



# Strengthening ASHA Support Mechanisms for Improved Newborn Care in Uttar Pradesh

October 2012

## Background

The Government of India launched the National Rural Health Mission (NRHM) in 2005 to improve health outcomes, especially for women and children. One of NRHM's core strategies provides for a new cadre of community health worker in every village known as accredited social health activists (ASHAs) to mobilise communities to seek health services and adopt healthy behaviours.

Although significant progress has been made in recent decades towards child survival in India, there is still need for increased attention, especially for newborn survival. Nearly 53 percent of all under-five child deaths in India occur in the first 28 days of life. Uttar Pradesh (UP), the most populous state in India, faces a particularly challenging situation, with a neonatal mortality rate of 47.6 per 1000 live births in 2005-06<sup>1</sup>.

ASHAs, as one of the first points of contact for pregnant women in rural areas, can provide important information at critical time periods (e.g. antenatal period, immediately following birth, and periodically throughout the postnatal period), to promote healthy maternal and newborn care practices and facilitate identification and referral of maternal and newborn complications. To reduce the infant and neonatal mortality rates, the Government of Uttar Pradesh (GOUP) launched the Comprehensive Child Survival Programme (CCSP) in 2007. One of the key objectives of CCSP is to support ASHAs in promoting home-based newborn care, information and essential services in the community and identifying high risk newborns for timely referral and management. CCSP is largely based on World Health Organization's Integrated Management of Neonatal and Childhood Illness (IMNCI) initiative.

In 2007, GOUP requested the USAID-funded Vistaar Project led by IntraHealth International to provide technical assistance (TA) to support the CCSP and ASHA programme in five districts in the state. The Project worked collaboratively with state and

district officials within the Department of Health and Family Welfare (DHFV) to develop ASHA support mechanisms, including improved capacity-building and supervision systems. The Project also served in an advisory capacity for newborn care issues for the state NRHM and CCSP.

The Project facilitated evidence reviews with GOUP and other experts (September 2007), which showed that counselling of pregnant women and mothers about maternal and newborn health practices, especially during home visits, contributed to significantly better health outcomes. The evidence review indicated that supportive supervision, regular monitoring and use of the monitoring data, also led to improved health worker performance. The Project also conducted performance needs assessments and a baseline survey and used the findings to inform the technical assistance approaches (Box 1).

### Box 1: Key Findings from Performance Needs Assessments and Baseline Surveys in Uttar Pradesh (2008-2009)

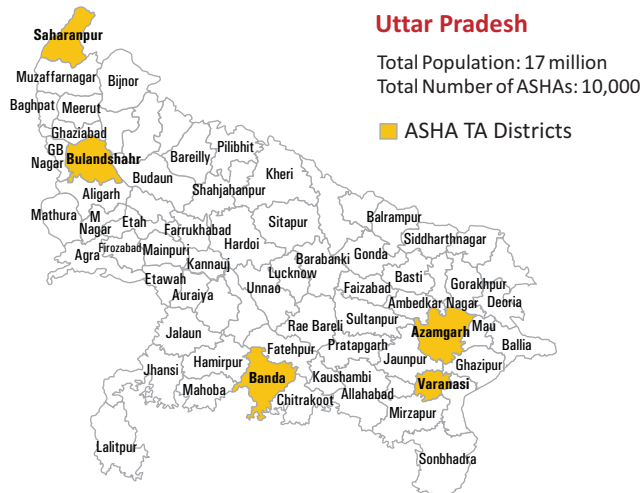
- Only two percent of recently delivered women received a home visit from an ASHA after delivery.
- The frequency of ASHA home visits was low and ASHAs needed improved counselling skills to effectively negotiate behaviour change at the household level.
- A strong system was not in place to provide ongoing capacity-building or support to the ASHAs.
- There was considerable scope to improve the usefulness of the monthly ASHA meetings, especially for capacity-building, problem-solving and progress reviews. The meetings were too large and lacked structure.
- There was no mechanism in place to support ASHAs at district level for continuing education and the ASHA mentoring group was not active.

DHFW and the Project agreed to work collaboratively to improve ASHA support mechanisms for ongoing capacity-building and mentoring to specifically improve newborn care.

## Scale of Technical Assistance

The Project supported DHFW in five districts of Uttar Pradesh (Azamgarh, Banda, Bulandshahr, Saharanpur and Varanasi), which have 63 blocks and a total population of 17 million and a rural population of 12.8 million (Figure 1). There are almost 10,000 ASHAs in these districts, and the Project and DHFW reached over 80 percent of them with capacity-building and support through regular monthly meetings. The Project team also built the supervision skills of almost 1,900 Auxilliary Nurse Midwives (ANMs) and Lady Health Visitors (LHVs), who provide support to the ASHAs. In addition, the Project supported the identification and capacity-building of 461 block facilitators and 25 district facilitators (who lead capacity-building sessions at the monthly meetings), which has ensured that the improvements are institutionalised in the government structure.

Figure 1: ASHA Technical Assistance Districts



## Key Technical Assistance Approaches

The Project, in partnership with state and district officials, identified specific TA approaches to strengthen ASHA support mechanisms. These approaches were:

- Building ASHA capacity in counselling and conducting home visits
- Strengthening monthly meetings for continuing education and performance improvement
- Strengthening supervisory skills of ANMs and LHVs to provide guidance and on-site support to ASHAs

- Forming and building capacity of Technical Resource Groups (TRGs)
- Integrating equity and gender focus in technical assistance approaches

Figure 2. Vistaar Technical Assistance Approaches



The Project contracted with non-governmental organisations, Catholic Relief Services (CRS) and MAMTA Institute for Mother and Child in UP to support these interventions, especially at the district and block levels.

### Building ASHA capacity in counselling and conducting home visits

**Enhancing interpersonal communication and counselling skills of ASHAs:** During home visits, ASHAs interact with currently pregnant women, recently delivered women and household decision-makers. Apart from building rapport with family members ASHAs communicate key health messages and offer support and guidance for adopting positive healthcare practices. Weak interpersonal communication and counselling skills in ASHAs undermine their self-confidence during home visits and render home visits less effective. The Project supported DHFW to introduce a continuing education programme for ASHAs that optimised use of the existing monthly meeting platform.

**Developing short modular capacity-building sessions:** For continued capacity-building at monthly meetings, the Project developed two-hour, highly participatory, interactive and skill-based sessions on topics functionally relevant to ASHAs such as interpersonal communication, steps and process of counselling,

critical maternal health and newborn care messages, use of job aids, planning home visits, and organising community meetings.

In alignment with the evidence reviews, the ongoing capacity-building of ASHAs and their supervisors focused repeatedly on home visits and counselling. Important elements of capacity-building included the relevance of home visits, the established schedule regarding home visits, skills needed to conduct home visits, cultural, equity and gender norms, and recordkeeping on home visits.

In all, the Project facilitated development of 28 sessions for learning reinforcement of ASHAs during the monthly meetings. New sessions were also developed on performance difficulties and challenging issues emerging from the field. As of September 2010, 8071 ASHAs had been trained in interpersonal communication and counselling, achieving over 80 percent coverage of ASHAs in the five districts. Data collected in the endline survey has shown that ASHAs have valued capacity-building sessions. Over half (57%) of the ASHAs interviewed listed improved communication and counselling skills as a benefit of capacity-building sessions along with improved knowledge (40%) and improved confidence (37%).

**Creating and building capacity of a pool of block and district facilitators:** In consultation with district and block officials, the Project supported the creation of a pool of six to eight block-level facilitators consisting of Health and Education Officers, ANMs, LHVs and male supervisory staff designated from within the department at each block in all five districts. A team of two block facilitators are responsible for leading one ASHA monthly meeting each month. Block facilitators delivered this service in addition to their regular responsibilities without any additional compensation. The CMOs identified four to five district facilitators in each district. District facilitators included deputy or additional CMOs, District Health Education & Information Officers and staff from the NRHM District Programme Management Unit. Engagement of district facilitators ensured commitment to the process and provided the required administrative support.

The Project supported DHFW to implement a cascade training model to scale-up ASHA capacity-building in all blocks of the five districts through the block-level facilitators. A pool of consultants served as state-level master trainers to roll out the session content for ASHA monthly meetings to the district and block-level facilitators, who then trained the ASHAs.

**Developing and promoting use of job aids:** To facilitate ASHAs in organising home visits systematically and to provide standard

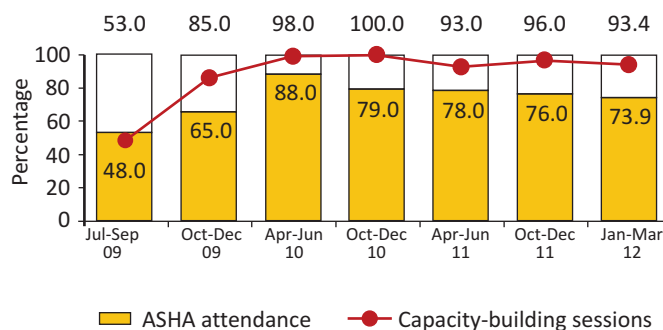
messages, the Project developed prototypes of six newborn care job aids consisting of frequently asked questions (FAQs), pictorial flipbooks and checklists for GOUP. Endline surveys indicate nearly 88 percent of ASHAs had received job aids, indicating that districts were successful in disseminating these resources. Access to job aids was generally similar across districts. The vast majority of ASHAs reported that they carry the job aids with them while making home visits (81%) and use them when needed (80%). ASHAs reported that job aids offer several benefits including ease of counselling (58%), complete messaging (46%) and assisting in communicating with illiterates (37%).

### Strengthening monthly meetings for continuing education and performance improvement

**Restructuring ASHA monthly meetings:** As a result of advocacy by the Project, CMOs in each district initiated directives to restructure ASHA monthly meetings to occur on multiple fixed days each month, in smaller groups of 40-50 ASHAs at a time (as compared to the initial group size of 100-150) and with ASHAs and ANMs assigned to a particular meeting. The small group size enabled skill-building, experience-sharing, problem-solving, facilitated stronger peer networks among ASHAs and better relationships with their supervisors. This restructuring led to greater utilisation and effectiveness of the ASHA monthly meeting as an 'operating platform' for capacity-building, programme review and problem-solving.

The State Programme Management Unit (SPMU) of NRHM, Uttar Pradesh, subsequently issued guidelines to all districts across the state to organise ASHA meetings along similar lines. Restructuring of ASHA monthly meetings led to an improvement in ASHA attendance and regularity of capacity-building sessions in the Project districts (Figure 3).

**Figure 3: ASHA attendance and frequency of capacity-building sessions at ASHA monthly meetings**



Source: The Vistaar Project MIS data collected from Azamgarh, Banda, Bulandshahr, Saharanpur and Varanasi

The endline evaluation corroborated these findings as nearly all 235 ASHAs surveyed reported that ASHA monthly meetings were happening routinely with a median of 32 ASHAs in attendance for the meeting which lasts about four hours including capacity-building. Three out of four ASHAs indicated that they had participated in a monthly meeting in the last month. Results were similar across all districts.



### **Strengthening supervisory skills of ANMs and LHVs to provide guidance and on-site support to ASHAs**

The Project supported capacity-building of ANMs/LHVs on supportive supervision to change the perception of supervision from a punitive approach to one of mentoring and providing support to improve ASHA performance. To make their conversations with ASHAs more respectful, systematic and in-depth, the Project introduced the use of a supervisory checklist. To the extent possible, ANMs were encouraged to make joint home visits along with ASHAs, in which ANMs provided the necessary support to ASHAs in difficult and resistant households and a home visit and counselling checklist was introduced. The ANM/LHV monthly meeting platform was also restructured to include progress reviews, problem-solving and ongoing capacity-building. Block facilitators also ensured continued learning of ANMs on supportive supervision at monthly meetings. Village Health and Nutrition Days (VHNDs) served as significant platforms where ANMs offered support to ASHAs. Block facilitators trained over 80 percent of ANMs and LHVs (1,890) in the five districts in supportive supervision.

In the endline survey, ASHAs reported that they regularly received supervisory support from ANMs, especially during VHNDs where ANMs address issues related to home visits, counselling on newborn care, timely referrals and maintaining records. Additionally, 78 percent of ANMs mentioned that the monthly meetings have contributed to developing a better understanding of supporting ASHAs and 77 percent said that the meetings helped enhance their knowledge.

*“Previously, we gave messages during our routine training but I don’t think it was effective. With so many people, it was difficult to deliver them effectively. With smaller groups I can see who understands the messages and who doesn’t.”*

Health Education Officer/Block Facilitator

Key Informant Interview

Qualitative Study

### **Forming and Building Capacity of Technical Resource Groups**

**Capacity-building of Technical Resource Groups:** The Project facilitated formation of TRGs in all five districts with the aim of sustaining capacity-building and supportive supervision efforts to support ASHAs. These TRGs are intended to function as a subgroup of the ASHA Mentoring Group (AMG) mandated under NRHM guidelines. The need for TRGs was felt due to infrequency of AMG meetings at the district level and the AMG being too diverse and big a group to focus on the technical aspects related to ASHA mentoring. The Project team identified government health officials to provide leadership to the Project’s efforts to build local capacity to guide, implement and monitor ASHA support mechanisms in the district. The TRG, chaired by the Chief Medical Officer, is responsible for overall planning, implementation and monitoring of ongoing capacity-building of ASHAs and ANMs at monthly meetings. The Project team organised training for TRG members to build their skills to design and develop capacity-building sessions and facilitate monthly meetings. The Project trained 20 TRG members in the design and development of capacity-building sessions and 18 TRG members on facilitation skills.

**Use of data to identify performance gaps:** The Project collated data on ASHA and ANM/LHV capacity-building and ASHA home visits and developed a one-page reporting format to promote data use. This form is submitted to the District Community Mobiliser each month and the TRG review summary data every month to track progress on key indicators. They discuss gaps observed and prepare follow-up action points as required for programme improvement.

### **Integrating equity and gender focus in technical assistance approaches**

The Project and DHFW brought a focus on social and gender equity based on equity and gender needs assessment conducted with stakeholders in 2008. Capacity-building sessions, programme materials and data collection formats for ASHAs and ANMs included equity and gender components. Block facilitators sensitised ASHAs and ANMs/LHVs on equity and gender related issues relevant for their day to day

functioning through the monthly meeting platform. Results presented later in this brief demonstrate that ASHAs were effective in reaching out to disadvantaged groups.

*“There are changes in their (ASHA) home visits in the way they talk, how they include the entire family, prepare topics beforehand, make a priority list, etc. Now they even go to hard-to-reach areas.”*

Block Facilitator, Key Informant Interview  
Qualitative Study

## Monitoring and Evaluation

The Project established a Management Information System (MIS) to capture process-level data during July 2009-March 2012 in all Project-supported districts. The Project also contracted an external research agency supported by an independent expert to conduct a qualitative study to validate successful trends indicated from Project MIS data and to better understand the factors underlying its successes. These studies were conducted in October 2011 in two Project-supported districts: Banda and Saharanpur.

For the purpose of evaluation, the Project contracted external agencies to conduct a baseline survey in December 2008-February 2009 and an endline survey in January-March 2012. These surveys were conducted in all eight Project districts in Uttar Pradesh with pregnant and recently delivered women, household decision-makers, district officials, and frontline health workers.

## Key Findings

The findings from quantitative and qualitative data collected from the five ASHA TA Districts demonstrate that efforts to strengthen systems to support ASHA performance have contributed to an increase in the number and quality of home visits and newborn care knowledge and practices. Asterisks (\*) in the table and graphs highlight when there is a statistically significant difference at 5 percent level of significance, between baseline and endline data.

### Increased newborn care visits

Eighty-eight percent of newborns had at least one check-up/visit compared to 78 percent at baseline either at home or while still in a health facility. Further, 64 percent received a second visit compared to just 23 percent at baseline. The incidence of third visits also improved highlighting that frontline workers, including ASHAs, are paying increasing attention to

supporting the health of newborns. ASHAs are reaching recently delivered women multiple times during the newborn period and there is an improvement in newborn care visits conducted by ASHAs over the baseline (Table 1). However, ASHAs have yet to reach all women in their communities.

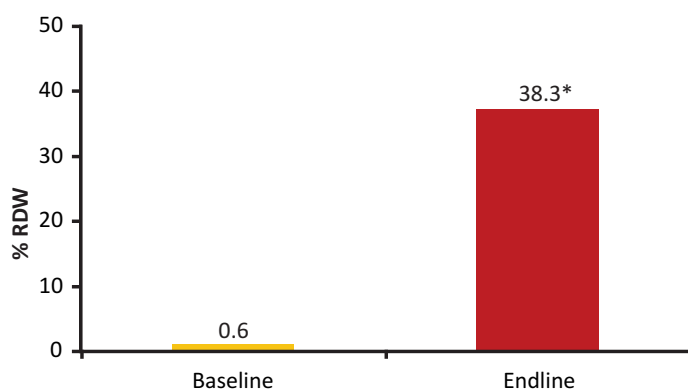
**Table 1: Newborn care visits reported by recently delivered women by health worker**

Newborn visits/check-ups	% RDW			
	Received ASHA visit		Received visit from any health personnel <sup>#</sup> (including ASHA)	
	Baseline	Endline	Baseline	Endline
First	0.9	14.0*	77.8	88.0*
Second	1.1	35.3*	22.6	64.4*
Third	0.2	24.9*	8.3	43.8*
Number of recently delivered women with infants aged 0-11 months	4,213	3,850	4,213	3,850

<sup>#</sup> Includes MOs, LHVs, ANMs, private providers, ASHA or other health personnel

As per Table 1, ASHAs conducted many of these newborn care visits and these visits were happening soon after birth. Thirty-eight percent of recently delivered women with newborns aged 0 to 11 months in rural areas received a home visit from an ASHA within seven days of birth compared to less than one percent at baseline (Figure 4). Within one month of delivery, 54 percent of women had been visited by an ASHA. The relative likelihood of receiving newborn care visits following birth was the same regardless of standard of living, caste/tribe, or education. However, ASHA home visits for newborn care were significantly higher to women who delivered at government health facilities (66%) as compared to those who delivered at home (45%) or at a private health facility (37%).

**Figure 4: Newborn care home visits by ASHAs (within seven days)**



According to CCSP guidelines ASHAs are to make newborn care home visits on the first, third and seventh day after delivery. The first ASHA home visit is not required if the woman stays in the health facility for the first day. Endline data indicated that 15 percent of recently delivered women received two newborn care visits by ASHAs at home within the first seven days.

### Improved quality of newborn care counselling

The quality of ASHA counselling to recently delivered women on newborn care improved as evidenced by women’s recall of newborn care messages they received from ASHAs during home visits in the antenatal period (Table 2).

**Table 2: Recall of newborn care messages received from ASHAs during antenatal period by recently delivered women**

Newborn care messages	% RDW	
	Baseline	Endline
Getting the newborn immunised (OPV-0 dose and BCG)	14.9	36.7*
Initiation of breastfeeding within an hour of birth	10.3	35.2*
Exclusive breastfeeding up to six months	12.9	33.0*
Benefits of colostrum feeding	NA <sup>2</sup>	29.9*
Getting the newborn weighed	3.8	22.1*
Keeping the newborn warm	5.3	21.8*
Drying and wrapping of newborn immediately after birth	6.6	19.9*
Delaying bathing the newborn for seven days	NA <sup>2</sup>	16.5*
Taking care of the cord (home births only)	4.7	11.3*
Number of recently delivered women with infants aged 0-11 months	4,213	3,850

Ten percent of women visited during pregnancy by an ASHA reported that she used a job aid during counselling. ASHAs reinforce messages that women were also receiving from other providers. Recently delivered women’s recall of newborn care messages received within one month of delivery has also increased significantly.

**“Earlier we just spoke to the mother-in-law and expected her to pass on the message to her daughter-in-law...now we say: no, I want to talk to your daughter-in-law...we are not scared to do that.”**

ASHA, Focus Group Discussion  
Qualitative Study

ASHA counselling to pregnant and recently delivered women covered many important newborn care topics. Women were more likely to recall messages if they received more ASHA visits during pregnancy (Table 3). Recall rates were over 50 percent for many messages among those women who had five or more visits. Women who received no visits from ASHA reported much lower awareness of key newborn care messages.

**Table 3: Recall of newborn care messages among recently delivered women by number of ASHA home visits received at endline**

Newborn care messages received during the antenatal period <sup>*</sup>	% RDW			
	Received no ASHA Visits	Up to 2 ASHA Visits	3-4 ASHA Visits	5+ ASHA Visits
Exclusive breastfeeding for six months	4.9	30.9	42.3	59.1
Initiation of breastfeeding within an hour of birth	6.4	34.6	44.8	58.3
Getting child immunised (OPV-0 dose and BCG)	7.4	37.7	45.1	58.1
Keeping the newborn warm	3.0	18.9	28.2	42.9
Getting the child weighed	4.9	18.9	28.6	40.9
Taking care of the cord	1.5	7.8	15.6	25.1
Number of recently delivered women with infants aged 0-11 months	686	1,434	1,101	629

<sup>\*</sup>The recall of newborn care messages was statistically significant for almost all messages between women who received no ASHA visits and those who received up to two ASHA visits; between those who received up to two ASHA visits and those who received three to four visits; and between those who received three to four ASHA visits and those who received five or more visits.

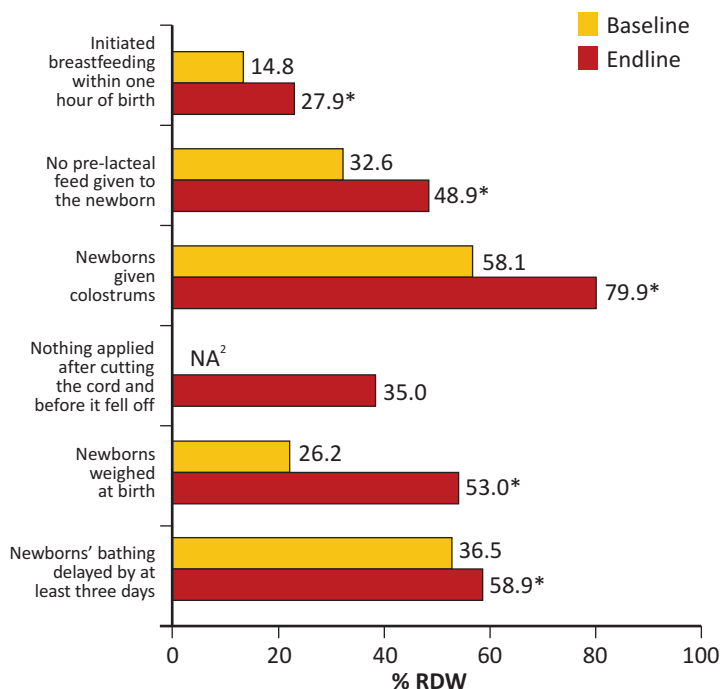
### Improved newborn care practices

Increased frequency and quality of ASHA home visits and increased institutional deliveries that ASHAs encourage through promotion of the *Janani Suraksha Yojana* (JSY) programme has likely contributed to improvements in several newborn care practices (Figure 5).

- The proportion of newborns who were not bathed until at least three days increased from 37 percent to 59 percent.
- Weighing of newborns at birth increased from 26 percent to 53 percent.
- Colostrum feeding increased from 58 percent to 80 percent, consistent with data that women were more likely to recall receiving messages about the importance of colostrum feeding at endline.

- Similarly, the incidence of not giving pre-lacteal feeds has improved from 33 percent to 49 percent. This is higher for women who delivered in a government health facility.
- Women overall were more likely to initiate breastfeeding within one hour of birth which showed a gain from 15 percent to 28 percent. Breastfeeding initiation rates were highest (39%) among women who delivered in a government health facility.

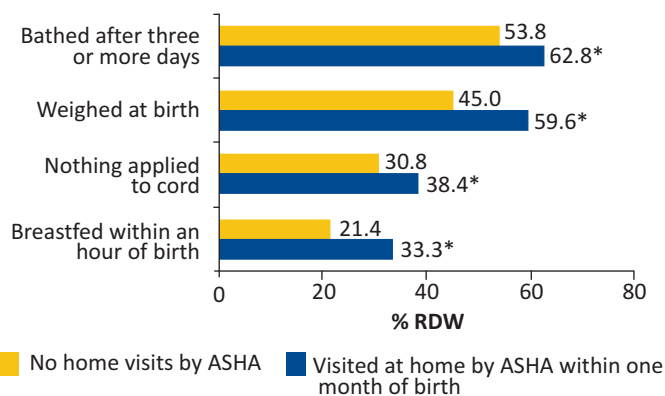
**Figure 5: Improvement in newborn care practices**



Care-seeking behaviour for newborns experiencing health problems has also improved. Recently delivered women at endline (26%) were somewhat more likely to recognise if newborns had a health problem within the first month compared to women surveyed during baseline (19%). Newborn referrals were higher at endline (89%) compared to baseline (84%), which is an indicator that women are increasingly seeking care for newborn problems.

Endline data indicates that women who received a visit from an ASHA either during pregnancy and/or in the newborn period were significantly more likely to follow recommended practices than women who had no contact with ASHAs. These women were more likely to delay bathing, not apply anything to the cord and initiate breastfeeding within one hour of birth compared to mothers who did not receive an ASHA home visit. This finding corroborates evidence that home-based counselling can improve health practices and ultimately health outcomes for women and children (Figure 6).

**Figure 6: Newborn care practices disaggregated by ASHA home visits at endline**



## Costing

A cost analysis of strengthening ASHA support mechanisms in UP was carried out for one district, Varanasi, to identify the cost of all the approaches used to strengthen ASHA performance. The annual cost of the ASHA support activities was estimated at Rs. 3,603,989 for this district with eight blocks. There will be a variation in cost depending on the number of blocks within each district. Nearly all of these costs are for the time of government staff to carry out these ASHA strengthening activities by using their time more effectively and do not represent additional costs for government. For example, block facilitator participation in these ASHA support activities represents roughly 38 days effort per year or about 15 percent of their time.

## Lessons Learned and Recommendations

As a result of these collaborative interventions, government systems to support ASHAs are stronger, more home visits to mothers with newborns are taking place, and most importantly more women are adopting essential newborn care practices. The major lessons and recommendations from the collaborative efforts of the Project and GOUP to strengthen ASHA support mechanisms are summarised below:

- Increased contacts, improved counselling and message delivery by ASHAs have likely contributed to changes in newborn care practices, demonstrating that ASHAs can be effective change agents to promote healthy behaviours at the household level. Efforts to improve the counselling skills of ASHAs should be scaled up across the state.
- Improvements in newborn care practices have been reported across rural areas in all five Project districts, indicating that support to strengthening government programmes which are intended to operate at scale can be achieved with focused technical assistance at district and block levels.

## Vision

IntraHealth International believes in a world where all people have the best possible opportunity for health and well-being. We aspire to achieve this vision by being a global champion for health workers.

## Mission

IntraHealth empowers health workers to better serve communities in need around the world. We foster local solutions to health care challenges by improving health worker performance, strengthening health systems, harnessing technology, and leveraging partnerships.

For more information, visit [www.intrahealth.org](http://www.intrahealth.org)

## The Purpose of the Vistaar Project

To assist the Government of India and the State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn, and child health and nutritional status

- The extent and reach of ASHAs offers a significant opportunity to bring about improved health care behaviours at the community-level at scale. To realise this potential, ASHA support mechanisms need to be established and scaled up in all districts.
- Ongoing capacity-building is critical to build and retain knowledge, skills and confidence in ASHAs to carry out their responsibilities. On-the-job capacity-building of ASHAs can be strengthened through effective utilisation of ASHA monthly meetings. Restructuring existing monthly meetings for ongoing learning and supportive supervision reduces the need for standalone training events.
- Providing supervisory skills and tools to ANMs (as supervisors of ASHA) can help them address essential support needs of ASHAs. ANMs can provide effective supervision for ASHAs through routine field visits. For example, VHNDs are potential opportunities for ANMs to provide on-site support to ASHAs, as are monthly meetings. Effectively utilising these opportunities is essential as ANMs are very busy with many job responsibilities.
- While ASHAs appreciate the value of job aids and indicate that they use them, data from beneficiaries about whether

frontline workers use flipbooks during home visits indicates that usage levels are low.

- Improvements in frequency and quality of newborn home visits occurred even in the absence of performance payments for carrying out these visits. If ASHAs were to receive compensation for making such visits, they may reach even more women.
- A key insight from the cost analysis is that the government, by utilising its existing resources in an efficient manner, can replicate and sustain these support mechanisms to help ASHAs to provide more and higher quality home visits. The costs involved are minimal and mostly require leadership and time of government staff.

## Conclusions

The Project and district teams have demonstrated simple, cost effective ways to support ASHAs so that they can improve essential newborn practices. Effective support mechanisms include high quality and participatory capacity-building (especially in key areas like counselling), improving supportive supervision, strengthening monthly meetings and building the capacity of TRGs that provide ongoing ASHA support.

IntraHealth International, Inc. is the lead agency for the Vistaar Project. For more information on the Vistaar Project, see: [www.intrahealth.org/vistaar](http://www.intrahealth.org/vistaar)

### Technical assistance partners:



<sup>1</sup>International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS

<sup>2</sup>This data was not collected during baseline.