tools (namely HBMNC, ETT/CDL and SCMT), three processes (namely convergence meetings, Arogya Mantapa and FFC) are workable and scalable concepts.
- The ASHA diary is a concept that is not only scalable but has also been embraced whole-heartedly by the GoK.
- The quality of roll-out (one-time) trainings needs to be emphasized.
- In addition to one-time trainings, on-the-job handholding trainings and regular review & reflection based trainings need to be emphasized as well. Both the set of trainings should go hand-in hand, and not one after another.
- There is a need to reduce reliance on external RPs to be the driving force behind the interventions. This is will impact sustainability

5.2 Changes in Implementation Strategy in Scale-up Districts

Based on the lessons learned in the pilot districts, several changes were made in the implementation strategy during scale-up. This is not to say that pilot experience was a mistake but the team learnt what works better. Similar principles guided the processed in both phases.

Changes in staff structure- District Resource Persons (DRPs)

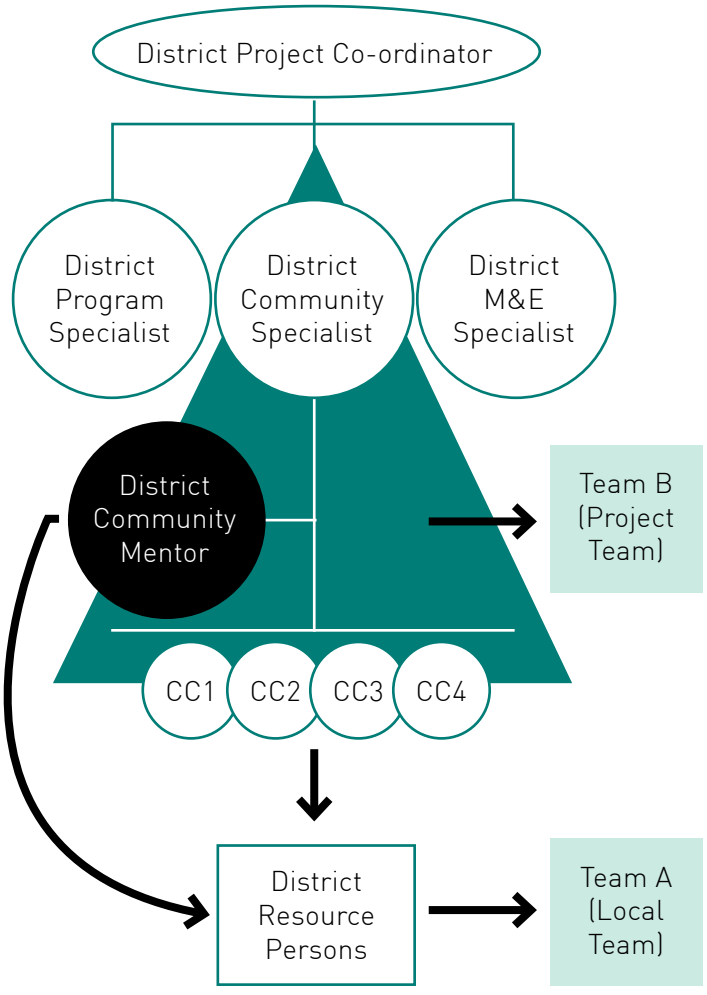
One of the main changes was in the staff structure in the scale-up districts. During the pilot/ experimental phase we needed an intensive program to learn from the experience; later we refined the programs to ensure that it fits into the existing system and henace the whole cadre of Sukshema RPs has been eliminated for the scale up districts. In order to ensure sustainability, as given in the figure below, instead of Sukshema RPs, the scale-up districts will rely on District Resource Persons (DRPs) who are recruited from within the Health Department. A team of DRPs for each Taluk will be chosen from a pool of high-performing ASHAs, ASHA facilitators, JHAs, AW supervisors etc. They are supported by a Sukshema team of Taluka Community Co-ordinators (CC). DRPs will be mentored and supervised by a new cadre called District Community Mentors (DCM). The DCM is the point person for the DRPs in the scale-up district. Similar to the pilot districts, the District Community Specialists are responsible for all management-related decisions in the community intervention at the district level.

As is evident from the changes in staff in the scale-up districts, sustainability is the driving force behind the interventions during scale-up. In addition to increased reliance on DRPs from within the Health Department to power the interventions, the name & logo of the project have been removed from ASHA diary.

a) Advisory role of Central Team
In the scale-up districts, the project team is striving to have more of a technical advisor and facilitator role in addition to the technical service provider role that the team had in pilot districts.

b) Shift to Experiential Learning
The emphasis has shifted from class room trainings

Figure 9: Staff structure of the District Teams and Local Teams



to more experiential learning such as on-the-job handholding, and group review and reflection centred trainings. Scale-up districts also have a Taluka (CC) centric action plan for implementation rather than the District (DCS) Centric action plan in the pilot districts. In the scale-up districts, more emphasis is given to handholding rather than the roll out trainings. Thus, the total number of training days for FLWs are reduced compared to the pilot districts and a total of three interactions have been planned between ASHA supervisors and ASHAs .

c) Focus on Behaviour change rather than information dissemination

The ultimate goal for Sukshema's communication strategy for the community intervention was that it should go beyond information dissemination and raising awareness—it should focus its limited resources on concrete actions and influencing behaviour change. However, this was not operationalized to its fullest extent in the pilot districts because of the sheer volume of trainings and roll-outs that drained all the district teams. Also, the district teams were so focused on delivering high-quality trainings and IEC material that the end goal often became blurred. Thus, in the scale up districts, a concerted effort has been made to re-orient the district teams to the ultimate goal which is to influence voluntary behavior of target audiences (such as FLWs, community, district health staff) to achieve better MNCH outcomes rather than merely to disseminate information.

d) Changes to Arogya Mantapa

In scale-up districts, there is no emphasis on the discussion of targets or CDL/ETT during the trainings and the meetings. Based on the learnings from the pilot district, the team realized that for the FLWs to take ownership of the AM process, they need to set their own agenda for the AM monthly meetings and they were entitled to use the forum for more social activities rather than to discuss MNCH issues, since the intended purpose of this intervention is to facilitate improved co-ordination of FLWs' activities.

e) Transition HBMNC tool to Health Department Officials

The responsibility to train the FLWs on this tool and scale it up to all districts has been handed over to the Government of Karnataka. Efforts are being made to transition the tool in its entirety (including printing and distribution) to the Government of Karnataka since the Government of India has already accepted and approved of the HBMNC concept based on its success in the pilot districts.

f) New Home-based-Family Focussed Counselling tool (HB-FFC)

The HB-FFC tool is an interactive dialogue-based behaviour change counselling tool. It consists of 12 key messages around the issues of MNCH. These priority messages emerged from the CBTS outcomes as key needs/ gaps on the field. This tool is entirely pictorial. It serves as a job aid for the ASHAs while counselling (one-on-one) the pregnant women and family during her home visits. (Please see section below for more details)

g) Implementation guided by CBTS outcomes

All implementation activities in the scale-up districts were based on CBTS outcomes. While CBTS outcomes guided implementation activities in the pilot districts as well, there has been a concerted effort by the central and field teams to use the CBTS data iteratively to guide implementation in the scale-up districts.

h) Filling-up vacant ASHA positions to improve coverage

During the process of selecting DRPs, the field teams (CCs, DCMs and DCSs) were able to identify vacant ASHA positions and to advocate with the Health Department to fill these positions. In addition, they were also able to identify eligible candidates through the DRP network, notify the Health Department, organize their trainings and get them recruited.

5.3 Implementation Strategy in Scale-up Districts

The implementation strategy in all the scale-up districts of Bijapur, Bellary, Yadgir, Bidar, Gulbarga and Raichur is outlined in the tables below. The activities in scale-up have been categorized into A(Central Team Activities), B (Roll-out activities) and C (Regular mentoring activities).

In some taluks, the ASHA diary orientation and distribution preceded the FLW trainings. This strategy also seemed to work well for the ASHAs.

5.3.1 District Resource Persons (DRPs) and Their Role in the Scale-up Districts

DRPs see their main role as being ASHA trainers. They also identified co-ordination between departments to be one of their main roles. In addition to their roles as ASHA trainers, they also

- facilitate village health and nutrition days and VHSC meetings
- provide handholding support for ASHAs and support with HBMNC and ETT/CDL formats.
- Consolidate ASHA reports
- Conduct and facilitate Arogya Mantapa meetings

Selection Process of DRPs

The central team helped develop the criteria for the selection of DRPs. The criteria were as follows:

- SSLC pass
- Should have training experience
- Should have good communication skills

Selection of DRPs was undertaken by the CCs and the DCMs after consultation with the Health Department staff. A number of venues and forums had to be used for identifying and selecting DRPs such as PHC-wise ASHA meetings, SC visits, field visits, some VHSNC meetings etc. As mentioned above, the DRP teams in the scale-up district comprised mainly of ASHA Facilitators (39%) and JHAs (38%). For example, in Yadgir, 96 DRPs (38 ASHA Facilitators+ 42 JHAs + 7 Anganwadi Worker Supervisors + 1 Block Health Education Officer) were selected and a strong DRP team has been formed.

Table 3: Implementation activities in Scale-up Districts

Strategic Activities	Training/ implementation Activities	Follow up Activities
A1 Conceptualising, developing and fine tuning the 3 tools- HBMNC, SCMT and CDL/ETT	B1 4-day DRP ToTs	C1 Taluk level monthly DRP meetings (One per taluk per month)
A2 Conceptualizing, developing and fine tuning the 3 processes- FFC for HBMNC, Arogya Mantapa, PHC level process for promoting convergence	B2 2-day FLW trainings	C2 PHC level monthly ASHA review meeting
A3 Conceptualizing, developing and printing ASHA diaries 2013-15	B3 2-day SCMT trainings	C3 SC level monthly Arogya Mantapa
A4 Conceptualizing and developing strategies & processes for encouraging and handholding DRPs	B4 1-day ASHA Diary orientation & distribution	C4 Village level monthly VHSNC meeting
A5 Developing training modules all training processes (20 training days)	B5 ASHA reminder card orientation and distribution	C5 Village level ASHA handholding – with CDL (once per month per ASHA)
A6 Complete Process documentation of Community Interventions	B6 Advocacy for filling-up vacant ASHA positions	C6 and C7 Household level ASHA handholding – with HBMNC and FFC (One family visit per ASHA per month)

Lessons learned during DRP selection

What worked well:

- The process followed for identifying and recruiting DRPs worked well. The project was able to recruit high calibre DRPs. This view was mirrored by Health Department officials as well.
- All DRPs greatly appreciated being selected as DRPs and said that they were glad that Sukshema recognized their potential and skills as key resource persons.
- ASHAs, who were initially reluctant to become DRPs, had a boost of self-confidence and started taking on more leadership responsibilities once they were led through the ToTs
- DRPs did not need extensive training, compared to the Sukshema RPs in the pilot, since they already had a good amount of technical MNCH knowledge

Challenges:

- **Conceptual shift for district teams:** Some field staff in the scale-up districts (such as CCs, DCMs and the DCS) had originally worked in the pilot districts. So there had to be a conceptual shift to the need for DRPs in scale-up districts vs Sukshema RPs in the pilot districts. As a result, they found it challenging to articulate the need for DRPs and to convince health department staff to help identify DRPs
- **Limited support from Health Department in some districts:** In some of the districts, initially, the MO and other senior officials were not interested in sticking to the criteria for short listing DRPs and the CCs had less support from them. This was probably because Yadgir is a new District with new Health department staff.
- **Potential bias in DRP selection:** Although the DRP selection process was intensive, it is possibly not free of bias of the health department staff.
- **Limited DRP pool:** Some taluks had a smaller DRP pool to choose from, and as a result DRP selection was challenging. Also, it took CCs over 2-3 months to select DRPs. They had to consult with ASHAs and community members to ensure that the right candidates were recruited as DRPs.
- **ASHAs' reluctance to become DRPs:** Some ASHAs were hesitant to become DRPs since they thought that they would have to take on more responsibilities.
- **Power dynamics within DRP teams:** Although the intent was to for the DRP pool to comprise mainly of ASHA facilitators and not ASHAs, in some taluks the CCS had to select some ASHAs as DRPs, in addition to ASHA facilitators. This led to a shift in power dynamics within certain DRP teams. To counter these negative group dynamics, the Bijapur team of CCs, DCM and DCS started team building sessions in clusters, and had started internally grading their DRPs as A, B and C. By doing so, they were able to provide C category DRPs with more opportunities to observe and participate.

Lessons learned about the DRP concept in scale-up districts

What worked well:

- **Clear understanding of roles and project objectives:** DRPs were able to articulate their roles very clearly. They were able to communicate the vision of the program clearly.
- **Ownership of project:** The ownership of the entire program seems high and immediate since they feel that the project recognized their strengths and skills and made room for expression. Also, they do not see their roles as DRPs separate from their roles as FLWs.
- **Established skill sets and linkages:** The internal DRPs seem to work much better than external Sukshema RPs in the pilot districts. The DRPs already have the knowledge, the department connections and understand the field.
- **FLWs' acceptance of DRPs:** DRPs are not perceived as a threat but rather as examples by the rest of the FLW fraternity.
- **Appreciate the 'Grass roots approach' of Sukshema:** The biggest achievement is that they recognize that this process is an entirely bottom-up process and not a top-down approach. THO, Bijapur felt that the key gap in the Department is the absence of this approach.

Challenges:

- **Sustaining motivation among DRPs:** One of the major challenges that the project and GoI will face with DRPs will be to find ways to keep this team motivated about their work as facilitators in the community intervention processes. Recognition and appreciation of their efforts is a key strategy to prevent the DRPs from getting frustrated, discouraged and tired of the project.
- **Tailoring on-the-job support to DRPs' needs:** All DRPs have varied skill sets. Thus the handholding process would need to cater to individual level gaps.
- **Power dynamics within DRP teams and Non co-operation:** Personal agendas and power struggles could taint the group dynamics of DRPs. Perspective building exercises should address this. On the other hand, non cooperation from other FLWs is a possibility due to jealousy, personal ambitions and absence of vision oriented action
- **Multi-tasking DRPs:** Compared to the Sukshema RPs, DRPs are not able to spend as

much time in the field since they have other responsibilities as well. For example, some of them are ASHA facilitators and even ASHAs, so their responsibilities place an additional burden on their field activities.

- **Historical hierarchies:** A peer led approach might take time to establish itself in a strongly hierarchical set-up which has been, until now, used to a supervisory approach rather than a supportive one.
- **Health Department's changing priorities:** New programs and newer responsibilities is a reality within the health department. So there is a high possibility of losing focus on MNCH goals.
- **Lack of DRP remuneration:** DRPs are not being remunerated for their time. Considering that all DRPs already have other Health Department responsibilities, there needs to be some advocacy at higher levels to compensate DRPs for their time spent as DRPs.

DRP TOTs

The Four-day ToT for DRPs is one of the 19 project activities of Sukshema's community interventions. The implementation of this activity began in the last week of September 2013, and was completed successfully in March 2014. During this period, a total of 19 ToTs were organized and 865 DRPs were trained across the six scale-up districts. Bijapur and Gulbarga district teams conducted the highest number of ToTs because of higher volumes of DRPs in these districts.

When asked about what they had learned during the TOTs, in addition to mentioning some of the technical content, such as the tools and processes of Sukshema, almost all the DRPs mentioned soft skills such as the importance of working together and learning how to work in a systematic way. The most repeated response, however, was that they learned how to communicate well. One example given was an AW supervisor who, despite being in her position for 26 years, was not able to speak at meetings. But after the TOT, she was able to articulate herself well at meetings.

Lessons learned during DRP TOTs

What Worked Well

- **Good training design and methodology:** The flow of the sessions, the methodology, participation and co-ordination seemed very good. Also, the sessions seemed to have broken the ice and brought about attitudinal changes very successfully. DRPs learned to respect each other's responsibilities. One of the MOs in Yadgir considered the ToTs as a refresher for the DRPs and thought that it helped strengthen their skills. On the flip side, the DRPs felt that while the trainings did not teach them anything new in terms of their technical knowledge, it taught them how to be systematic.
- **Appreciated stress on conceptual issues:** DRPs liked the emphasis on conceptual issues, such as women right's and engaging the entire family during home visits, rather than interventions. Many DRPs appreciated this and that was their favourite part of the training.
- **Improved communication skills among DRPs:** DRPs spoke about an improvement in their communication skills. This seemed to have been a great which the ToTs met. DRPs felt empowered because of this.
  One of the Yadgir DRPs felt that "After the ToT, our skills just took a U-Turn"
- **DRPs empowered:** When asked whether they could sustain these efforts if Sukshema CCs were not around, everybody had an unequivocal 'yes' as a response. This was a major difference from the pilot districts.

Challenges:

- **Better planning:** The central team felt that there needed to be better planning of the ToTs. In the first five months of scale-up implementation (Sept 2013 to Jan 2014) they organised 7 ToTs. But subsequently, in the next 50 days the teams successfully conducted another 12 ToTs.

5.3.2 Changes in FLW Training Strategy in Scale-up Districts

FLW trainings follow the DRP ToTs and are conducted by the DRPs. This is a 2-day non-residential training where all the FLWs are oriented towards the project's tools and processes and are also given a chance to learn from each other. During the time of the visit, only a few FLW trainings had occurred.

Some of the key changes that have been made in the FLW training strategy in the scale up districts are:

- DRPs are the ones conducting the FLW trainings in contrast to the pilot districts where the Sukshema RPs conducted the trainings.
- The training content has changed considerably in the scale-up districts. In the scale-up districts, most of the interventions are addressed in the FLW trainings instead of starting with FFC and then having multiple trainings for the other interventions (which was the strategy in the pilot districts).
- Class room training hours have been reduced drastically and there is more emphasis on on-the-job handholding trainings and monthly reviews and reflections (eg ETT/CDL, FFC)

- There is more focus on experiential learning rather than a didactic format.
- There is more emphasis on a group approach and more on reviews and reflection-based self-learning processes.

Lessons learned during FLW trainings

What worked well:

- **DRPs as trainers:** DRPs seemed very confident and did a really good job at the one training observed. They had excellent communication skills and were lively and interactive. DRPs were able to emphasize 'soft skills' such as changing attitudes and perceptions rather than interventions, which is good strategy to employ since it creates a strong foundation for the project.
- **FLWs understand project objectives:** FLWs are able to articulate why all 3 groups have been brought together. They felt that the trainings increased their confidence.
- **Plan for Post-Training Activities:** In Bijapur, they seemed to have a plan for post- training activities such as CDL discussions at cluster levels, linking Arogya Mantapa to VHSNC/ VHND. A DRP-wide post roll out plan should be in place at the taluk levels, with CCs and DCMs leading the process.

Challenges:

- **Lack of support for trainings:** There seemed to be a lack of manpower and leadership during the trainings and all CCs talked about a general lack of support from the MOs.
- **Ensuring only DRPs lead trainings:** DRP teams are new but they should be encouraged to lead the trainings and CCs should be encouraged to support the DRPs and not facilitate the trainings themselves. The CCs' focus perhaps should be to really invest in and strengthen the DRPs which will then trickle down.

DRP Scoring

The central team has developed a transparent scoring system to address the concerns outlined above regarding sustaining motivation levels among DRPs. The CCs will score the DRPs on 5 areas every month for a total of 500 Reward Points (see table below). This scoring will be discussed at the monthly DRP meetings. The team will evolve different ways of translating these reward points into tangible expressions of appreciation.

Table 4: DRP Scoring System

Areas for Scoring	Reward Points
DRP review meeting	100
PHC Meeting	100
Arogya Mantapa Handholding	50
ASHA Handholding	100
SCMT Handholding	50
Attitude, involvement, creativity	100
TOTAL	**500**

5.3.3 Community Co-ordinators (CC) and Their Role in Scale-up Districts

Community Co-ordinators are a new cadre of staff introduced in the Scale-up districts. Their main role is to support and handhold the DRPs. However, some of their supplementary roles have been to conduct DRP ToTs, conduct VHSNC surveys, collect case studies on maternal and infant mortality and facilitate Arogya Mantapa meetings. Most of the CCs in the scale-up districts were Sukshema RPs in the pilot districts.

CCs faced a number of challenges carrying out their roles as CCs in the scale-up districts. Some of them are:

- Initially, CCs had to build rapport with PHCs and conduct field visits to understand things at the ground level. They had to understand the community and culture in their taluks. It took them about 5-6 months to carry out this process. This was in stark contrast to the pilot districts since they had already spent a whole year building these connections.
- The demographics of the population in the scale-up districts were very different from the pilot districts. For instance, there are more lambani groups, poor literacy, increased migration, fewer ASHAs and AWWs, fewer MOs etc
- Bijapur was a challenge because of its history with HIV/AIDS NGOs so Sukshema staffs were looked at very suspiciously.
- One of the main changes that they had to deal with was to think of themselves as CCs and not RPs, since in contrast to the pilot districts where they were direct implementers, in the scale-up districts they played more of a supportive and managerial role to DRPs. They all felt that they had more responsibilities as CCs than as RPs.
- One of their key challenges also was to identify the right department officials to liaise with and how to

focus their communication and clearly articulate issues with them, such as the how to speak to the MO and what to discuss with the THO.

- Another main challenge that they faced was the differences in FLWs between scale-up and pilot districts
  - Based on the need for handholding support, CCs felt that FLWs in scale-up districts had poorer literacy skills
  - Non-working ASHAs were higher in number
  - Non-local ASHAs were higher in number, i.e. they travelled from other towns/villages to their allotted catchment areas and as a result their field work and home visits suffered
  - Sindagi was a particularly challenging taluk since there is a lack of manpower i.e. fewer ASHAs and JHAs and a very poor NGO history.

5.3.4 Tools and Processes in Scale-Up Districts

As mentioned above, there are some changes to the tools and processes in Scale-up districts, compared to the pilot districts. However, even in scale-up districts, most of the components of the community intervention still remain the same and aim to improve management and delivery of outreach services, shape demand and strengthen accountability.

Improving management and delivery of outreach services and shaping demand

1. ASHA Diary
   a. Enumeration and tracking tools and methods for ASHAs to improve coverage (CDL Package)
   b. Integrated maternal and newborn management tool for ASHAs to improve identification and actions for postnatal danger signs (HBMNC)
2. Home-based Family focussed communication tools and materials for ASHAs to use while counselling families (HB-FFC)

Strengthening accountability

3. Supportive Community monitoring tools (SCMT) for Village Health Sanitation and Nutrition Committees (VHSNCs) to strengthen accountability
4. Sub centre forum (SCF – Arogya Mantapa)
5. Increasing functionality of the Primary Health Centre (PHC) Convergence Meetings

The experience in the pilot has been encouraging and the FLWs have been sufficiently empowered to function more effectively. The focus in the scale up districts has really been to strengthen handholding and sustainable processes on the ground.
Note: Only the tools and processes that are different in the scale-up districts, compared to the pilot districts, are discussed below. For more information on all tools and processes in the pilot districts, please refer to the section "Overview of Sukshema's Community Intervention".

a. Community Demands List (CDL) Package

Purpose of the CDL package

The objective of the CDL package is still the same as it was in the pilot districts, i.e., to provide tools that help in the consolidation of th e information and reduce (if not eliminate completely) duplication of efforts. The purpose of the improved CDL package in the scale up districts is to help ASHAs record, plan, review and report her work in a systematic manner.

The improved CDL Package has the following components:

a. Tracking tool for ASHA in her area (CDL 1). This is a recording tool.
b. Community Demand List (CDL 2) which is a self reflection and planning and review tool for the ASHA
c. CDL 3 which is an abstract of CDL-2 and a self reporting tool.

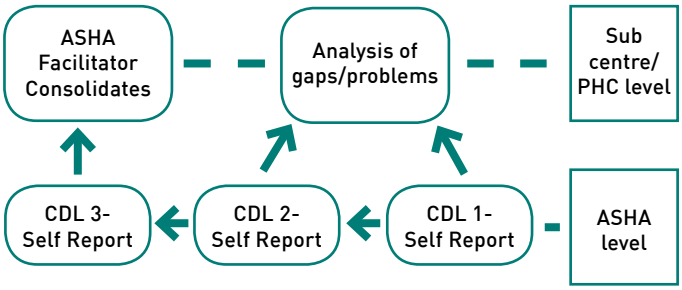
All the three CDL tools- 1, 2 and 3 are to be filled by ASHAs.

In addition to the introduction of the new CDL package in the Scale-up districts, all the changes in CDL package have also been introduced in the pilot districts. The entire CDL package has been piloted in Koppal and Bagalkot for a period of one year and the tools have now attained a final stage. The trainings for CDL will not focus anymore on individual tools rather on the CDL as one entire package with the three tools.

Similar to CDL 2, CDL 3 has two components-

1. Reporting of the previous month's progress which enables the ASHA to record total demand and review her performance on the specific 16 tasks outlined by GoI.
2. Planning - Capture the planning for the next month in terms of her targets. This is an extract of the following month's CDL 2. She copies her CDL 2 data as is, in this section.

Figure 10: Flow of information across levels for gap analysis



On the 21st of every month, after she completes CDL 2 of the reporting month and planning (CDL 2) for the next month, then she abstracts her CDL 2 data in to CDL 3. CDL 3 is to be submitted to the ASHA facilitator during the ASHA meeting that will be conducted on the 21st of every month.

Roll-out process of CDL-3

In the pilot districts, there was an exclusive training only for CDL (as mentioned in Chapter 2). However, in the scale up districts, it is a part of the ASHA Diary orientation. ASHA Diary and the CDL package will be a 1 day orientation through DRPs at the PHC level, in the presence of MO and THO.

Supportive supervision of ASHAs

As mentioned above, DRPs are responsible for providing handholding support to ASHAs in the scale-up districts. The emphasis in the scale up is on-the-job training. As the initial step, all ASHAs will be encouraged to fill out CDL 1, listing all pregnant women and children under 2 years of age in their catchment areas. Based on that the ASHA facilitator will help the ASHA plan for the month, i.e., how to set targets. Handholding interactions happens three times in a month (see below).

First interaction - This happens on the 21st of every month and is at a PHC level. Every ASHA is supposed to complete her CDL 1 and fill her CDL 2 (both the progress and planning sections) She will then abstract the details of CDL 2 into CDL 3 and submit CDL 3 to ASHA facilitator

Second interaction - ASHA facilitator meets the ASHA at the AM and provides handholding support to her. The ASHA facilitator also helps the ASHAs with any personal or professional problems that she may have.

Third interaction - ASHA facilitator meets the ASHA in the village where she will check CDL 1 / CDL 2 details.

ASHA grading

The purpose of ASHA grading is to enable ASHAs to self-monitor their performance in a given month. The basis for this approach is 'self improvement through self grading'. This grading process also helps the ASHA facilitator with providing handholding support, since she would know who needs more support in the following month. As mentioned above, every ASHA facilitator meets with her ASHAs on the 21st of each month. All ASHA names are recorded and are graded as follows:

- Grade 1 ASHA- Completion of all three CDL tools (where all the 5 objectives are met)
- Grade 2 ASHA- Completed CDL 1 and 2
- Grade 3 ASHA- Completed CDL 1
- Grade 4 ASHA- Has received ASHA DIARY but not filled out CDL 1
- Grade 5 ASHA- Has not received ASHA diary
- Grade 6 ASHA- Absent ASHA (or data unavailable for that ASHA)

ASHA facilitator grading

There are 50 ASHA facilitators in every district. ASHA facilitators are graded similar to the DRP scoring mentioned above. The CCs score the ASHA facilitators on 5 areas every month for a total of 500 Reward Points (Refer to the DRP scoring section above for further details). This scoring is discussed at the monthly meetings. The team will evolve different ways of translating these reward points into tangible expressions of appreciation.

b. Home-Based Family Focussed Communication (HB-FFC)

The HB-FFC tool is an interactive dialogue-based behaviour change counselling tool. It consists of 12 key messages around the issues of MNCH. These priority messages emerged from the CBTS outcomes as key needs/ gaps on the field. This tool is entirely pictorial. Every message has four sections:

1. Pictorial representation of the message
2. The key message (in words)
3. An interactive question to check whether the message has been understood by the recipient
4. Call to action

Purpose

It serves as a job aid for the ASHAs while counselling (one-on-one) the pregnant women and family during her home visits. The HB-FFC evolved as a simplified and pictorial tool to strengthen to the existing HBMNC tool. This tool helps ASHAs counsel more effectively. HB-FFC tool can also be viewed as an improvisation to the reminder cards.

Every ASHA has a copy of the tool. When the ASHA first meets the pregnant or lactating woman at her home in the presence of her family members, she tries to assess the woman's knowledge on key areas. Based on the woman's current knowledge and need, the ASHA chooses the messages that are most relevant to her. She uses the pictures in the tool to discuss this further. She verifies that the woman has understood the message and encourages her to make a decision regarding it.

Testing of and Orientation to the tool

The tool has been field tested in two PHCs of two districts. There have been several consultative meetings with the district teams regarding the tool. This involves orientation to the tool and its implementation. There has also been advocacy with district, taluk and PHC level officials to build acceptance of the tool. The roll-out of this new and improved tool was carried out in campaign mode, and was done alongside the SCMT roll-out.

Training

The tool will be introduced to the DRPs and other ASHA facilitators at the monthly review meetings. ASHA facilitators will then train the ASHAs on the tool and its usage at the PHC level. Handholding of trained ASHAs will happen soon after the orientation (i.e. on-the-job handholding).

Monitoring

HBFFC usage is one of the line items for reporting by the ASHAs, as part of the monthly progress report of the ASHA facilitators. The ASHA facilitators will report on its progress to the ASHA mentors and CCs at the DRP meetings.

Efforts are underway to advocate with the State to incorporate HB-FFC within the existing MOTHER'S CARD and the ASHA Diary.

c. Supportive Community Monitoring Tool

A campaign mode was adopted for SCMT roll-out to enhance community participation and was called The "Namma Habba" campaign.

Purpose

The Supportive Community Monitoring tool (SCMT) attempts to involve the community through Village Health Sanitation and Nutrition Committees (VHSNC) in planning and monitoring village health service delivery to realize community participation and ownership of village health programs as envisaged in the goals of NRHM. It aims to strengthen community accountability towards village health and improved MNCH outcomes and to provide opportunities for FLWs to be supported by the community in their efforts to improve MNCH outcomes.

SCMT teams serve as an effective medium that the VHSNC committee members can utilize to get first hand information regarding mother and child health in their villages. Sukshema has been instrumental in the formation of these SCMT teams (see section titled "Supportive Community Monitoring Tool") in the pilot and scale-up districts. However, what still remains unclear is how these SCMT teams interact with and support the ASHAs and the other FLWs.

Thus, in the scale-up districts, the project has attempted to address these concerns by creating a festival like atmosphere (Namma Habba means 'Our Festival' in Kannada) through adopting a campaign approach at the sub center level where the SCMT teams are formed and the 'torch of health' is handed over to them.

The shift from a didactic method of behaviour change communication to a more organic campaign mode was in the wake of the following:

- It provides scope for better advocacy since it is escapes the formal requirements of a traditional classroom training methodology
- This campaign mode should not be considered a routine activity but as an accelerator. It is part of a layered approach to behaviour change communication and is complementary to all the other components in Sukshema's community intervention.
- The acceptance and appeal of a process like the campaign mode (using theatre), which touches the cultural and emotional threads of the community and focuses on real time needs of communities, is always higher rather than a formal training process. In fact this shift has garnered a high level of acceptance from the Health Department as well.
- This mode of training could also serve as a means of strengthening and increasing the engagement of the FLWs and VHSNC members in the the Arogya Mantapas.
- It provides scope for social proofing. Transparency and unanimity is evident in such a process.
- It involves various players such as general community, AWW and all FLWSs along with the VHSNC members
- Motivational shift from VHSNC to the FLWs is paving the way for greater accountability from both ends
- Such a process is empowering in itself for DRPs
- In the pilot district, the focus was only on skill building but in this approach the focus is more on building perspectives. Skill development will happen through the handholding process.

Details of The Namma Habba campaign

The purpose of the Namma Habba campaign is to sensitize the SCMT members regarding the SCMT tool and its use. During the initial scale-up implementation activities, the district teams realized that not all VHSNCs in the scale-up districts were active. Thus, in the scale-up districts, DRPs are trying to form and strengthen the VHSNC in areas where they are not strong or functional, during handholding visits and Arogya Mantapas. All the SCMT teams in a given Sub centre will be involved during the Namma Habba campaign. The campaign aims to help VHSNCs understand the importance of utilizing the SCMT teams and the tool to plan and monitor MNCH in their villages.

Objectives of the habba:

1. To introduce the SCMT tool within the VHSNCs
2. To form as well as restructure VHSNCs wherever needed
3. To bring community representatives and FLWs together

The themes for the Namma Habba movement are standardized across districts to build message recall.

Standardized messages conveyed during the Habba are:

- The health of our village is our responsibility
- A hospital has the responsibility to treat mothers and children, while the VHSNC has the responsibility to safeguard the village's health status.
- Let us set aside one day a month for our village's health
- The community supported monitoring team or SCMT team is our support platform
- Let's put our mistakes behind us, and take our next step with confidence
- ASHA is the light of our village and the SCMT team is the fuel.

Duration of the Habba and key stakeholders:
The Namma Habba campaign is a one day program at the sub centre level involving all the VHSNC members of the villages under that sub centre as well as the Front line health workers. ASHAs, AWWs, JHAs, all VHSNC members and the 6-member SCMT team are the primary stakeholders. Along with these members, the local Medical Officers at the PHC level and other health workers can also be invited.

This one day program brings together all the VHSNC members from the villages of that sub centre where the Intimate Interactive Theatre team (consisting of DRPs) involves them in a discussion through interactive theatre around issues such as gender, maternal and child death, role of community and the VHSNC's responsibility in improving health conditions of their community. This performance is preceded by competitions and programs such as singing, rangoli, acting with the objective of bringing the VHSNC

members together. Officials such as the medical officer and other department officials were also invited for the program. In this festive milieu, the team launches the SCMT tool at the end of the program and the VHSNCs draw up the next action steps.

This habba commenced on Independence Day and end on Gandhi Jayanthi (August 15th to October 2nd).

Implementation Process

The process of implementing the Namma Habba movement within a sub-centre comprises of the following activities:

- **Designing the 'Habba' concept and Consultative Meetings :** The central team first assesses the situation at the grass roots level (with respect to how active the SCMTS are and whether there are functional VHSNCs in the area)and the findings are used at the time of planning the Habba. This is followed by a consultation meeting with the district teams, as needed. A rough draft of the design concept is then prepared.
- **Engaging the DRPs:** A meeting is arranged with DRPs at each Taluk where they are introduced to the concept, design and importance of Namma Habba. Their roles and responsibilities at the Habba will also be clarified here. DRP teams in each Taluk are given a target of staging 10 – 15 shows within 45 days. The dates of the Habba are also finalized at this meeting.
- **Consultations with GoK Staff:** Consultations are held with officers of the Health and Woman and Child Development departments at the district, taluk and PHC levels. Since this Habba is being voluntarily staged as part of the Arogya Mantapa, a written permission from the departments is not necessary. However, this step is key to obtain buy-in from the two main GoK departments involved.
- **Training and Formation of the Intimate Interactive Theatre (IIT) team:** A ToT for the IIT is arranged for four important members of the district implementation team (the IIT team comprises of the DCS, the DCM and 2 CCs) . The interactive intimate theatre is designed to be deliver the target messages effectively. A script is prepared, the cast is identified, facilitators and directors of the play are also identified and a pilot screening of the play is staged in at least 2 subcentres in a Taluk. However, the IIT teams during implementation will comprise of FLWs as well.

Monitoring and evaluation indicators to gauge the success of Namma Habba:

- The number of VHSNC members, SCMT members, ASHAs, AWWs and Karnataka Municipal Administrative Service members who participated in the Habba
- The number of SCMT meetings conducted and decisions taken during the duration of the Habba
- The support extended by officers from different levels of the health and woman and child development departments.

Table 2. Personnel Costs in Six Scale-Up districts

District	# of Habba conducted	# of VHSNC trained	# of VHSNC reformed	# of SCMT formed
Bellary	255	526	20	526
Raichur	177	779	189	813
Yadgir	160	470	62	470
Vijaypura	238	608	278	537
Kalaburgi	317	823	210	823
Bidar	268	619	68	598
Total	**1415**	**3825**	**1451**	**3767**

Lessons learned: Namma Habba campaign

- **Have a clear focus for the Habbas:** The initial plan was to use the habba as an orientation platform for both Arogya Mantapa and the SCMT Tool. But the teams realized that this approach was diluting the focus since both concepts are very distinct from each other. Thus, the habba is now focused purely on introducing the concept of SCMT and strengthening SCMT teams.
- **SCMT training will lead to strengthening of VHSNCs in Scale-up:** In the pilot districts, VHSNCs were already established and functional which was an advantage to the SCMT roll-out. Conversely, in the scale up districts, VHSNCs were either not yet formed or were not functioning effectively. Thus, the strategy in scale up districts was to start with the SCMT training and roll-out, with the hope that this would organically lead to building and strengthening the VHSNCs eventually.
- **Common Habba formula for all districts works:** The implementing teams realized that having a common formula to conduct habbas in all the districts works well, as long as a basic framework and clear expected process level outputs were articulated. The teams could then innovate and tailor habbas in their districts or taluks to suit local needs.
- The initial plan was to have a DRP orientations and ToTs simultaneously across all taluks but we changed the strategy are waited to finish the DRP orientations, TOTs and begin implementation in one taluk and then move to the other taluk. That gave the field teams enough experience to carry out this process elsewhere.

Challenges during implementation:

- Eliciting support from the department and the panchayat needed continuous effort and engagement
- Facilitation skills of the team of performers needed rigorous honing since the IIT team was in–house and not everyone had experience in handling such an exercise
- Ensuring that the campaign sent uniform messages across all sub centres was not easy
- Sustaining this process at low cost

Positive instances from the field that emerged during the Namma habba process:

1. Kavalaga Subcentre (Farathabad PHC) of Kalaburgi district had been closed for the last 2 years. There was a barber shop in the same building, hence women stopped coming to this sub-centre. The JHA of this SC made an attempt to shift the barber shop. This issue was discussed with the GP president during the occasion of "Namma habba". The GP President directed those concerned to vacate the shop and now the sub centre has started functioning as usual.

2. Many of the famiIies in Harji village of Kalamoda SC (Sonta PHC) in Kalaburgi district were not immunizing their children and this was a huge challenge to the FLWs. This issue was raised during Namma habba and everyone agreed to stage the namma habba process with similar performances using IIT techniques in Harji village to educate these families. Now all the families have agreed to immunize their children. Their attitudes have been positively changed.

3. During the discussion following the Namma habba performance at the Halagani SC (Bhabuleshwara PHC) in Vijayapura district, the AWW reported that eggs were not given to the Anganwadi children due to delays in releasing funds from the department. The PDO present at the habba took this issue up with the Panchayat and directed them to release funds. The AWW also shared that the kitchen in her Anganawadi did not have a door and people often walked in and out and dirtied the place. VHSNC president and other members responded to this and took up the repair work and installed a door to the kitchen. This serves as a good example of intersectoral support as a result of the namma habba campaign.

4. During the Namma Habba at Gunadala SC (Kambagi PHC) in Vijayapura district, the VHSNC President who attended it realized the importance of VHSNC. He therefore invited key people from the village and reformed the VHSNC as per the guidelines. He also invited members for the 1st VHSNC meeting and started discussions using the SCMT tool. One of the AWWs expressed her dissatisfaction with the Panchayat and the department for not appointing an AWW helper. A member of the VHSNC came forward to resolve this issue. He recommended a marginalized woman from the community for this job and finalized the candidate at the meeting. He also recommended that the Panchayat pay her salary in case the department failed to. He has paid her a salary advance of 500 Rupees.

5. During the Namma Habba discussion at the Baradola SC in Vijayapura district, the VHSNC president questioned the FLWs on a recent infant death in the village and asked them why they did not conducting any health camps in Vittalanagar village for the past year. The FLWs responded saying that the access road to the village was bad and transport facilities poor. The President discussed this with the MO who was present. The MO agreed to provide a vehicle to conduct immunization camps. Now the camps in Vittalnagar have resumed.

6. At Haranal SC (Nidagundi PHC), Vijayapura district, the issue of ASHAs' irregularity at work came up during the Namma habba discussion. ASHAs responded that they had not been given incentives on time. So, the VHSNC president decided to bring this issue up with the Panchayat and requested them to provide a monthly honorarium of Rs. 1000 per ASHA. On discussing this, the Panchayat made allocation for this under the NREGA scheme.

5.3.4 Coordination between project components in scale-up districts

Although the levels of change for Sukshema's Nurse-Mentoring intervention and the Community Intervention are different (facility and community respectively), it is crucial that both interventions are well coordinated to affect MNCH outcomes within a community and are viewed as being complementary considering the project's focus on providing services across continuum of care and integration. The project saw great scope for the three teams to work in harmony (Nurse mentoring, Community intervention and M & E)

The platforms for coordination such as district level coordination meetings chaired by DPCs and zonal level coordination chaired by zonal DDs and the central level coordination chaired by technical directors have been put in place to ensure that there is greater coordination between the two interventions.

To assess the level of coordination between the mentoring and community interventions, mentors, CCs and RPs in Koppal District were interviewed in October 2013. Project staff collected qualitative information on district-level coordination again in April 2014 in Gulbarga and Yadgir districts where the restructured community intervention was still being scaled up. This included focus group discussions with

mentors and community teams in one district and observation of a district-level coordination meeting in another.

Early Stages of Coordination

As of October 2013 the level of coordination between the two different project interventions was still in the early stages in Koppal and other districts. Mentors were asked to describe the community intervention. Collectively, they were able to name the key components, but no single mentor was able to readily describe it. Features they mentioned included the Arogya Mantapa meetings, the ASHA diaries, the RPs who work with ASHAs and JHAs and key chain counseling cards. Two mentors had seen ASHAs with their diaries.

Mentors met the community team in February 2013 when they were first hired and again in August 2013. It required extensive probing to get them to recall this meeting, but they described that they shared information about what each group was doing and discussed how they could support each other. One example given was getting CCs and RPs to help with access to ARS meeting funds.

By April 2014, the project leadership was more intentional about promoting coordination and introduced a meeting platform call the district coordination meeting in which teams from the mentoring and community intervention components met once a month in each district. This meeting included the DPS, M&E specialist, DCS, district community mentor, CCs and mentors. RPs were not present in this forum, which was for project staff only. In some districts, facilitation of the meeting rotated among the DPS, DCS and M&E officer. The project also tried for a short time to appoint a central team member to serve as adistrict coordination manager (DCM)for each district, although having eight individuals serving in this capacity for eight districts created challenges in standardising approaches.

According to project staff, the district coordination meetings tended to vary from district to district. In Gulbarga, the two teams met together seven times between September 2013 and April 2014. These joint meetings helped build a sense of connectedness among project staff.

As one mentor noted, "Earlier we used to think these people were with another project [referring to CCs] but now we realize that we work together." In joint meetings, participants discussed problems they saw in their PHC service areas. They reviewed indicators from the mentoring program and quarterly community-based tracking surveys that the project carries out. During the meetings, mentors and CCs jointly prepared action plans for their PHCs and district-level staff (DCS, DPS, DCM, M&E specialist) prepared separate action plans. They also made plans to do joint visits to PHCs.

Examples of Coordination

One CC related a story to illustrate coordination. During his visit to a PHC to attend an ASHA monthly meeting, he learned that the PHC's delivery volume was low. ASHAs were complaining about the PHC because staff had stopped giving drugs to speed up labour, so they were now referring women to another PHC that still practised labour augmentation. The CC tried to explain to them why labour augmentation was not a good practice. He then informed the mentor who counseled staff nurses at that PHC to stop labour augmentation.

Another example of how the two programme components tried to support each other was when mentors and CCs identified low-volume PHCs and worked together to see if they could increase deliveries. In one PHC, the mentor identified that hardly any deliveries were coming from certain sub-centres and informed the CC. The CC learned from the RP that ASHAs in that area were not referring women to that PHC but referred instead to a nearby CHC. The CC met with the RP and them to advise ASHAs to counsel mothers to come to the PHC for deliveries. This type of intervention also happened in three other PHCs. Interestingly, CCs stated that deliveries had increased in the three PHCs, although mentors and programme monitoring data did not show any noticeable increase. Nevertheless, this promising example illustrates how CCs and mentors worked together to identify a challenge and take action to try to resolve it.

Lessons learned: Community intervention linkages

The linkages between the two programme components evolved somewhat organically as the two teams got to know each other and found ways to work together. As the project moves into its final year, it will be important to develop clear guidance on what role mentors can play in extending AMMA to the community level and how this relates to the community intervention. Mentors' ad hoc participation in ASHA monthly meetings and collaboration with CCs have been interesting examples of how this support could be more intentionally provided in the future.

06 MONITORING AND EVALUATING SUKSHEMA'S COMMUNITY INTERVENTION- COMMUNITY BASED TRACKING SURVEY (CBTS)

In addition to routine monitoring data collected at the districts as well as data from GoK, Sukshema also conducted routine community based tracking surveys (CBTS) in each district. CBTS is a simple and rapid sample survey of target populations to measure intended outcomes in the population. The survey is conducted once every 4 months in a representative sample of women who have delivered in the past 2 months to collect data on

- Knowledge of mothers on key MNCH issues
- Utilization of MNCH services from the front line workers and health facilities
- Practices regarding newborn care

CBTS provides information on short-term changes and real-time data that are required for program monitoring. It is short, more frequent, and better focused to track short-term changes in indicators at district level. Results from the CBTS help the central project team and field staff tweak program implementation strategies in order to stay focused on outcomes.

Survey Design and Methodology

The area covered by an ASHA is the primary sampling unit. In each district, approximately 200 ASHA areas will be selected. With Taluka and PHC as strata, ASHA areas will be selected systematically (areas without an ASHA will also be listed in the sampling frame). Within each selected ASHA area, the households will be enumerated in a clockwise fashion with a random start, eligible women were listed and interviewed, until the target of 5 mothers who have delivered in the last 2 months is achieved. Thus, the target sample is 1000 respondents per district.

For Round 1 of CBTS in the pilot districts, RPs collected baseline CBTS information and conducted household surveys manually over a period of 2 months. However, the mode of conducting the surveys has changed from round 2 onwards. From round 2 onwards, the survey has been administered by trained external enumerators (10 enumerators per district/month) and data recorded electronically using mobile phones on to which the survey questionnaire has been loaded. The data is transmitted from the phones to a central location for processing and analyses.

Table 5: CBTS Sample Implementation

		Bagalkot	Koppal
Round-1	Start date	05-Jun-12	06-Jun-12
	End date	10-Jul-12	05-Jul-12
	Sample areas	400	400
	EW identified	853	888
	Response rate	99.7	99.2
Round- 2	Start date	01-Mar-13	01-Mar-13
	End date	19-Apr-13	18-Apr-13
	Sample areas	200	200
	EW identified	839	896
	Response rate	61.0	67.2
Round- 3	Start date	18-Jul-13	17-Jul-13
	End date	17-Aug-13	25-Aug-13
	Sample areas	200	200
	EW identified	910	815
	Response rate	63.9	70.9
Round- 4	Start date	23-Nov-13	26-Nov-13
	End date	22-Dec-13	28-Dec-13
	Sample areas	200	200
	EW identified	911	888
	Response rate	61.1	69.1

Critical indicators to be measured through the community behaviour tracking survey

Once every 4 months, the survey periodically tracks the priority indicators listed below:

1a. Percentage of pregnant women visited by ASHA at least once during this pregnancy

1b. Percentage of pregnant women visited by ASHA 3 or more times during this pregnancy

2a. Percentage of pregnant women visited by ASHA within the first trimester during this pregnancy

2b. Percentage of pregnant women registered within first trimester by JHA during this pregnancy

3. Percentage of women who delivered at a health facility

4. Percentage of women who received postnatal care for 48 hours or more at a health facility

5. Percentage of women who received a postnatal home visit by ASHA within one month of delivery

6. Percentage of women who received 6 postnatal home visits by ASHA

7. Percentage of children who received BCG Vaccine at birth

8. Percentage of children who received Oral polio vaccine at birth (OPV 0)

9. Percentage of children who received Hepatitis B Vaccine at birth (HepB 0)

10. Percentage of women who initiated breastfeeding within an hour of birth

11. Percentage of women who received the full range of continuum-of-care services (Percentage of women who had 3+ ANC visits & Institutional Delivery & Stayed at least for 48 hrs in the facility after delivery & Received at least one PNC home visit from ASHA)

12. Percentage of pregnant women who consumed 100 IFA tablets during the pregnancy

13. Percentage of women who did not apply anything to their babies' cords

14. Percentage of recently delivered women who are able to correctly identify each element of birth planning and birth preparedness listed below:
    a. Identify a health facility
    b. Identify a doctor
    c. Vehicle to reach health facility
    d. Vehicle to return home
    e. Arrangements for expenses
    f. Warm clothes for newborn
    g. Food arrangement for family
    h. Childcare arrangement

15. Percentage of recently delivered women who are able to correctly identify the danger signs during pregnancy listed below:
    a. Swelling of hands and feet
    b. Excessive fatigue
    c. Bleeding
    d. Convulsions
    e. Visual disturbance
    f. Hypertension

16. Percentage of recently delivered women who are able to correctly identify maternal danger signs during postpartum period listed below:
    a. Excessive bleeding
    b. Convlusions
    c. High/Low BP
    d. High fever
    e. Lower abdominal pain
    f. Foul smelling discharge
    g. Severe headache

17.Percentage of recently delivered women who are able to correctly identify the danger signs among the newborns during the postnatal period listed below:
    a. Baby not crying
    b. Blue tongue and lips
    c. Poor breastfeeding
    d. Convulsions
    e. Lethargic
    f. Breathing difficulty
    g. Cold to touch
    h. Fever
    i. Redness/ pus around cord
    j. Yellow staining of palms and soles

18. Percentage of recently delivered women who are able to correctly identify the elements of essential newborn care listed below:
    a. Breastfeed soon after birth
    b. Exclusive breastfeeding
    c. Ensure warmth for baby
    d. Apply nothing to cord
    e. Wipe neck, face and underarms
    f. Bathe after cord stump falls off
    g. Put nothing in eyes and ears
    h. Immunize

19. Percentage of recently delivered women who are able to correctly identify the specific government schemes and incentives to promote utilization of

MNCH services listed below:

a. Janani Suraksha Yojana
b. Prasuti Araike
c. Madilu kit
d. Thayi Bhagya
e. Bala Sanjeevani

Using CBTS data to maintain project focus

After each round of CBTS, data for all the indicators is shared with project staff at all levels as well as with FLWs for further deliberation. However, of the 20 core indicators, only 7 of the indicators listed below are considered 'dashboard indicators' and their progress is tracked very closely by the central and district project teams on a regular basis.

Any deviations in the data would suggest that the district teams need to increase the depth of outreach or tweak program implementation to regain focus. In addition, routine use of the CBTS data has enabled all the district teams to have a common focus while being involved in a complex set of interventions.

This was a major learning from the pilot districts, because despite having put in a tremendous amount of energy into trainings and roll-out, the subsequent rounds of CBTS found gaps in coverage of beneficiaries by FLW's. This was a wake-up call for the district teams to direct their attention to a more impact-oriented roll-out and to support the FLWs with on-the-job training rather than focus more on a classroom-type training.

Using CBTS data during trainings

Usually, a round of CBTS (baseline or Round 1) is conducted in a district prior to start of implementation. This data is then analyzed in a timely manner and shared with the district teams as well as the FLWs. This 'baseline' CBTS data is then used by trainers during training sessions, thus providing FLWS with a 'context' for their outreach activities.

Using CBTS data for project implementation in Bellary District- A Unique Approach

The Bellary district team decided to use CBTS data to review the progress made in their district, in a unique way. Taluk teams were formed comprising of a Nurse Mentor & a CC in each team. Each Taluk team chose one CBTS indicator such as 48hrs post-delivery stay in the facility, breast feeding within 1 hour of birth, etc. that they would monitor in their Taluk. Both the Nurse mentor and CC in each team developed a joint action plan and conducted a situational analysis based on consultations with facilities and interactions with FLWs and the community they served. From these consultations, they understood the need for the Nurse mentor and the CC to conduct joint visits, as well the need for a convergence meeting between the community & the facility. Based on these learnings, they worked out joint facility and community strategies to improve their chosen CBTS indicators. This joint action plan was first 'piloted' in one PHC, and then scaled up to the rest of the PHCs in their taluk. These learnings were shared with the district coordination team comprising of DCS, DPS, District M& E specialist, DPC, CCs and Nurse Mentors. Thus, the Bellary district team used CBTS indicators to not only guide their implementation process but also to help improve co-ordination between the facility intervention teams and the community intervention teams.

Table 6: Key focus CBTS indicators for the community interventions

#	Progress indicator (Community Interventions)
1	Percentage of pregnant women visited 3 or more times by FLWs during pregnancy
2	Percentage of women who were NOT visited by FLW within one month of delivery
3	Percentage of women who were visited by FLW within 1 day of delivery
4	Percentage of women who were visited by FLW within 3 days of delivery
5	Percentage of Infants who received BCG Vaccine
6	Percentage of mothers who initiated breastfeeding within an hour of birth(CBTS)
7	Percentage of women who did not apply anything to the newborn's cord(CBTS)

CBTS: Voices from the field

"CBTS data has been an eye opener for me. For example, previously we never used to give the Thayi card to all the pregnant women. Now we've started giving Thayi card to all"
- Sarojini, JHA of Gote PHC, Jamakhandi taluk,Bagalkot district

"While CBTS data gives us a broader understanding of the district, it also helps me get a better understanding of the progress in my taluk. It helps me see where I have to focus in my taluk."
- Amaramma, Additional CC, Gangavathi taluk, Koppal district

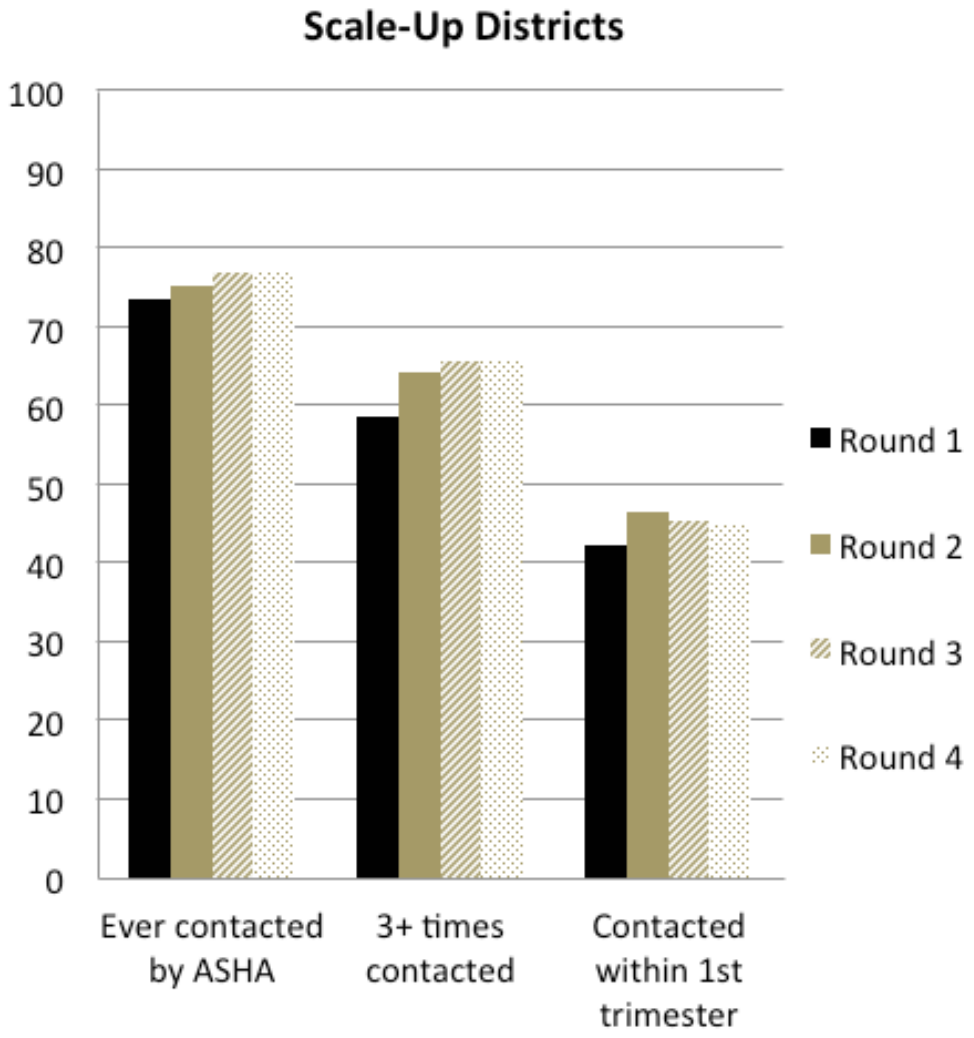
"It gives very minute level findings, that helps me gauge where I really need to focus. For example, cord care practices, as per our field experiences nothing was applied for the cord, but CBTS data says that still around 30% of mothers are applying turmeric powder/oil/ talcum powder. This made us rethink and focus our efforts to improve this particular behaviour. I can honestly say that every round of CBTS data help me to think more innovatively to achieve project goals."
- Manjunath Dodwad, District Community Specialist, Bijapur district

"At the zonal level, it gives me a broader understanding of the progress made in the districts. It helps me understand which indicator is performing well in the district. This also helps inform the district plan and helps revisit the implementation process accordingly."
- Prathibha Rai, Zonal manager-CI

"CBTS data is like a vehicle dashboard. It helps me see where I am and where I have to go. It helps me see which behaviour needs to be addressed & also when to address it."
- Suresh Chitrapu, DD-Communication

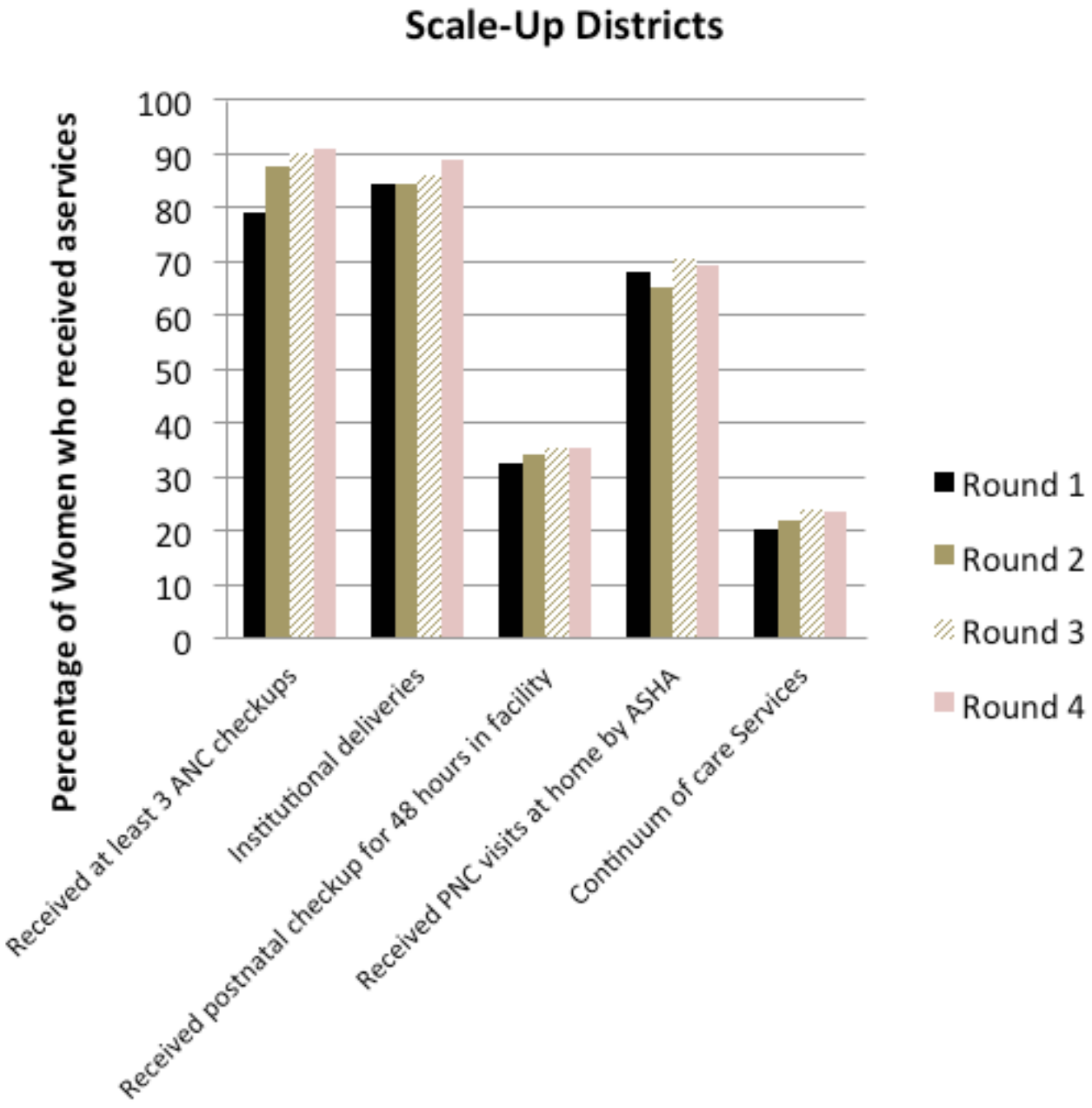
Sample CBTS Progress Indicator 1:

Number of pregnant women visited 3 or more times by an ASHA in scale-up districts



CBTS results from indicate that the number of pregnant women contacted 3 or more times by a FLW has improved compared to round 1 (baseline) CBTS levels in scale-up districts. There is also an increase in the number of pregnant women ever contacted by an ASHA and those contacted within the first trimester in all districts, compared to round 1 CBTS data. However, overall percentage of those contacted within the first trimester still remains below 50%. But further examination revealed that at any time in the districts, there are about 15-20% ASHA positions that are vacant. If these areas happen to be far off from the designated working areas, the in-charge ASHAs or in-charge JHAs/AWWs are unlikely to provide required services.

Sample CBTS Progress Indicator 2:
Percentage of women who received services in scale-up districts

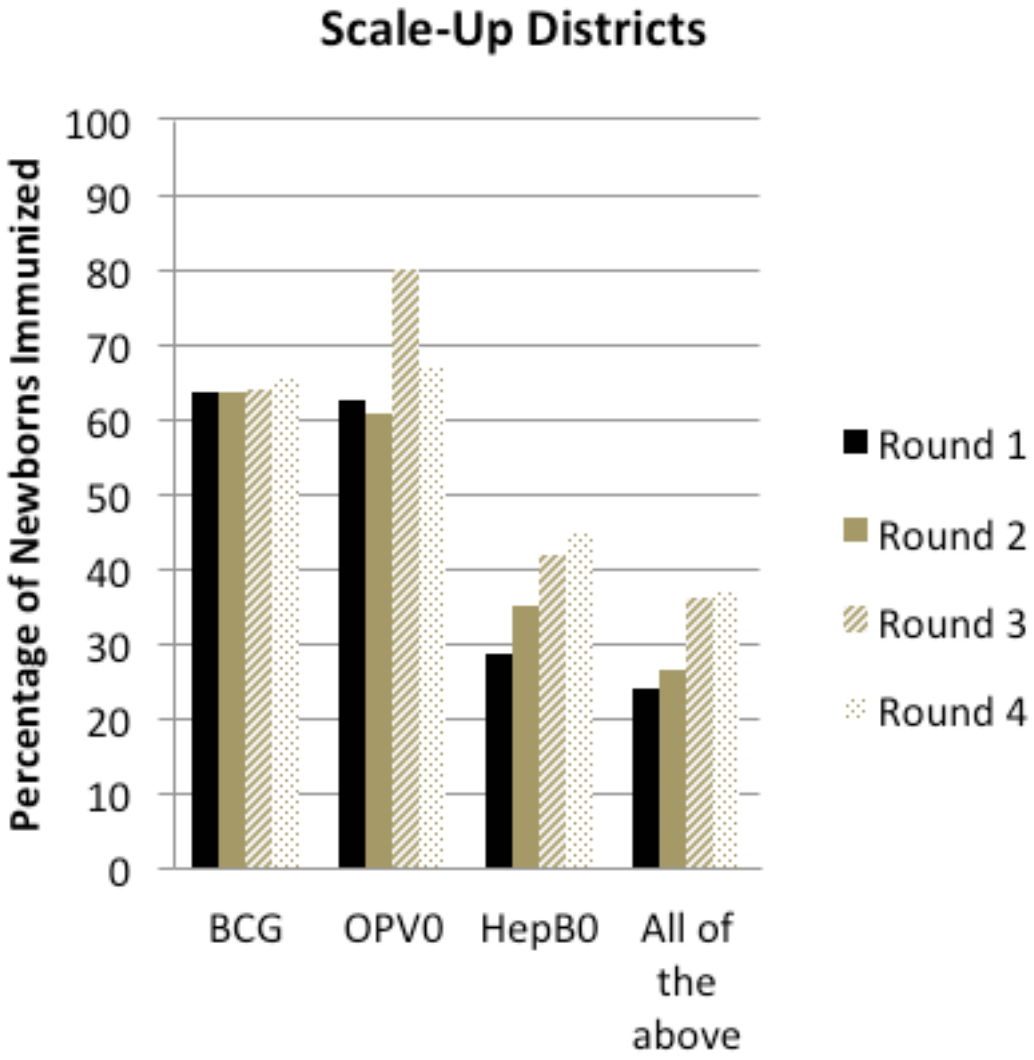


(*Continuum of care services= Received at least 3 ANC checkups, institutional delivery, Received postnatal check-up for 48 hours in facility and received PNC home visits by ASHA)

The percentage of women who stayed 48 hours at a facility post-delivery has increased compared to Round 1, and further examination revealed that the highest percentages were reported from the districts of Raichur and Bellary. However, in Yadgir, only 25% of the women reported to have stayed for more than 48 hours in the facility after delivery, and incidentally, Yadgir leads the other districts in terms of proportion of deliveries reported in PHCs (around 40% of all deliveries), in comparison to around 30% in other districts.

Although the overall rates of institutional deliveries have increased since Round 1, Yadgir and Raichur report the lowest rates of institutional deliveries. During this period, the number of deliveries in private facilities in the neighbouring districts of Bagalkot and Bijapur have increased which could account for the 40% of the deliveries in the district.

Sample CBTS Progress Indicator 3:
Newborn immunization results in scale-up districts



CBTS results indicate that as of Round 4 of CBTS, i.e. within last 6 months, there have been substantial gains in the percentage of newborns who received all their birth immunizations in all scale-up districts. However, overall gains in percentage of newborns immunized are not uniform for all the key newborn vaccines. The percentage of newborns who received BCG at birth has increased in Round 4 compared to Round 1, albeit to a lesser degree. Further examination of the results indicates that the districts of Yadgir and Raichur are lagging behind in terms of early BCG administration (50% and 60% respectively). The percentage of newborns who received HepB0 in scale-up districts has almost doubled, particularly in Gulbarga from around 20 to 40%.

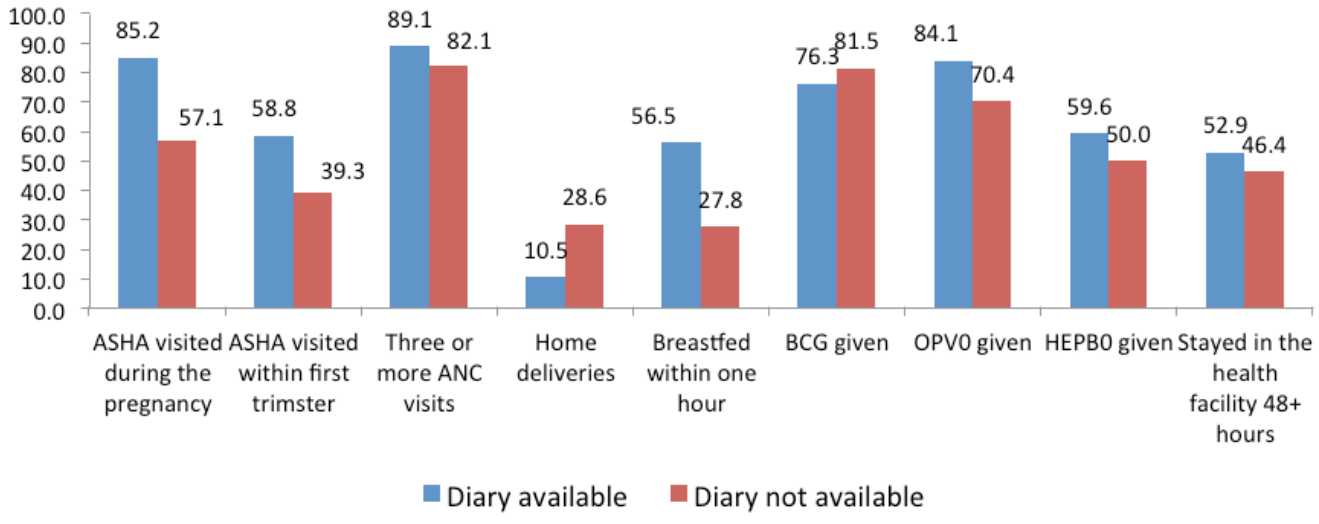
Monitoring Of Community Interventions- Our Experience

Both data from the CDL and CBTS were envisaged to help in programme monitoring. While CBTS helped in measuring mainly outcomes, CDL 1 & 2 were aimed at generating evidence for improvement in coverage of beneficiaries and strengthening the data of Mother and Child Tracking System (MCTS), which is maintained by Department of Health and Family Welfare. . However, the experience of the implementation of the CDL tools (both CDL 1 and 2) in the scale-up districts was different from that of the pilot districts. Majority of the ASHAs (70%) were able to use CDL 2 to do an opportunity gap analysis with regards to coverage of services at the village level on a regular basis in the pilot districts. This level was achieved in June 2014 and after that this was reduced to 40% in December 2014. The ASHAs in the scale-up districts derived other simpler ways of ensuring that the gaps were identified and addressed. While CDL 1 was used extensively, fewer ASHAs (only5% to 30% in scale-up districts as on December 2014) used the CDL 2 to derive summaries. Gaps in the use of CDL 2 in the scale-up districts could be due to our complete dependence on the ASHA facilitators to handhold ASHAs. Whereas, in the pilot districts we had large presence of project staff (community coordinators) to closely support the ASHAs in the process during the period of intensive intervention; the gaps in use of CDL was also related to capacities of the ASHAs and ASHA vacancies which was close to 25% at any time of the year.

CDL therefore provided us with incomplete information on the coverage status of critical MNCH services in as far as deriving the estimates at the block or district level The tool therefore came to be viewed as an output monitoring tool rather than an outcome or impact monitoring tool since all ASHAs were not reporting and further, the volume of information that was required to be collected and collated was not manageable with the existing number of project staff. Had the tool been institutionalised or had there been minimum reporting hassles with greater number of ASHAs using the tool, CDL would have served as a programme monitoring tool as envisaged.

The data from the CBTS on the other hand helped monitor the impact of the community interventions. The CBTS approach provided valuable information on the key MNCH indicators the project expected to influence in a timely manner. Though the CBTS data worked best at the aggregate level (district level), the data from the CBTS was still made available to the teams at the taluk level to enable the teams develop a better understanding of the data that was a result of their effort on the ground. The timely availability of the data allowed the project staff to act on the information, focus efforts and to know whether the focused efforts had yielded any improvements within a few months of time. However, some of the CBTS indicators, influenced mainly by deeply rooted cultural practices, would not change in a short duration of time and so it was not realistic to track changes in those indicators.

A validation exercise was conducted to look at responses of beneficiaries on few indicators in both the CBTS and CDL. The purpose of this exercise was to assess the accuracy of reporting in CDL in comparison to CBTS. The validation exercise proved that use of ASHA diary helped in identification of more pregnant woman and thus improving the coverage in MNCH services. The following chart illustrates that wherever the ASHA had diary, most of the outcomes of CBTS were also better as compared to areas where the ASHA did not have a diary.



07 DRP "SAMMILANA"- A FORMAL HANDING OVER PROGRAM

The team conceptualised a program to formally mark the handing over of the community interventions and the concepts to the real owners of the entire exercise- the department and the community members.

The DRP *Sammilana* (get together) was planned to be an event to appreciate and recognize the achievements and successes of the interventions, share learnings and express commitment to the department. The *Sammilana* marks the stepping back of the project and the surging forward of the department in carrying the work forward and sustaining the field level impact of Sukshema project. This end-of-project event was successfully conducted in all the districts.

The participants include all district and taluk level officials such as the DHO, DPMO, RCHO, taluk health officer, officials from the Women and Child Department, all the DRPs in the district (about 120 per district), ASHA mentors and ASHA facilitators.

The project Community coordinators start preparing for the Sammilana and the date is decided after consultation with key officials. The day begins with registration. The program is facilitated by the DRP or CC.

The schedule for the day is as follows:

- Registration of all participants
- Informal start to the program by inviting volunteers from the participants to perform on stage-singing, mono acting, dance etc
- Formal inauguration and introductory speech about Sukshema and the way forward
- Experience sharing by DRPs (A few DRPs from each taluk are invited to speak)
- Inter-taluk cultural competition for about half hour where every taluk team will be invited to perform
- Award function- This includes distribution of certificates of appreciation to the DRPs, taluk awards for achievement in different areas around the interventions. For example: SCMT roll out, CDL data, Namma Habba roll out, HB-FFC handholding. Each of the taluks will be recognized for their excellence in any one of the core areas and the memento will be handed over to the THO. Also included is the award for a district for its contribution and excellence in any of the following areas: Departmental support, Coordination among FLWs, DRP performance etc.
- Group photos of taluk and district teams
- Speeches by district official sharing experience and commitment
- Closing ceremony
- Lunch

During *Sammilanas*, taluk teams will also set up exhibits with different themes. For example, in Raichur district, the exhibits were around themes of Nutrition, Gender and general handicrafts. Stalls are usually set up the previous day.

The Sukshema team felt that the DRP *Sammilana* gave everybody a chance to reflect on the project activities, their impact and the way forward for the department staff and community representatives. The *Sammilana* provided opportunities to DRPs and other officials to share their thoughts on stage.

Voices from Sammilanas:

Health Department Officials:

"*Most of the time we don't recognize the people who work on the ground (like the ASHAs). It is important to recognize and appreciate them. I also want to add that mentoring intervention has helped us a lot especially the case sheets and the M & E specialists' contributions to the department has been tremendous"*
– Dr. Srikanth Basur, DHO, Koppal

"Sukshema has laid a foundation for us and we will build on that foundation... Case sheet, ASHA diaries are very useful"
– Dr. Gundappa, DHO, Vijaypur

"This sammilana is an excellent programme. We will make sure that we organize similar events in future that helps all of us to come together"
– DHO, Raichur

DRP Voices:

"*Arogya Mantapa is helping us work in a coordinated manner."*
- DRP, Bagalkot district

"I developed the courage and the confidence to address a gathering and speak to people only because of the exposure and training given to us through the Sukshema Project"
– DRP, Koppal district

"This is not the end. It is the beginning. What Sukshema has started, we will complete. Cannot thank Sukshema enough for giving us the ASHA dairy. It has helped us a lot"
– DRP, Koppal district

"Namma habba has given us the needed recognition in the community. The VHSNC did not know anything about the work of the ASHA/AWW/JHA. But after the Habba program they are contacting us and we are beginning to work together. I thank Sukshema team for bringing us together"
– DRP, Vijaypura district

The Project team members usually share their reflections at the end of the project period. They add that they have successfully been able to leave behind a very strong cadre of DRP as well as FLWs. They see increased confidence and self esteem levels among FLWs, greater coordination among themselves, increased understanding of MNCH issues. In addition to this, the team also feels that the department officials have begun to view DRPs as a real resource and have begun to recognize their contribution to the system.

Sukshema central team members:

"We have not only helped FLWs realize their potential and identify their skills but have also equipped them to use their skills effectively."

"No one in the field was obligated to participate and neither did we at any point of the project promise monetary benefits. In spite of this, we achieved excellent participation."

"All tools and processes have been successfully institutionalized within the system."

"Promoting and strengthening DRPs has only been half success achieved. We should have aimed at bringing them together as a team at the district level."

08 COLLABORATING WITH GOVERNMENT OF KARNATAKA (HEALTH DEPARTMENT) STAFF

In the scale-up districts, Sukshema's community interventions were largely carried out by the Government of Karnataka health department staff, unlike the pilot districts. This was possible because of the introduction of the DRP cadre in the scale up districts (since DRPs are GoK staff) and aggressive rapport-building with the Health department staff by the district field teams. This resulted in all the ToTs and the roll-outs being facilitated by GoK staff. Thus, unlike the pilot districts, there was greater ownership of the interventions right from the beginning.

Key informant interviews with the Health department staff (Medical Officer, Taluka Health Officer and the Reproductive and Child Health Officer) re-iterated these points. The various GoK staff interviewed for this documentation were not just aware of the various components of the Community Interventions in their districts, but were very appreciative of the efforts of several Sukshema staff. In general, the various tools and processes were well accepted by Health Department officials. The ASHA diary was a particular favourite among the key informants.

The THO was in line with Sukshema's objectives of enhancing grass-roots level planning and monitoring, as opposed to extensive policy decisions which may not address the real barriers to health care access and uptake on the ground. The THO's opinion was that FLWs were good at handling crises but failed at regular monitoring and he felt that this was a gap that Sukshema could address. Also, he stressed on the need to ensure that FLWs and DRPs understand why MNCH indicators were important.

At all levels Sukshema interventions has worked in collaboration and convergence with the Health, Women and Child Development and Rural Development and Panchayat Raj departments. The principle of convergence has helped integration of project activities into the existing diaspora of initiatives across these departments. Efforts have been made through the community interventions to bring this convergence right down to the level of the individual villages where activities are not driven by departments but by needs. Ensuring integration has been a key mantra guiding the teams across all levels.

09 PROGRAMME COSTING

A multi-faceted community-based intervention using frontline workers and VHSNCs was piloted and scaled up within the context of the Sukshema project in eight districts of northern Karnataka from 2012 to 2014. This chapter describes the costs involved in implementing the programme.

Costing Considerations

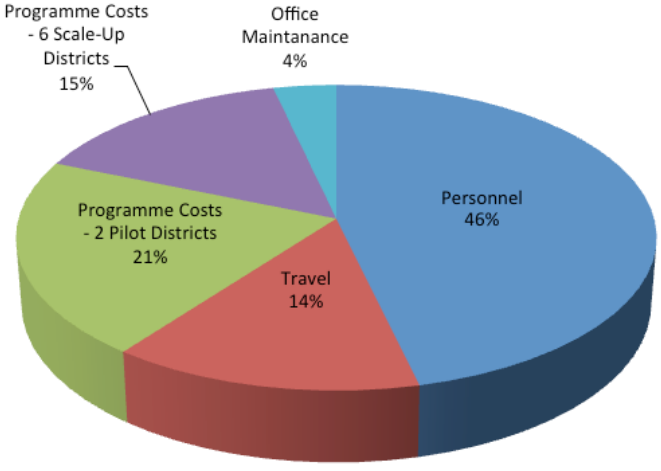
The actual expenditure for implementing the programme in eight districts from March 2012-August 2014 was considered for the cost analysis.

- A major percentage of the costs are related to staff (salaries, travel, per-diems), material costs (printing of tools and job-aids) and events (training, refreshers, review meetings).
- The costs are mentioned both in Indian rupees (INR) and US dollars (USD) considering the exchange rate of 58 INR per USD.
- The costs are categorized into one-time and recurring costs. One-time costs include expenditures that were made once during the time of intervention such as DRP meetings, trainings, whereas the recurring costs include expenditures that recur regularly such as staff salaries, travel, per-diems etc.

Total Expenditure of Sukshema's Community Intervention

The total cost for implementing Sukshema's community intervention was **INR 67,636,786** with the average cost per month being **INR 2,332,303**. Programme costs, such as TOTs, FLW trainings, family focussed communication, printing of tools and job-aids etc and personnel costs, such as staff salaries, formed the largest proportion (~82%) of the of the total cost.

Total Expenditure from March 2012 to August 2014



Recurring staff-related costs

The Sukshema project developed a management structure and management processes to oversee implementation of the community intervention. A central technical management team based in Bangalore handled both technical and administrative matters and provided guidance and support to the district field teams. The core team at the district level consisted of District Community specialist (DCS) who supported and supervised the taluk level teams headed by the taluk community coordinators. Each Taluk Community Co-ordinator, in turn, supervised and supported 8-12 District Resource Persons (DRPs). Additionally, district community mentors (DCMs) mentored taluk community co-ordinators and DRPs and formed a mid-level cadre of district personnel in each district. In the 2 pilot districts, district level staff were employed for a total duration of 30 months while the district level staff in the 6 scale-up districts were employed for a total of 18 months.

Salaries and travel costs of central management team in Bangalore

The central technical team involved in the overall management and implementation of the community intervention comprised of 2 Zonal Technical Managers, 2 Senior Community Specialists, a project documentation specialist, an administrative assistant and the Community Intervention Team Leader. The Zonal Technical Managers were involved in guiding the teams through strategic/ programmatic inputs throughout the project implementation; they were offered monthly salaries of 50,000 INR each and a monthly travel allowance of INR 14,000 (which included accommodation, travel and per diems) for about 8 days a month for a period of 30 months. The Zonal Technical Managers reported to the Community Intervention team lead, who was the overall lead for implementing this intervention.

Salaries and travel costs of district level staff in the pilot and scale-up districts

Each district had a District Community Specialist (DCS) who managed all the taluk level staff in his/her district. Thus, there were a total of 8 DCSs (social work graduates with seven year work experience in the development sector) who were offered monthly salaries of around INR 22,000 and travel costs of about INR 4000 each. The District Community Mentors (8 in total; 2 in the Pilot districts and 6 in the Scale-up districts) were graduates with experience in co-ordinating programmes at the field level and

liaising with community structures such as Gram Panchayats. They were offered salaries of INR 12,000 each and INR3500 for travel costs. Community Co-ordinators (CCs) has a minimum of Standard 12 education. Their attitudes, skills and abilities were assessed during recruitment and they were offered salaries of INR 12,000 each and INR2500 for travel expenses. There were a total of 42 CCs (10 in the pilot districts and 32 in the scale-up districts). In the pilot districts of Koppal and Bagalkot, there were a total of 75 Resource Persons who had a minimum qualification of SSLC, and were offered salaries of INR 6000 each and INR 2000 for travel. This cadre was only recruited in the 2 pilot districts. Initially, for about 5 months of implementation, a total of 75 'Supportive to Community Co-ordinators') were recruited in the pilot districts to assist in rolling out the trainings, which was an intensive process. They had a minimum Standard 12 education and they were only recruited for 5 months. They were offered salaries of INR 6000 each and INR 2000 for travel. Total costs for staff and their travel in the 2 pilot districts were INR 24,840,000 or USD 414,000 (See Table 1).

Table 1. Personnel Costs in Pilot districts of Koppal and Bagalkot

Category	Sub-category	Unit Rate (INR)	No. of Units	No. of months	Total costs	Total costs USD	Comments
District Community Specialist (DCS)	Salary	22000	2	30	1320000	22000	March'12-March'15
	Travel	4000	2	30	240000	4000	
District Community Mentor (DCM)	Salary	12000	2	30	720000	12000	March'12-March'15
	Travel	3500	2	30	210000	3500	
Community coordinators	Salary	12000	10	30	3600000	60000	
	Travel	2500	10	30	750000	12500	
Resource Persons	Salary	6000	75	25	11250000	187500	
	Travel	2000	75	25	3750000	62500	
Supportive to Community Coordinators	Salary	6000	75	5	2250000	37500	
	Travel	2000	75	5	750000	12500	
TOTAL					**24840000**	**414000**	

Similarly, in the six scale-up districts, 32 'supportive to Community Co-ordinators' were hired for 5 months. They were standard 12 educated and were offered salaries of INR 8000 and travel expenses of INR 2500. Total costs for staff and travel in the 6 scale-up districts were INR 14,514,000 or USD 241,900 (See Table 2).

Table 2. Personnel Costs in Six Scale-Up districts

Category	Sub-category	Unit Rate (INR)	No. of Units	No. of months	Total costs	Total costs USD	Comments
District Community Specialist (DCS)	Salary	22000	6	18	2376000	39600	March'12-March'15
	Travel	4000	6	18	432000	7200	
District Community Mentor (DCM)	Salary	12000	6	18	1296000	21600	March'12-March'15
	Travel	3500	6	18	378000	6300	
Community coordinators	Salary	12000	32	18	6912000	115200	
	Travel	2500	32	18	1440000	24000	
Supportive to Community Coordinators	Salary	8000	32	5	1280000	21333	
	Travel	2500	32	5	400000	6667	
TOTAL					**14514000**	**241900**	

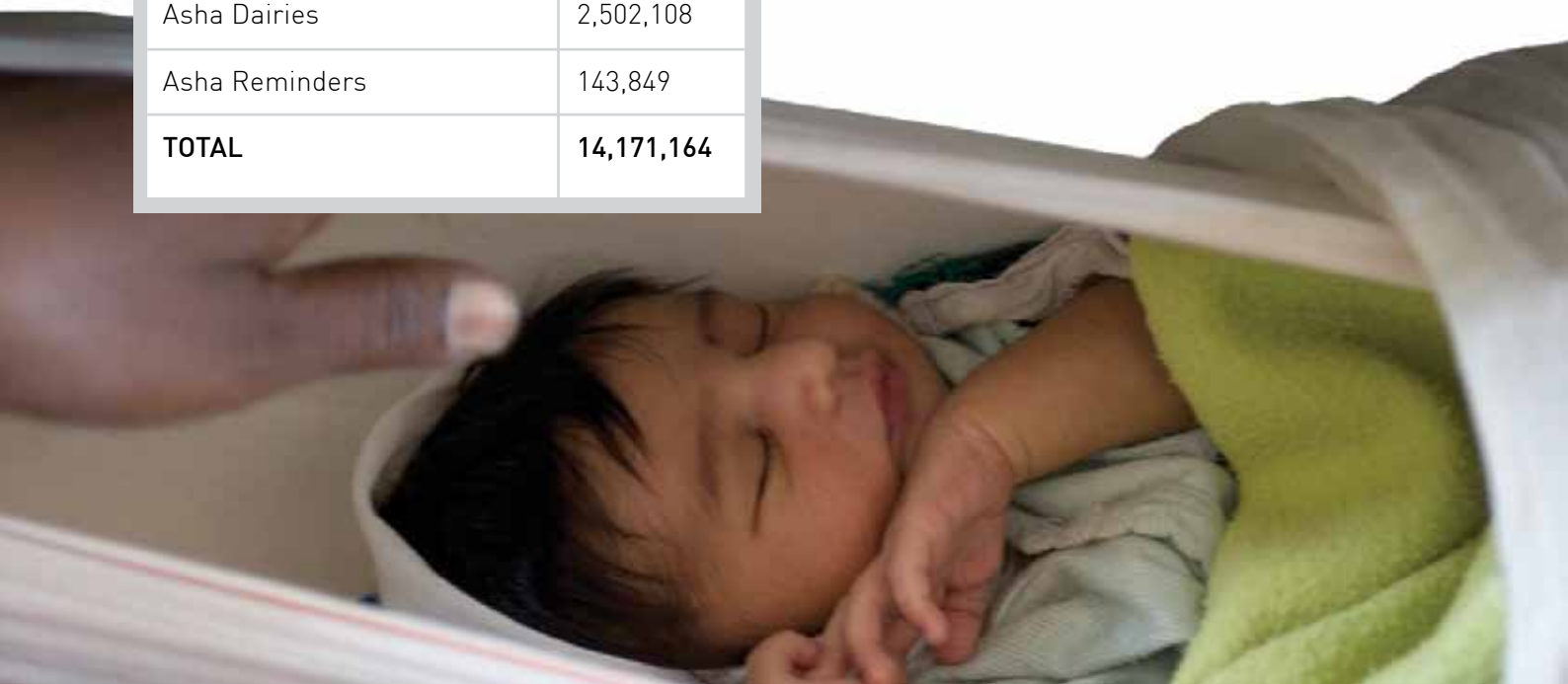
Programme costs in pilot and scale-up districts
The total programme cost for all the community intervention activities in the 2 pilot districts of Koppal and Bagalkot was INR 14,171,164 which worked out to be an average expenditure of INR 488,678 per month. For the breakdown of expenses, please refer to the table below.

Table 3: Programme Costs for Koppal and Bagalkot (Pilot Districts)

Category	Total Expenditure from -01-Mar-12 to 31-Aug-14
Family focussed communication	4,735,439
Community Monitoring & structures	2,378,802
Mid Media/Arogya Mantapa/ Sub Center Forum	552,139
Mass Media (include CFAR)	190,130
Innovations	121,871
Micro Planning	1,730,175
Printing of Tools & Formats	1,421,047
Rollout Trainings -Residential	142,391
Rollout Trainings - Non Residential - Followup	2,076
SCMT Non Residential	251,647
Asha Dairies	2,502,108
Asha Reminders	143,849
TOTAL	**14,171,164**

Total programme cost for the implementation activities in the 6 Scale-up districts was INR 10,247,583 which worked out to be an average of INR 353,365 per month.

General Category of Expenditures	Total Expenditure from -01-Mar-12 to 31-Aug-14
Family focussed communication	478,065
Micro Planning	40,132
Participatory Programme Review	366,718
TOT	1,141,322
Rollout Trainings -Residential	595,261
Rollout Trainings - Non Residential – Followup	2,221,381
SCMT Non Residential	2,143,956
DRP Meetings	1,256,150
Arogya Mantapa	1,674,773
TOTAL	**10,247,583**



10 SUCCESSES AND WAY FORWARD

Sukshema has implemented a top-notch, scalable MNCH program in eight priority districts in northern Karnataka: Bagalkot, Bellary, Bidar, Bijapur, Gulbarga, Koppal, Raichur and Yadgir, over the last 4 years. The project has introduced simple yet innovative solution levers to support the Governments of Karnataka and India improve maternal, newborn and child health outcomes in rural populations. The entire process of implementation, using the "Think Big, Start Small and Scale-up" philosophy, has been a resounding success since the experiences gained from the pilot districts have helped the project teams re-evaluate some of their activities during scale-up and rethink their strategy to achieve Sukshema's ultimate goals.

In particular, Sukshema's community intervention has utilized innovative strategies to support communities and FLWs take ownership of their health and wellbeing. The ASHA Diary has been, arguably, the most well-received innovation by all levels of the health system, from the FLWs to the District Health staff. In fact, the Goverment of Karnataka has adopted this Diary in its current form, as part of its commitment to enhancing the skills of and supporting ASHAs through a systematic, user friendly, simple and contextual job aid that will empower and equip them to meet their daily challenges on the ground.

The Arogya Mantapa or Sub-centre forum is another innovation that has enjoyed tremendous acceptance and ownership by FLWs. The intended purpose of this intervention is to facilitate improved co-ordination of FLWs' activities. Initially in the pilot districts, there was a greater emphasis on FLWs using this forum to discuss ETT/CDL targets and achievements and to troubleshoot any issues that arise. However, the FLWs saw it as a social forum and this has helped them take ownership of the Arogya Mantapa process. They set their own agenda for the AM monthly meetings and use the forum for more social activities rather than to discuss MNCH issues. This organic evolution of the AM process will probably lead to greater sustainability of this intervention even after Sukshema is long gone.

Concurrent monitoring through CBTS was received very well by the state. This helped strengthen the existing data on the field. Sukshema's approach of convergence and integration trickled down even to the lowest levels. This has been a huge success for the project.

In addition to that, none of the interventions have been borrowed from an already existing experience but were designed, tested and scaled up based on the local context and need in collaboration with the end users such as the FLWs and the community members.

The focus has been to address a gaps in the MNCH care continuum and not individual gaps in specific services. The effort has been to change the ASHA from being a service provider to a change agent with the right attitudes, skills, confidence and vision for community health. This brought in tremendous ownership of our interventions. ASHAs began to view themselves differently and so did the community.

The transition of project interventions, activities and processes to the Government is a key aspect of Sukshema's phasing out. However, the foundation for this has already been laid by virtue of extensive involvement of the Health Department staff (particularly at the DRP level) in all implementing districts and the high level of buy-in that the Government has demonstrated towards the project, so there will be a relatively seamless transition of the project's processes to the Government of Karnataka. Encouraging and building ownership by the state of the interventions has been strived for at all levels by the project's staff at the centre, district and field levels. With the state functionaries and department officers being involved at every stage of the project, transition has already begun.

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