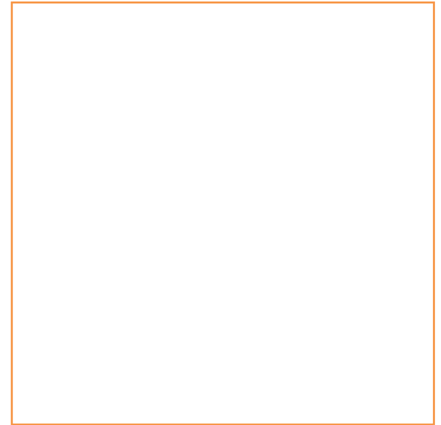

Implementation pathway report: Community Resource Person

An intervention by the Technical Support Unit Uttar Pradesh, India

February 2015

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Acronyms

Acronym	Definition
AAA	ASHA, ANM and AWW
ANC	Antenatal care
ANM	Auxiliary Nurse and Midwife
APHC	Additional Primary Health Centre
ARO	Assistant Research Officer
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi worker
BCPM	Block Community Process Manager
BCS	Block Community Supervisor
BMV	Block Monitoring Visit
BPHC	Block Primary Health Centre
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
BSPM	Bal Swasthya Poshan Maah
CBTS	Community Behaviour Tracking Survey
CGA	Community gap assessment
CHC	Community Health Centre
CMO	Chief Medical Officer
CRM	Community resource mapping
CRP	Community Resource Person
DCPM	District Community Process Manager
DCS	District Community Specialist
DPM	District Programme Manager
DPMU	District Programme Management Unit
ETT	Enumeration Tracking Tool
FLW	Frontline worker
FRU	First referral unit
HBMNC	Home-based maternal and newborn care
HMIS	Health management information system
ICDS	Integrated Child Development Services
IEC	Information, education and communication
M&E	Monitoring and evaluation
MCTS	Mother and child tracking system
MOIC	Medical Officer In-Charge
NHM	National Health Mission
NM	Nurse Mentor
NRC	Nutrition Rehabilitation Centre
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PNC	Postnatal care
PRI	Panchayati Raj institution
RBSK	Rashtriy Bal Swasthya Karyakram
RMNCH+A	Reproductive, maternal, neonatal, child and adolescent health
SC	Sub-Centre
TSU	Technical Support Unit
UP	Uttar Pradesh
UP-TSU	Uttar Pradesh Technical Support Unit
VHIR	Village Health Information Register
VHND	Village Health Nutrition Day
VHSND	Village Health Sanitation and Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committee
ZCS	Zonal Community Specialist

Executive Summary

Who is a Community Resource Person?

Community Resource Persons (CRPs) are cluster-level workers implementing the community intervention of the Uttar Pradesh Technical Support Unit, a technical support grant on reproductive, maternal, neonatal, child and adolescent health (RMNCH+A) interventions in Uttar Pradesh. It works in 100 blocks across 25 high priority districts in the state. Each project block has three clusters (of villages, facilities and frontline health workers), covered by one CRP per cluster. CRPs have been recruited from local graduate women to support Accredited Social Health Activists (ASHAs) in their area in record keeping, conducting home visits and other support that they may require. CRPs work on coordination between the frontline workers - ASHAs, Auxiliary Nurse Midwives (ANMs) and Anganwadi Workers (AWWs), and strengthening Village Health, Sanitation and Nutrition Committees (VHSNCs) for improved community monitoring of health services and schemes.

The need for Community Resource Persons: the context

The CRP emerged from the Government's need to improve community level coordination between ANMs and ASHAs, who are employed by the health sector, and AWWs, employed by the Department of Women and Child Development (WCD), to improve the performance of community health and nutrition indicators. The three cadres of health workers are not adequately trained on RMNCH+A interventions. ASHAs also require stronger technical skills, to improve record keeping and coverage of mothers and newborns under the RMNCH+A care continuum, and to coordinate with other village level forums to improve public health services. Moreover, community-based monitoring mechanisms like the VHSNCs are not functioning effectively and need to be strengthened. The CRP is working to bridge the gap between these three groups of frontline health workers (collectively called AAA) and also to improve their overall working.

Working together: collaborative implementation process

The project was implemented in collaboration with the state and district health system. The technical content of the CRP training is based totally on government guidelines. Senior government officials were involved in finalising the module content. Six days of field visits to the blocks, to see the health system and interact with functionaries were arranged during the training period. The Village Health Information Register (VHIR), a tool for CRP's, has been designed with state National Health Mission officials and is meant to strengthen the ASHA's work in reaching pregnant women, performing home visits and recording programme data, the coordination of AAAs, and strengthening the VHSNCs through close interaction with block and district health officials.

The Uttar Pradesh Technical Support Unit provides all-round oversight, guidance and technical support to CRPs through its dedicated block, district, zonal and state level staff supporting this intervention. Block Community Supervisors are the first point persons for support and guidance, while District and Zonal Community Specialists also provide supportive supervision and monitoring at their respective levels.

1. Description of the innovation

The Uttar Pradesh Technical Support Unit (UP-TSU) has developed an innovation called Community Resource Person (CRP) to improve the quality and quantity of frontline worker interaction at community level and within households, to drive priority reproductive, maternal, new-born, child and adolescent health (RMNCH+A) services and behaviours. The CRPs are cluster-level workers who have been recruited from among local community women, preferably graduates, after a rigorous process of interview, written test and group discussion to identify socially committed women with good communication skills. CRPs implement the community intervention of the UP-TSU, which is a project for providing technical assistance to the Government of Uttar Pradesh on RMNCH+A under the National Health Mission (NHM) to reduce maternal and neonatal mortality.

The programme is being implemented in 100 blocks across 25 high priority districts, in close collaboration with the state Health Department and the NHM at state, district and sub-district levels. It aims to provide field-based mentoring and support to the frontline workers (FLWs) – Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs) and Anganwadi Workers (AWWs) (known collectively as AAA) - in a block, through a dedicated cadre of CRPs and Block Community Supervisors (BCSs). Another objective is to support the block-level Medical Officer In-Charge (MOIC) in integrating the community processes with facility-based services and care.

Each project block is divided into three clusters (of villages, facilities and FLWs), with one CRP posted per cluster. The three CRPs in each block are supported and supervised in their daily tasks by the BCS, who are in turn supported by the District Community Specialist (DCS) at the district level. CRPs and BCSs are given a 16-day training comprising technical knowledge on RMNCH+A services, use of tools and job-aids, as well as field work. CRP's duties are to:

1. Improve the coverage and frequency of outreach/home visits by ASHAs in the assigned cluster
    a. By supporting them with the Enumeration and Tracking Tool (ETT) or the Village Health Information Register (VHIR)
2. Improve the quality of interactions between ASHAs and households in the assigned cluster
    a. By supporting them with the home visit checklists and family-focused communication materials/tools
    b. By supporting the running of Village Health and Nutrition Days (VHNDs)
    c. By strengthening the Village Health, Sanitation and Nutrition Committees (VHSNCs)
3. Improve coordination and problem solving among the FLWs in the assigned cluster
    a. By supporting the conduct of AAA forum meetings
4. Improve community processes and review them through real-time data in the assigned cluster, through:
    a. A gap analysis and updates
    b. A VHIR/ETT summary

The CRP ensures that all pregnant and postpartum women, newborns, infants and adolescents are included and continue in RMNCH+A care continuum. She enhances participation of community-level structures in supporting and monitoring, utilisation and coverage of RMNCH+A services.

2. Context

2.1 Geographic area

Situated in northern India, Uttar Pradesh (UP) is the most populous state in the country. Yet it is also one of the most underprivileged states. Agriculture is the predominant economic activity in the region, dominated by fertile Indo-Gangetic plain. However, malnutrition levels are quite high with 51 percent women aged 15-49 years reported to be anaemic.[1] On an average three-quarters of the state's villages have a health Sub-Centre (SC) located within a 3km radius.[2]

2.2 The health system: frontline health workers

UP has a pluralistic health system with diverse providers including public, private for-profit and non-profit; traditional complementary and alternative medicine; and informal and faith healers. The NHM is a significant public health programme implementing maternal and neonatal health services at village level. Under the NHM ASHAs have been recruited as an incentive-based cadre of frontline, village-level health volunteers, linked to an ANM, who is in-charge at the SC or lowest level health centre serving a population of approximately 5,000 people. Each ASHA covers a population of around 1,000-1,500 people. She maintains a complete demographic record of her area and enrols pregnant women to receive antenatal care (ANC). She also conducts home visits for basic antenatal and postnatal checks and counselling. ASHAs and ANMs together ensure complete coverage of community maternal and newborn care. Besides the Health Department, the Women and Child Development Department also provides supplementary nutrition to women and young children through the Integrated Child Development Services (ICDS) scheme.

2.3 The population and behavioural context

UP is among India's least developed regions with low urbanisation and significantly higher maternal, neonatal and child mortality rates than the national average. Studies indicate that poor maternal and neonatal outcomes in UP are due to a complex interplay between low socioeconomic development, entrenched cultural practices and poor service delivery.[3] Various demographic and health surveys have shown sharp divisions of caste and class in coverage rates of basic healthcare. Recent data show that just over half of mothers (52%) gave birth in health facilities.** Almost a quarter (23%) did not receive any postnatal care (PNC). Less than half (48%) of children aged 12-23 months were fully immunised.[4]

The two districts selected for the IDEAS implementation pathway – Hardoi and Barabanki, also exhibited poor RMNCH+A indicators.

Community practices around maternal and newborn care and immunisation

The following practices are observed around maternal and newborn care in the community:

- Women often register late for pregnancy and do not complete the recommended four ANC checkups. Birth preparedness, including planning for emergencies is also low.
- Though in recent years institutional delivery has increased, home deliveries without skilled birth attendance remain persistently high.
- Community practices around newborn care include pre-lacteal or supplementary feeding with water, honey or tonic (ghutti); use of kohl (kaajal) to line the infant's eyes soon after birth and use of a red cloth to wipe the baby's lips (as it is believed that this will make the baby's lips red).
- Community members do not realise the necessity of child immunisation and often a lot of follow-up is required to ensure complete coverage. Some groups are resistant to immunisation.

Issues related to the functioning of frontline health workers

Some common issues related to the functioning of FLWs is as follows:

- Listing and tracking of pregnant women and children by FLWs is often incomplete.
- There are gaps in the follow up of pregnant women for ANC and children for immunisation.
- Home-based postnatal care coverage is not complete as ASHAs often do not follow the complete schedule of postnatal home visits.
- ASHAs are often not able to maintain records efficiently.
- A lack of technical knowledge and communication skills affects the coverage and quality of counselling by ASHAs for antenatal and postnatal women, on maternal and newborn care.
- There is a lack of coordination between ASHAs, ANMs and AWWs, which affects the efficiency and quality of community health work.
- ANMs often do not follow protocols while administering community based ANC and immunisation.
- ANMs often do not provide community health and nutrition education or counselling to women. The community on the other hand, takes an ANM's advice seriously and is more likely to follow it, owing to her reputation as a qualified health provider.

3. Description of implementation pathway

3.1 Planning the intervention

The CRP intervention was designed for strengthening community level services provided by ASHA, ANM and AWW through better coordination, planning and execution supported by CRPs. The intervention was designed for collaborative implementation with the state and district public health administration. The UP-TSU supported the Government of UP in designing their NHM Project Implementation Plan (PIP) and District Health Action Plans in 25 high priority districts. They conducted a community resource mapping (CRM) and situation analysis to assess community processes pertaining to RMNCH+A services. Gaps were identified concerning the availability of complete village level information including population, the number of households, ASHAs, ANMs and AWWs, the performance of VHSNCs and VHNDs, and detailed information on active SCs along with availability of health services, infrastructure, staffing, equipment, drugs and supplies.

This was followed by a review of current quality improvement strategies being implemented in India. The community intervention programme by the Sukshema Project in Karnataka was selected, but expanded to include the full RMNCH+A spectrum and both strengthening and activation of RMNCH+A services at the community level. [Figure 1]

The CRP intervention is designed to:

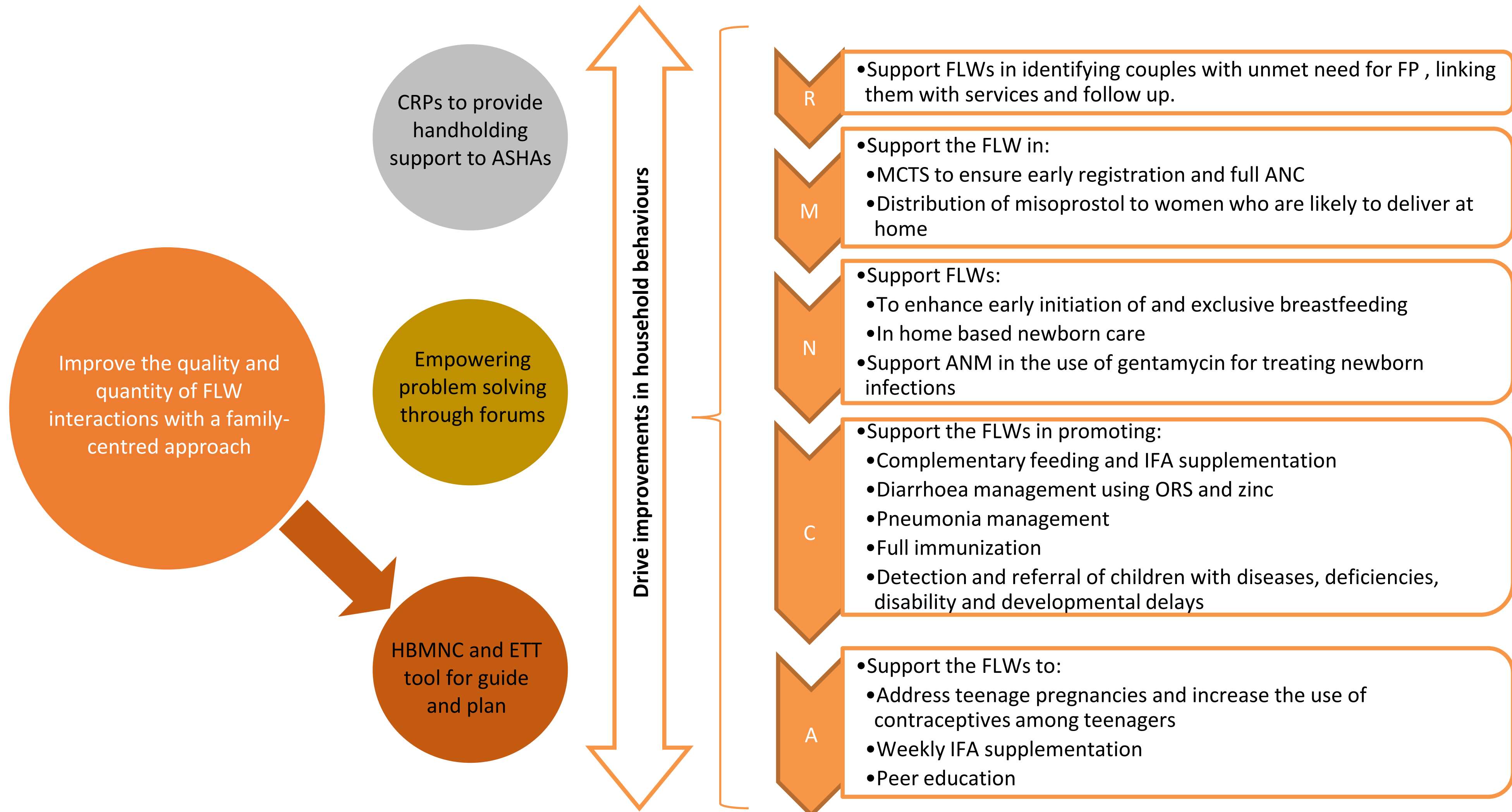
1. Strengthen FLWs' skills and capabilities through on-site mentoring and supportive supervision to improve the equity and quantity of interactions in households, at VHNDs and facilities; and to improve access to and the utilisation of maternal, neonatal and child health, nutrition, and family planning services.
2. Support ASHAs in record keeping, conducting home visits and any other support as required.
3. Coordination of ASHAs, ANMs and AWWs, and strengthening VHSNCs for improved community monitoring of health services and schemes.
4. Counselling to pregnant and lactating mothers on VHNDs, to showcase counselling techniques to ASHA, ANM and AWW.

In this intervention, CRPs will provide on-the-job hand-holding to FLWs to improve their skills and capabilities in the use of data, record keeping, communication methods, attendance, and quality and quantity of home visit contacts. CRPs will identify the gaps in community processes and suggest corrective measures at the SC forum for better coordination to identify and address opportunity gaps among them, for better performance.

Furthermore, to improve the community health processes at state and district levels, UP-TSU is supporting Government of Uttar Pradesh in the following tasks:

1. Design and implementation of a clear training plan at state, district and block levels to complete the training of FLWs.
2. Development and implementation of simple-to-use tools and job aids for FLWs to improve coverage and communication. These tools will be introduced in the UP-TSU blocks through the CRPs, for possible scale-up beyond the project districts.
3. Design and implementation of mentoring and supportive supervision systems, including tools and methods, for FLWs.
4. Design and implementation of appropriate communication and messaging to communities (mass and mid-media efforts).
5. Adapting successful innovations for scale-up in non-programme areas, and finance the implementation of these innovations through the PIP process within and beyond the project period.

Figure 1: CRP intervention on the RMNCH+A continuum of care



Source: UP-TSU Design document

3.2 Sequence of implementation of Community Resource Person intervention

The CRP intervention has followed the sequence of activities outlined below. CRPs were first selected through an elaborate process, then trained and placed in their respective clusters. Their range of functions are outlined, along with the support provided by the BCS. The intervention's supportive supervision and monitoring systems are also detailed.

3.2.1 Selection of CRPs

CRPs were selected through the following eight key steps -

3. **Defining the cluster of blocks:** Each project block has three clusters, each of which is managed by one CRP. They were demarcated on the basis of the number of SCs, ASHAs and gram panchayats in the block. The UP-TSU held meetings with block level health officials to define clusters. A prominent village in every cluster having an Additional Primary Health Centre (APHC) or SC with easy accessibility was referred as cluster headquarter.
4. **Development of job description:** The job description of CRPs included the support to ASHAs in tools, job aids and methods; promoting coordination among ASHAs, ANMs, AWWs and VHSNCs; capacity building of FLWs in effective functioning, particularly in reporting; and working with VHSNC & Panchayati Raj institutions (PRIs) or rural local bodies, especially on community-based monitoring of public health services.
5. **Eligibility:** A female from any village of that cluster, or village in the block, who was preferably a graduate or possessed an intermediate-level education with 1-3 years of work experience in the field of health, nutrition or community development programmes with a focus on community mobilisation, outreach and on-the-job support was eligible for the CRP's position. Her willingness to travel within the block was also considered.
6. **CRP shortlisting process:** An advertisement or call for application was published and applications were shortlisted by the district or zonal team on the above mentioned eligibility criteria. A second level of shortlisting was conducted by the team through telephone or in-person interviews. The final cluster-wise applications were sorted and approximately 670 candidates were invited to a selection workshop.
7. **CRP selection workshop:** A one-day non-residential workshop was arranged to test skills and aptitude of shortlisted candidates through a written test and group discussions, followed by a personal interview.
8. **CRPs' finalisation:** On the basis of their performance in the selection workshop, 306 candidates were finalised as CRPs.
9. **CRP's offer letter:** An offer letter, outlining their role and responsibilities was presented to selected candidates.
10. **Joining of CRPs:** The CRPs joined their positions after a 16-day training.

3.2.2 Placement of Community Resource Persons

Currently in each district under UP-TSU, 12 CRPs are working in four blocks. Altogether 300 CRPs are providing on-site mentoring support to FLWs, improving their coordination with each other and making their planning fool-proof and flawless. The primary target of CRPs are FLWs (ASHAs, ANMs and AWWs); ASHA Sangini (ASHA facilitator); VHSNCs and PRIs; and communities and households.

3.2.3 Functions performed by Community Resource Person

The CRPs perform the following functions in their clusters:

1. **Support ASHAs in tools, job aids and methods**
    a. Support in developing a block-level feedback mechanism to be taken forward through an ASHA mentoring group for policy decisions;
    b. Strengthening of the community-based monitoring system;
    c. Facilitate introduction of job-aids and tools for ASHAs, i.e. the ETT, the community's need list, family focused communication and home-based maternal and newborn care (HBMNC) for ASHAs and their effective use at household and community level
    d. Providing hand-holding support to ASHAs in regular updates of the VHIR and ASHA Diary
    e. Supporting ASHAs with analysis and use of data as a planning tool
    f. Conducting home visits with ASHAs and AWWs for on-the-job hand-holding and also to counsel pregnant and lactating women. ASHAs and AWWs will also learn CRP's counselling techniques through such home visits
2. **Promote coordination among ASHAs, ANMs, AWWs and VHSNCs**
    a. Facilitate and support SC forum strengthening
    b. Support ASHA Sanginis and ASHAs in garnering support from VHSNCs for village health planning, implementation, review and supportive supervision
3. **Support frontline workers in effective functioning, particularly in data use**
    a. Facilitate a gap analysis at ASHA level and support workplan development
    b. Support operationalisation of an ASHA grievance redress cell
    c. Support ASHA Sanginis in the ASHA monthly meetings
    d. Orient and support ASHA Sanginis in hand-holding and supportive supervision to ASHAs
    e. Support ASHA grading and provide hand-holding support to ASHAs on the basis of that grading
    f. Regular updates and reports on key deliverables to supervisors
    g. Identification and documentation of best practices, case studies etc.
    h. Any other task assigned by the supervisor

3.2.4 The role performed by Block Community Supervisor

The BCS performs the following functions at the facility:

1. Supportive supervision and hand-holding to ASHA Sanginis and CRPs to enhance the ASHA capacity.
2. Maintain database for ASHAs, ASHA Sanginis and CRPs on a regular basis.
3. Provide support for the review, implementation and monitoring of ASHA Sanginis, ASHAs, VHSNCs and other related community process activities.
4. Facilitate a gap analysis on social and behaviour change communication; orientation on job-aids and interpersonal communication tools; and an introduction to needs-based job-aids for enhancing the capacity and efficiency of FLWs.
5. Facilitate the monthly ASHA meetings.
6. Coordinate with other government departments such as Women and Child Development, Water and Sanitation, Education, PRIs and other development partners etc. at block level, for inter-sectoral coordination.
    a. Support and guide ASHA Sanginis and CRPs for strengthening the SC level forum for effective the coordination of ASHAs, ANMs and AWWs.
    b. Support the block MOIC in the effective implementation of ASHAs, the VHSNC and other related community processes activities in the block.
    c. Regular field visits to supervise field-level activities, documenting them and furnishing monthly reports.
    d. Support in any other task assigned by district/ zonal level supervisors.

3.2.5 Supportive supervision

The UP-TSU central team provides oversight and guidance to zonal and district teams, who are more actively involved with supportive supervision to the CRPs. CRPs receive overall managerial support and supervision from the DCS facilitated via the BCS who is the line manager of the CRPs. The DCS introduces the BCS and CRPs to district- and block-level government officials. The BCS is the first line of support for the CRPs, facilitates their work and supervises them on a daily basis. He helps them plan their monthly activities. He also assists them in their field visits, data collection for the CRM and on-site mentoring of FLWs. The BCS scrutinises the CRPs' daily diaries where they record their random visits. The district team provides further support wherever needed on mentoring FLWs. The DCS is supported at zonal level (each zone comprises four-five districts) by the Zonal Community Specialist (ZCS), who reports to the State Team Leader. A meeting between the Nurse Mentor (NM), CRP and BCS is held on a monthly basis to improve coordination. [Annex 1b, Figure 2] Apart from this, a weekly cluster-level meeting is organised at the block Primary Health Centre (PHC) where CRPs assigned to the cluster, ANMs and ASHAs gather under supervision of the MOIC to oversee the CRP's report of her activities, gaps identified and corrective measures undertaken.

3.2.6 Monitoring

Each CRP shares a monthly report on their activities with the BCS who forwards it to the district team. The report details the CRP's monthly activities, such as support provided to ASHAs in filling out the VHIR and preparing community need-list, the number of AAA meetings and VHNDs attended, and on-the-job hand-holding provided. Similarly, the BCS fills out his monthly progress report and submits to the district staff. A system of weekly and monthly meetings for the DCS, BCS and CRP has been put in place to give regular feedback to the programme.

The DCS conducts two block monitoring visits (BMVs) every month to assess progress and identify gaps, issues and challenges to block-level programme implementation. An activity plan and timeframe is prepared to address them, listing areas for improvement, the action required, the person(s) responsible and a timeline. The DCS briefs the Chief Medical Officer (CMO), Additional CMO and District Programme Manager (DPM) on the findings of the BMV. These visits are held in all four blocks of the 25 districts. The target is to cover all the blocks in the district at least twice a year.

3.3 Tools and job-aids

CRPs use a number of tools and job-aids to help them conduct and record their activities. These range from one-time activity based formats like 'Know your cluster' and CRM, to daily usage tools like the daily diary. One tool for ASHAs is provided under this intervention – the VHIR.

'Know your cluster'

This was the initial one-off task performed by each CRP to familiarise herself with her assigned cluster. She visited each and every village and met local village government officials. She also gained an idea of the population covered by health facilities, SCs and the ASHAs, ANMs and AWWs working in her cluster, with their respective population coverage. The CRPs attended and observed VHNDs, AAA meetings and accompanied ASHAs in their fieldwork to understand their work and build up a rapport with the FLWs. The CRPs recorded their observations and information in a format that they could refer to easily.

Daily diary

To keep track of their daily activities, CRPs note them in a daily diary. The components recorded include the day, date, time, place of working, details of activities performed in a day and the type of suggested corrective measures to FLWs. CRPs can use their daily diary notes to identify and present the areas of improvement to the MOIC in the weekly ASHA/ANM meetings at the Community Health Centre (CHC). The diary helps CRPs in preparing their monthly action plans.

Community resource mapping

Previously known as a community gap assessment (CGA), this is a tool to assess the health services at community level, particularly from revenue villages. It has seven components:

- **Tool 1: Village information-** Information on the village population; number of households with below the poverty line cards, number of ASHAs, AWWs and ANMs working in the village, number and types of healthcare service providers, basic health, nutrition, hygiene problems faced by villagers.
- **Tool 2: Information regarding VHSNC-** When and how the committee was formulated; records of meetings; the number of VHSNC meetings organised in last year; the variety of topics discussed, such as maternal and child health, hygiene, maternal and children's deaths etc.; the role and responsibilities of members of the VHSNC; financial accountability and the utilisation of funds; and registers maintained under VHSNC.
- **Tool 3: Information regarding VHNDs -** The venue for VHNDs; FLWs attending VHNDs; the regularity of VHNDs; due list preparation; information, education and communication (IEC) materials displayed; availability of vaccines, equipment and services; counselling on RMNCH+A; and information collected from beneficiaries about performance of VHNDs.
- **Tool 4: Detailed profile of the ASHA and her working area**
- **Tool 5: Detailed profile of the AWW and her working area**
- **Tool 6: Detailed profile of the ANM and her SC-** Services, drugs, medicines and consumables available at the SC; trainings undertaken by the ANM; visits by the MOIC; opening hours of the SC.
- **Tool 7: Profile of private health care service providers -** Information of all formal and informal private health care service providers in a village and the types of services they are providing.

Village Health Information Report

This forms the main component of the ASHA's diary. CRPs assist ASHAs in recording details of all beneficiaries in the RMNCH+A continuum of care and their utilisation of all services in the VHIR. CRPs use this tool to assist ASHAs with self-planning, self-review and self-reflection of their work. The VHIR comprises 24 components in one register including village related general information, ANC, PNC, vaccination, newborn and child care, family planning, adolescent health, VHNDs, VHSNC meetings, records of medicine distribution, due list and disease occurrence in the village.

Home-visit checklist and communication materials

Manuals have been provided to CRPs as a ready reference on recommended practices outlined in the national guidelines, to help in her mentor or instruct FLWs in home visits and family-focused or inter-personal behaviour change communication (Annex 1c: Table 3).

3.4 Trainings under the Community Resource Person intervention

Trainings conducted under the CRP intervention include the orientation of health officials on the programme and the training of functionaries. These are the CRPs and their supervisors at block and district levels. Refresher trainings are also discussed here.

Training of district level health officials

The district level NHM officials were given half day's orientation on the CRP intervention.

Training of CRPs

The 16-day CRP training included five days of introductory and technical training on the UP-TSU organisational structure, RMNCH+A, the health system at district- and block-level, and the roles and functions of FLWs. This was followed by six days of field visits to blocks to see the health system and interact with functionaries. The last five days were for feedback and further training on the role of the CRP, the use of job-aids and tools, data formats, and communication and leadership skills. A pre- and post-training assessment of CRPs was also carried out. (Table 1)

Technical training on RMNCH+A focused on ANC, birth preparedness, recognition of danger signs, safe delivery, management of emergencies, methods of family planning, PNC, including feeding and danger signs. The role of FLWs in maternal and newborn care was also explained. CRPs were also briefed on different health and nutrition programmes being implemented in the districts (Annex 1c: Table 4).

Table 1: CRP training schedule

Phase 1 (5 days):	Classroom training to introduce and give a technical knowledge of the UP-TSU, RMNCH+A, the health system at district level, the CRP's role and functions
Phase 2 (6 days):	Field visits to CHC or block PHC, SC and village to interact with health and ICDS officials and the community, including PRIs
Phase 3 (5 days):	Feedback, training on the roles of CRPs and FLWs, use of job-aids, tools, communication and leadership skills, HBMNC, VHIR, CRM

Supervisors

The BCSs and CRPs were trained together in the 16-day training programme. Thus, BCSs gained a better understanding of the CRPs' role and responsibilities. BCSs were also briefed on their role as moderator and facilitators between CRPs and Nurse Mentors (NMs). The UP-TSU district level staff were oriented on the CRP intervention by zonal- and state-level officials at the UP-TSU state office.

Refresher trainings

There is no specific plan for refresher trainings. They are needs-based – the training need is conveyed to the state team and they designate trainers accordingly. Weekly meetings with the BCS and monthly meetings with the DCS are held at block- and district-level for problem solving, as well as refresher training sessions.

4. Linkages with implementation pathway

This chapter describes the stakeholders in the implementation of the CRP intervention and their linkages in terms of the material and infrastructure supplied through the programme, supportive supervision, and implementation linkages with the government or public health system.

4.1 Description of key stakeholders

The two stakeholders in the CRP intervention are the government and the UP-TSU. There are also the beneficiaries of the intervention. Their structure and roles at different levels are described in this section.

Government

State: The state Department of Health and Family Welfare is responsible for all state-level planning and decision making for health. Besides the Directorate of Medical, Public Health and Family Welfare, UP also has the NHM state and district cadre of staff, headed by a Mission Director. The state-level government stakeholders provided the necessary permissions and intellectual inputs in conceptualising and finalising the CRP intervention details, including the CRP technical skills and the nature of the tools she can use to capture enhanced monitoring and reporting by the AAA and VHSNCs.

District: The CMO and CMO staff are briefed occasionally about the CRPs' activities. The DCS also liaises with the CMO office and District Programme Management Unit (DPMU) to help meet the supply gaps at the block level facilities.

Block: The BCSs usually interact frequently with the Block Programme Management Unit (BPMU) on the CRPs' activities. The MOIC holds weekly cluster meeting at the block PHC, to discuss the CRPs' activities and suggest feedback for ANMs and ASHAs.

Uttar Pradesh Technical Support Unit

District staff include coordinators at district- and block-level who organise trainings and meetings, provide technical support on the CRP intervention and any other activities for enabling its smooth implementation. The state-level UP-TSU community processes team consists of 10 members, including the Team Leader who reports to the UP-TSU Team Leader. The other members cover the areas of community outreach, communications, community mobilisation, training and advocacy. This team is responsible for designing and implementing interventions related largely to the FLWs and the community support structures. Additionally, the team provides leadership to the zonal, district and block level community processes teams.

Beneficiaries

The FLWs - ASHAs, ANMs and AWWs.

4.2 Materials and infrastructure

The physical material and other inputs from both stakeholders, that come together to enable programme implementation, are discussed in this section. They have been categorised as those by the government alone, those by the UP-TSU and those by both stakeholders together.

Government

Key government inputs included the technical content of the CRP training using government guidelines.

Uttar Pradesh Technical Support Unit

Key inputs from the UP-TSU were funds and administrative support towards the recruitment, training and posting of 100 CRPs; the development of tools and the programme monitoring mechanism. The UP-TSU also participated in finalising and printing the VHIR.

Technical Support Unit and Government

Worked with mutual consultation on designing the training and CRP tools. In addition, block and district health officials contributed to organising the six-day field orientation during the CRP training, such as arranging VHNDs, VHSNC and PRI meetings and exploring block functionaries. The UP-TSU contributed in developing the NHM PIP for its 25 programme districts.

4.3 Supportive supervision

Supportive supervision refers to the role of both stakeholders in supervising and guiding the CRP intervention implementers.

Government

Government is not directly involved in supportive supervision of CRPs, but the MOIC is involved consultatively. During weekly cluster meetings, CRPs share their activity report with the MOIC for discussion and feedback.

Uttar Pradesh Technical Support Unit

The UP-TSU's role includes- (i) support and supervision in CRPs' daily tasks by the BCS, who is in turn supported by district level staff; (ii) recording of implementation and outcomes through process documentation and pre-post evaluation.

4.4 Linkage with government, workforce and health personnel

State level

State-level government stakeholders provided the necessary permissions and intellectual inputs in conceptualising and finalising the CRP programme. The CRP tools and training plan were designed in consultation with the state and district health officials. Throughout the intervention state-level officials are briefed about the progress of the intervention and consulted on any facilitation that may be required for implementation, or strategic changes that may be required to improve the programme.

District level

The CMO is briefed occasionally about the CRPs' activities. The DCS also liaises with the CMO's office and the DPMU to help meet the community's need list.

Block level

The CRPs are posted at cluster-level in every block. All their activities are with the FLWs and in consultation with the BCS, the DCS and the MOIC. They share their weekly report, which they send to the BCS. CRPs share their activities with the MOIC during weekly cluster meetings, to address community-level gaps.

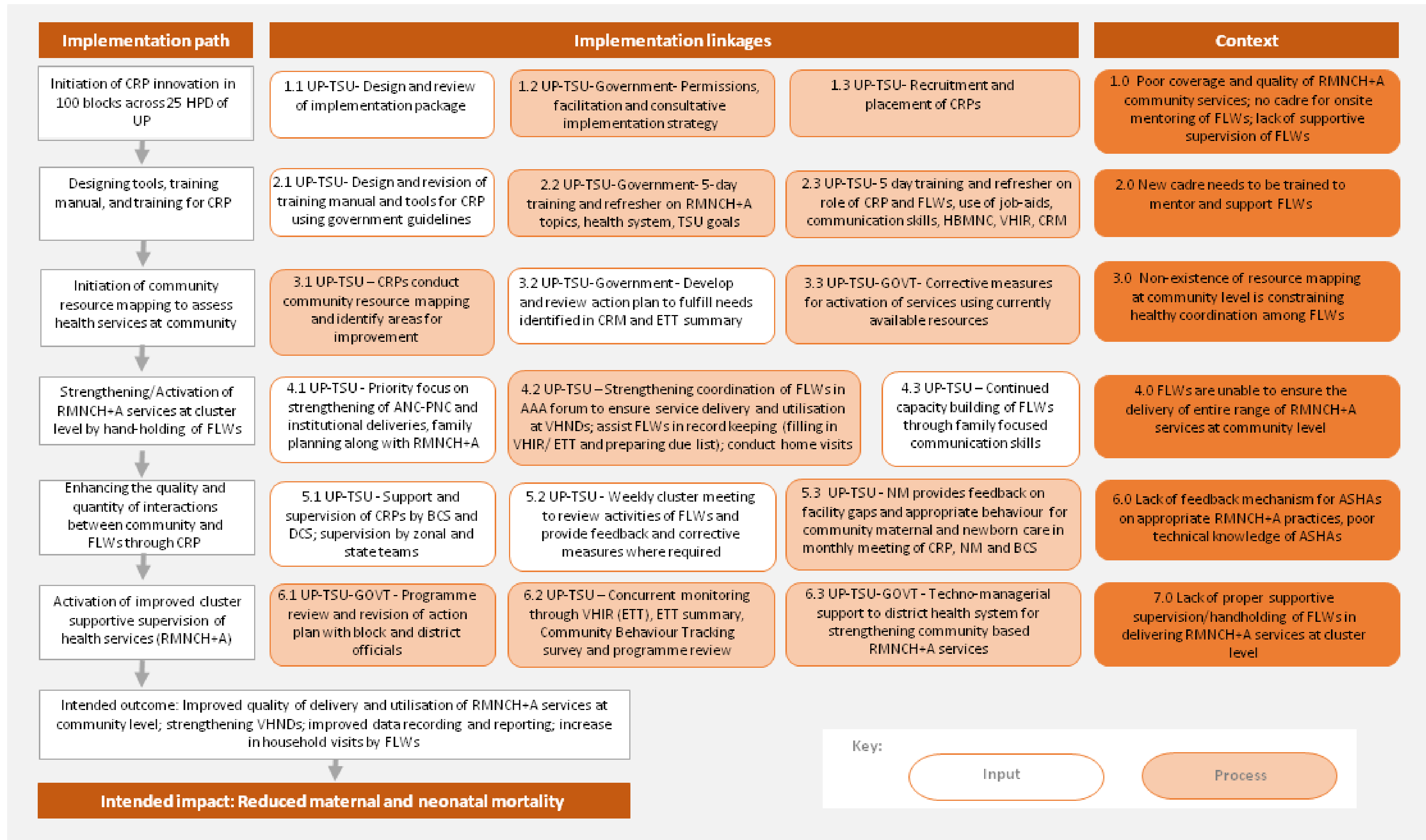
Facility level

A monthly meeting is conducted between the CRP, BCS and NM at facility level to share observations on inappropriate community RMNCH+A practices and obtain guidance and suggestions on improving the technical knowledge and skills of ASHAs.

Community level

At community level the CRP assists ASHAs, ANMs and AWWs in their day-to-day activities, record keeping, on-the-job mentoring. The BCS provides her with day-to-day implementation support.

Figure 2: Linkages in CRP implementation pathway



5. Description of databases

5.1 Nodal information sources which can capture the implementation effort of the innovation

Multiple data sources from the government and UP-TSU exist to understand the implementation of the CRP intervention. These include reports of trainings held, supervisory, monitoring and reporting formats, baseline data, meeting notes and financial records. [Annex 1c: Table 5] Some are listed below:

Details of trainings conducted

Training data included the number of participants, training sessions and hours of training given. The quality of training was assessed through pre- and post-training evaluation and also concurrent evaluation by the measurement, learning and evaluation partner.

Supervisory, monitoring and reporting formats

- The VHIR is meant to strengthen the ASHA's work under the NHM and has been designed by the UP-TSU in consultation with state NHM officials. Accurate and complete VHIRs reflect on the efficiency of the CRPs in supporting ASHAs, and is also being used as a monitoring indicator by the programme.
- The CRP's monthly activities are reported in a monthly progress report. The report is used to track all activities assigned to the CRP, including the number of ASHAs supported, home visits made with ASHAs, the number of AAA meetings supported, and the number of VHNDs and VHSNCs supported and reactivated. Formats for capturing CRPs' daily reports, other than the monthly progress report, are also occasionally piloted in the field.
- The ASHA coverage report records information on ASHA's completed tasks in terms of new and cumulative numbers, including ANC registrations, institutional deliveries, women receiving PNC, eligible couples for family planning and couples currently using any modern family planning method. The CRP gathers this information from ASHAs at cluster meetings.
- The CRPs in consultation with respective their BCS prepare field visit plans for the ongoing months and also maintain a daily diary to record all the accomplished activities against those planned.
- The CRM records information at village level on demographics, the health and nutrition status, performance of VHSNCs and VHNDs, a profile of FLWs and private health service providers.

Monitoring/baseline-end line evaluation

- The Community Behaviour Tracking Survey (CBTS) supports block, district and state level programme managers to monitor and periodically review programme activities based on real-time population-based data on coverage, utilisation and outcomes related to RMNCH+A, and also to validate block-level Health Management Information System (HMIS) and Mother and Child Tracking System (MCTS) data.
- Weekly cluster meetings at the Block Primary Health Centre (BPHC) under supervision of the MOIC provide a platform to review CRPs' activities and also to provide feedback to FLWs, wherever corrective measures are required. District review meetings are also held by DCSs and ZCSs with CRPs or BCSs for support or troubleshooting.

Financial data

All costs of the intervention can be obtained from two sources: the UP-TSU financial reporting and government spending on facility improvement in its PIPs.

Table 2 lists some critical indicators related to the community process that could be monitored to evaluate whether the CRP intervention is producing the desired improvements.

Table 2: Outputs and outcomes to be monitored under the CRP intervention

Outputs	Indicators to monitor CRP outcomes
• % of revenue villages visited in a month • % of ASHAs provided support on VHIR (ETT) • % of ASHAs provided support on updating due list • % of ASHAs with whom home visits were made • % of AAA meetings supported • % of VHNDs supported (including SC and outreach sessions) • % of VHSNC meetings reactivate • % of VHSNC meetings supported • % of cluster meetings attended in the reporting period	• % of frontline workers actively using updated enumeration, survey registers and home visit planners • % of Village Health, Sanitation and Nutrition Days (VHSNDs) and immunisation days observed, using a correctly made due list • % of FLWs attending monthly SC meetings • % of FLWs receiving at least one newly defined supervisory contact in the previous month • % of FLWs using communication methods and materials in their home visits • Number and quality of monthly contacts made by FLWs (against pre-determined project goals)

Note: Output indicators are taken from the monthly progress report and outcome indicators are sourced from the UP-TSU proposal document. Data for both output and outcome indicators are being captured in the monthly progress report.

6. Impact of Community Resource Persons on the health system, processes and maternal and newborn outcomes

6.1 Impact

We expect the CRP intervention to impact the routine service delivery of FLWs in the area, who are the beneficiaries of the programme. Ultimately there would be a positive impact on the maternal and newborn outcomes indicators in the region as well.

Impact on frontline and community level health workers (beneficiaries)

- Improved knowledge of ASHAs on maternal and newborn care, improved recording and submission of ASHA diaries
- Better tracking by ASHAs and AWWs, of home visits and overall coordination between ASHAs, AWWs and ANMs
- Increased accessibility, utilisation and coverage of RMNCH+A services at community level

Impact on the health system

- Improved coordination and supervision of ANMs, AWWs and ASHAs
- Improved quality of data capturing and transmission in the system, with greater potential for utilisation in decision making (e.g. identifying areas for improvement)

Impact on maternal and newborn outcomes

Positive impact on maternal and newborn outcomes in the implementation area

- % increase in the number of women receiving ANC checkups at the Anganwadi Centre (AWC)/SC/APHC/CHC/BPHC
- % increase in routine immunisation of women and children at the AWC/SC/APHC/CHC/BPHC
- % of still births, neonatal deaths and maternal deaths in the SC/APHC/CHC/BPHC

6.2 Challenges

We have identified some challenges in the implementation of the intervention through our field visits and observations. These are:

Problems in implementation

- Communication skills of CRPs need to be enhanced, for better coordination among AAA, which requires continuous technical support from the UP-TSU. This would also help them to improve liaising with PRIs and other community level functionaries.
- Refresher trainings and close monitoring of CRPs is essential for greater understanding and timely addressing of field-based hurdles in implementation.
- On average, one CRP is looking after approximately 60 ASHAs, which is a high workload. It is a challenge to reach all of them each month.

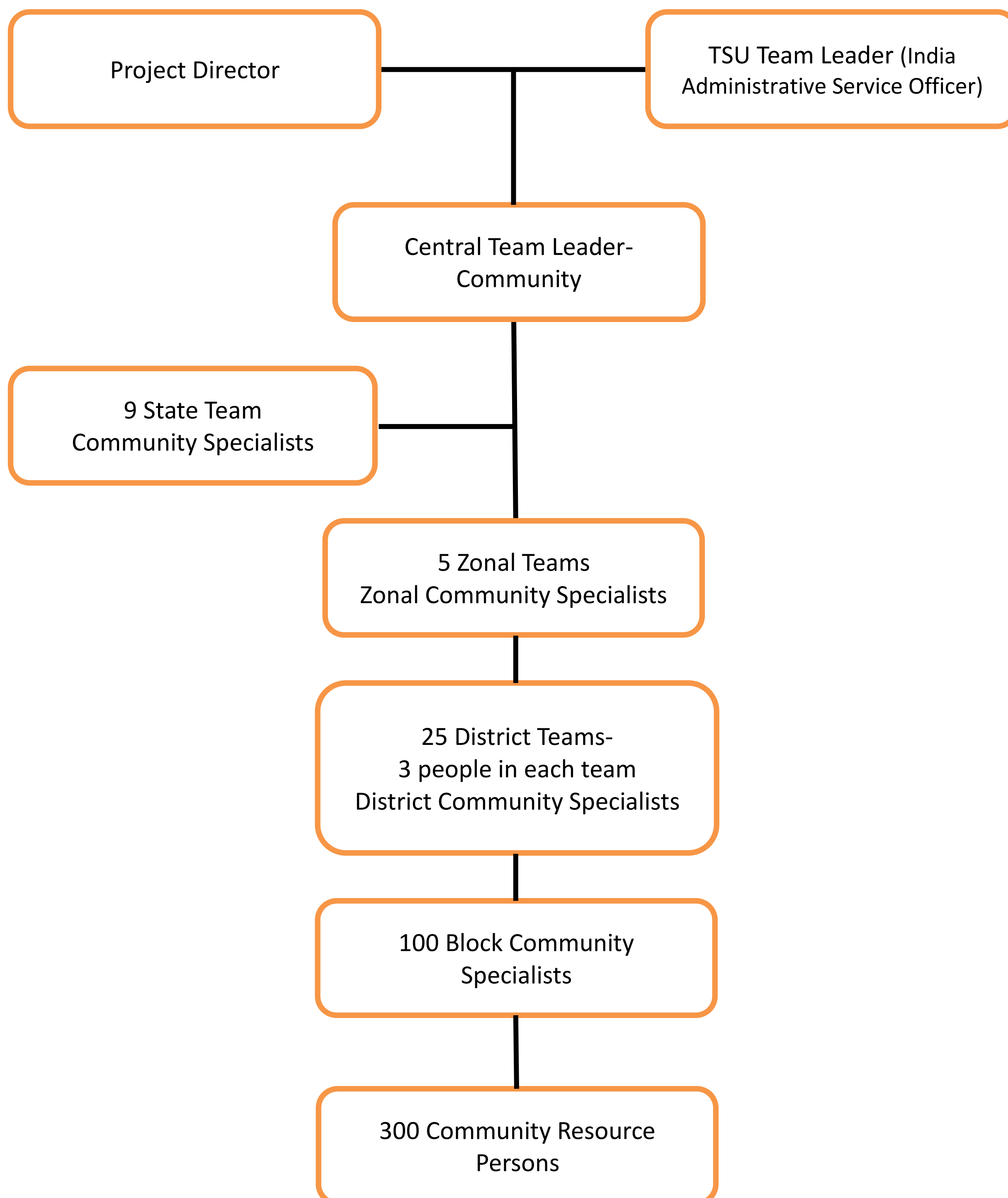
References

1. International Institute for Population Sciences. (2006). National Family Health Survey 2005-06; Fact Sheet Uttar Pradesh.
2. International Institute for Population Sciences. (2008). District Level Household and Facility Survey; Fact Sheet Uttar Pradesh.
3. IIPS and Population Council. (2009). Status of RMNCHN in Uttar Pradesh with Focus on Eight Target Behaviors: A Review of the Literature (draft report). New Delhi, India.
4. Programme Evaluation Organization, Planning Commission. (2011). Evaluation study of National Rural Health Mission (NRHM) in 7 states. New Delhi: Programme Evaluation Organization, Planning Commission.

** Based on births in the reference period: 1 Jan 2010 to 31 Dec 2010, to ever married women aged 15-49 years.

Annexes

Annex 1a: Organogram of Community Resource Person intervention



Source: Presentation on the CRP programme, UP-TSU.

Annex 1b: Job descriptions, supervisory and reporting structure, tools and job-aids

Table 1 (Annex 1b): Job description of UP-TSU staff responsible for CRP intervention

Operational levels	Position	Key responsibilities	Profile of the staff	Reporting structure	Interaction / linkage with health system representative
Central Team	Community Team Leader	• Lead the entire community process innovation • Provide leadership in developing strategic documents, guidelines, protocols and job-aids for the CRP intervention • Managerial and administrative support to the whole community process team, from state- to block-level • Liaise with government and NHM officials on developing strategies • Monitor and support TSU teams in RMNCH+A strategies	15-20 years of experience	Project Leader- TSU	Government of India, Government of UP, State Programme Management Unit and non-governmental organisation partners
State Team	Technical team	• Responsible for designing and implementing interventions largely for FLWs and community support structures • Complete generalised managerial support to all ZCS and DCS on RMNCH+A thematic areas • Updating of job-aids • Supportive supervision and corrective measures to district and block TSU teams • Orienting zonal and district TSU teams on new protocols and guidelines on the community process	Post-graduate qualification in social sciences 10-15 years' work experience	Central Team Leader	Government of India, Government of UP, State Programme Management Unit and non-governmental organisation partners

Operational levels	Position	Key responsibilities	Profile of the staff	Reporting structure	Interaction / linkage with health system representative
Zonal Team	Zonal Community Specialist (ZCS) Zonal Technical Specialist	• Provide overall management of CRP intervention in all five districts of the assigned zone • Provide on-site supportive supervision to the DCS, BCS and CRP as and when required • Lead training and orientation of DCS and CRPs on RMNCH+A areas	5-10 years of work experience in community processes with a formal background in social sciences	State Community Specialist and Central Team leader	CMO and CMO officials of 5 assigned districts; DPM and other divisional officials; DPM, District Community Process Manager (DCPM) and DPMU staff in 5 assigned districts; Block Programme Manager (BPM) and BPMU staff at block level; Assistant Research Officer (ARO) and MOIC at block facilities

District Team	District Community Specialist (DCS)	• Improve the quantity and quality of interactions between FLWs and households in the assigned district
		• Support the CMO/DCPM in the planning and review of the community processes in the district
		  ○ Through regular data sharing, joint field visits (including block monitoring and supportive supervision visits) and review meetings
		• Support the **BCSs and CRPs** in the **UP-TSU focus blocks**
		  ○ Through regular data analysis, field visits, trainings and review meetings
		• Support the MOIC/Block Community Process Manager (BCPMs) in the **other blocks**
		  ○ Through joint field visits and review meetings
		  ○ Sharing learning from the UP-TSU focus blocks through exposure visits
			Post-graduate qualification in social sciences, rural development or social work, with 2-6 years of work experience in community development programmes	ZCS and State Team Leader	CMO and CMO officials; DPM, DCPM and DPMU staff at district level; BPM and BPMU staff at block level; ARO and MOIC at block facilities

Operational levels	Position	Key responsibilities	Profile of the staff	Reporting structure	Interaction / linkage with health system representative

Block Team	Block Community Specialist (BCS)	• Improve the quantity and quality of interactions between FLWs and households in the assigned block
		  ◦ By supporting CRPs
		  ◦ Through regular data analysis, field visits, trainings and review meetings
		  ◦ By supporting the MOIC/BCPM
		  ◦ Through support in planning based on community gap analysis
		  ◦ Through joint field visits and review meetings
		• Improve the process to promote the continuum of care between the community and facility; and follow-up at community levels in the assigned block
		  ◦ By supporting regular feedback mechanisms between the FLWs and facilities (MOIC, Staff nurses, BPMs, etc.)
		• Support the quality and use of HMIS/MCTS data at SC level
			A graduate in any discipline with good communication, liaising and leadership skills; minimum 2-4 years' work experience in community or rural development	DCS	MOIC, BCPM/BPM, ARO, FLWs (ASHA, ANM, AWW), CRP, NM, District UP-TSU team

	Community Resource Person (CRP)	• Improve the coverage and frequency of outreach/home visits by ASHAs in the assigned cluster
		  ◦ By supporting them with the ETT
		• Improve the quality of interactions between ASHAs and households in the assigned cluster
		  ◦ By supporting them with home visit checklists and family focused communication materials/tools
		  ◦ By supporting the conduct of VHNDs
		  ◦ Strengthening the VHSNC
		• Improve coordination/ problem solving among FLWs in the assigned cluster
			Intermediate: Preference for graduates; 1-3 years' work experience in the field of health, nutrition or community development programmes, with a focus on community mobilisation, outreach and on-the-job support; Exposure or experience working with or mentoring ASHAs, ANMs and AWWs	DCS via BCS	FLWs (ASHAs, ANMs, AWWs), CRP, NM, BCS and District team

Operational levels	Position	Key responsibilities	Profile of the staff	Reporting structure	Interaction / linkage with health system representative
	Community Resource Person (CRP) continued	• By supporting the conduct of AAA forum meetings • Improve the community processes planning and review through real-time data in the assigned cluster • Gap analysis and updates • ETT summary			

Source: TSU background documents and interviews with district and block functionaries

Figure 1 (Annex 1b): Supervisory and reporting structure for CRP intervention

Source: Field observation and confirmation with district- and state-level UP-TSU staff

Table 2 (Annex b): Tools and job-aids for CRP

Information levels of UP-TSU	Name of the record	Description	Frequency of data collection	Collected by	Compiled at	Availability of information (hardcopy/ digital format)	Key contact person
Community level	Planned vs accomplished activities sheet	Detailed information on actual activities performed by CRPs against monthly planning	Daily	BCS	Block	Yes (both)	BCS
	Diary keeping	To track, record and report daily activities performed by CRPs and the BCS CRP should use her daily diary to identify and present areas of improvement to the MOIC in weekly ASHA/ANM meetings at the CHC Daily diary helps the CRP in preparing her next month's action plan	Daily	BCS	Block	Yes (hardcopy)	CRP and BCS
	Community gap assessment (CGA)/ community resource mapping (CRM)	A tool to assess the health services at community level particularly from revenue villages	It is a one-off activity. All seven CGA tools are completed for every revenue village	Filled in by CRPs and collected by the BCS	Block level; hardcopies are submitted to the DCS on a weekly basis DCS and district monitoring and evaluation (M&E) specialist check that the forms are complete and have been filled in appropriately DCS reports to the zonal team Data are scrutinised and entered zonal level	Yes (both)	BCS at block level DCS at district level

Information levels of UP-TSU	Name of the record	Description	Frequency of data collection	Collected by	Compiled at	Availability of information (hardcopy/ digital format)	Key contact person
Community level, continued					Data returned to the district concerned for analysis by the M&E specialist with the help of the DCS Primary analysis feedback shared with the CRPs and BCS		
	VHIR/ Enumeration tracking tool (ETT)	Assists ASHA with self-planning, self-review and self-reflection of her work	Daily	BCS	Block The role of CRPs is to assist ASHAs with problems they face in filling in the VHIR The CRP keeps a record of the kind of support she has provided to the ASHA in filling in the VHIR This enables the identification of ASHAs with poor record keeping skills, so as to increase the focus on building their capacities	Yes [CRP makes notes in her daily diary about support she has provided to ASHAs in filling in the VHIR. Thus, only hardcopies are available] [BCS reports to the DCS about low performing ASHAs and makes next month's plan accordingly, to provide them with more dedicated supportive supervision]	CRP and BCS
	CRP monthly reporting	To track all the assigned activities of the CRP – the number of: revenue villages visited; ASHAs supported; ASHAs supported on	Monthly	CRP	At block level, by the BCS; which in turn gets compiled at district level by the DCS	Yes [hardcopy filled in by CRPs and then entered digitally at zonal level]	CRP and BCS

Information levels of UP-TSU	Name of the record	Description	Frequency of data collection	Collected by	Compiled at	Availability of information (hardcopy/ digital format)	Key contact person
Community level, continued		VHIR; ASHAs supported on updating the due list; home visits made with ASHAs; AAA meetings supported; VHNDs and VHSNC meetings supported and reactivated; cluster meetings supported					
	ASHA coverage report	CRP collects data from ASHAs during cluster meetings	Monthly	CRP	CRP submits one compiled report for all the ASHAs in her cluster to the BCS	Yes [hardcopy filled in by CRP and then entered digitally at zonal level]	CRP and BCS
Block level	BCS monthly progress reporting /Programme Support Team activity sheet	A monthly sheet recording and reporting all activities performed by CRPs and the BCS BCS complies a progress report of all the CRPs in his block He also reports on his own activities such as – the number of visits made to provide hand-holding support; to VHNDs, VHSNC meetings, AAA cluster meetings monitored and supported Whether he participated or facilitated any RMNCH+A meetings, HMIS/MCTS and UP-TSU review meetings	Monthly	BCS	Block	Yes [hardcopy filled in by the BCS and then entered digitally at zonal level]	BCS
	Supportive supervision checklist for HMIS/MCTS	An additional responsibility for the BCS, to support the quality and use of HMIS/MCTS data at SC level BCS is expected to fill in this checklist by interviewing and observing ANMs' data records	Weekly during ANM meeting at CHC or By visiting	BCS	Block	Yes [both]	BCS

Information levels of UP-TSU	Name of the record	Description	Frequency of data collection	Collected by	Compiled at	Availability of information (hardcopy/ digital format)	Key contact person
Block level, continued		either at the SC or CHC BCS checks whether all components of HMIS are being filled in by ANMs	SCs				
	Block profile	A compilation of information from the entire block, regarding all three clusters, comprising: population, cluster mapping, contact details of ASHAs, AWWs, ANMs, *Gram Pradhan*, Members of VHSNC, MOIC, BPM, ARO and all relevant officials The compiled information assists the field activities of CRPs	Once	BCS	Block	Yes [hardcopy]	BCS
District level	DCS monthly reporting /Programme Support Team activity sheet	A monthly sheet recording and reporting a compilation of the activities performed by the CRPs and BCSs in his/her district Also reporting his/her own activities performed	Monthly	DCS	Block	Yes [hardcopy filled in by the DCS and then entered digitally at zonal level]	DCS
	Community gap assessment (CGA) / community resource mapping (CRM)	A tool to assess community-level health services, particularly in revenue villages	A one-off activity by CRPs in which they fill in all seven CGA tools of from every revenue village	BCS	Data compilation carried out at each level-block, district and zonal BCS submits hardcopies to the DCS on a weekly basis DCS and District M&E specialist check that the forms are complete and filled in	Yes (both)	BCS at Block level DCS at District level

Information levels of UP-TSU	Name of the record	Description	Frequency of data collection	Collected by	Compiled at	Availability of information (hardcopy/ digital format)	Key contact person
District level, continued					appropriately DCS reports to the zonal team Data are scrutinised and entered zonal level Data returned to district concerned for analysis by M&E specialist with the help of the DCS Primary analysis feedback shared with the CRPs and BCS		
	Block Monitoring Visit [BMV]	Visits are planned in coordination with CMO and DPMU officials to gather a holistic picture of the block, including the situation in facilities and in the community The BMV focuses on identifying gaps; areas for improvement in terms of infrastructure, human resources, skills and training, RMNCH+A services at facilities, in consultation with staff and at community level in consultation with beneficiaries	Two blocks in every district should be monitored in every month The intention is to monitor each block twice a year	District team	District	Both	District team

Information levels of UP-TSU	Name of the record	Description	Frequency of data collection	Collected by	Compiled at	Availability of information (hardcopy/ digital format)	Key contact person
District level, continued	Monthly action plan of CRPs, BCS and DCS	Action plan for the next month has to be prepared in the last week of every month	Monthly	DCS	District	Both	DCS
	Activity sheet (activities accomplished in a month)	Tracks activities accomplished in the month	Monthly	DCS	District	Both	DCS
	Cluster highlight	Information on the number of revenue villages, PHC/ APHC, SC, ANMs, ASHAs and AWWs in each cluster	Not regular it was requested for once	DCS	District	Soft copy	DCS
	• The DCS has to prepare and submit reports of the various community process activities organised by district and block government officials, where the DCS has participated as a trainer or facilitator e.g. Intensified Diarrhoea Control Fortnights, Maternal Death Review, VHIR training • Review monthly reports (for ETT/VHIR summary, VHND check-list, home visit check-list, AAA reporting/monitoring format), identify gaps, if any, provide guidance and share feedback (with block and district officials) in the focus blocks						
Zonal level	Review report	Review of district-wide output, input indicators, six-monthly work plan and planning The zonal team prepares the review report for the zonal planning and review meeting and compiles all reports and shares them with the state team Zonal level finalisation of tour plans	Monthly	ZCS	Zonal	Soft copy	ZCS
State level	Community Behaviour Tracking Survey (CBTS)	Biannual real time data collected at block and community level. Data are used in different forums, RMNCH+A meetings. UP-TSU use these data to show the picture of key health indicators in the block to the MOIC. Data collection is repeated	Six monthly	State communit y team	State and zonal	Soft copy	Team Leader

Information levels of UP-TSU	Name of the record	Description	Frequency of data collection	Collected by	Compiled at	Availability of information (hardcopy/ digital format)	Key contact person
State level, continued		every six months, the UP-TSU seeks assurance from the MOIC about how much the situation will change in the next six months UP-TSU also want to show this data to FLWs and fix targets for various indicators for the next six month These data are also compared with HMIS data from the same blocks. To understand the source of errors in HMIS data CBTS data are used ASHAs' catchment areas are considered as health units under CBTS					
	Protocols, guidelines	State community team develops and share the all relevant protocols, guidelines, documents necessary for community process through zonal and district level team	As and when required	State communit y team	State and zonal	Soft copy	Team Leader

Annex 1c: Data collection instruments for the pathway analysis of Community Resource Person

A combination of instruments was used to capture different aspects of information on the CRP intervention, from contextual information to reporting structure, the profile of key functionaries and the nature of the activities conducted. Instruments included field observation formats, interview schedules and structured formats for quantitative or objective data collection.

Format 1 (Annex 1c): Field observation format

Objective:

- To collect information on innovation with understanding the role of various stakeholders - government and the UP-TSU at different levels of implementation.
- To understand the linkage of CRP programme with the existing FLWs - ASHAs, ANMs and AWWs.

Method of recording and synthesising information: The process is to observe the implementation of the innovation with a special focus on the items listed in the guide. This information is useful for building up a picture of the implementation, as observed in the field.

Theme	Observation
Contextual observation: - Utilisation of community outreach services - Home visits by ASHAs - Availability of tools and job-aids to ASHAs - Organisation of VHNDs - Conduct of VHSNC meetings - Availability and practice of protocol and guidelines by FLWs - Maintenance of records and registers - Supervisory and monitoring structure for FLWs - Cultural practices around maternal, neonatal and child health care - Links and coordination between ASHAs, ANMs and AWWs	
Observation of activities under the CRP intervention: - Support provided by the CRP to ASHAs - CRP interaction with other FLWs and block government officials - Mentoring process and problem solving during VHNDs - Use of job-aids and tools - Maintenance of records and registers - Acceptance of the CRP by FLWs	
Observation of UP-TSU staff (the BCS and DCS) linked to the CRP programme. - Support to the CRP by the BCS - CRP and BCS interaction with the DCS - Frequency of interaction (CRP with the BCS; BCS with the DCS) - Supervision, problem solving and reporting	

Format 2 (Annex 1c): Guide for field verification

Objective: To verify information collected for the qualitative narrative with all stakeholders.

Potential respondents / stakeholders: Public health administration personnel at district- and facility-level, UP-TSU staff and CRP involved in implementing the innovation. Specific to CRPs – these would include ASHAs, ANMs, AWWs, BPM, BCS, CRPs and UP-TSU district level staff.

- Stakeholders interviewed for the CRP intervention
  - Frontline workers at block level: interviews with ASHAs, ANMs, AWWs, BPM
  - Field supervision and support at block and district level: BCS and DCS
  - Training and supportive supervision at state level: Technical team leader of the CRP intervention.

Method of recording and synthesising information: We met the team members from community-level up to district-level, to verify whether the process we have recorded is correct and to build a consensus on the implementation pathway. The verification process was to narrate the implementation pathway (from the report) with respect to the stakeholder's role and ask if it is correct, or if they would like to add to, or modify it in any way. The feedback was noted and any change or new information was recorded in the narrative report.

Format 3 (Annex 1c): Guide for in-depth interview with key stakeholders for CRP intervention

Questions to District Community Specialist
(Zonal Community Specialist or Team Leader if available)

1. List the high priority blocks in which the UP-TSU is implementing the CRP programme
2. What is the hierarchy of the UP-TSU workforce in the district for implementation of the CRP programme?
3. What is the CRP programme? Please explain in brief about the design of the CRP intervention particularly focusing on our information gaps?
4. Recruitment: How many CRPs were selected and what was the selection process? (Who was on the panel?) How were they selected (probe for the role of government)? [government / non-governmental organisation roles]
5. How were the clusters for the CRPs defined in the district? Is there any parameter for the design of clusters?
6. How many CRPs are posted and how many positions are vacant in the district? [Against the ideal of 12]
7. Who trained the CRPs? What were the key technical contents on RMNCH+A areas in the CRP training module. Which critical areas of RMNCH+A services are being focused on by CRP areas?
8. What about refresher trainings for CRPs? Timeline and further details on refresher trainings – at what interval, who will take them, how many CRPs will attend, where will the sessions be held?
9. Can you show us training related data such as the training log/ attendance/ pre- and post-knowledge assessment? [note down data heads]
10. The role of the CRP in supporting ASHAs, ANMs, AWWs and the VHSNC (record review). Do CRPs visit ASHAs, AWWs and ANMs in the villages for on-job hand-holding? Frequency of interactions and joint meetings.
11. What kind of on-job hand-holding is given by the BCS and DCS to the CRPs? (What support are CRPs getting from the BCS and DCS?)
12. How are CRPs being supervised and monitored? To whom do they report about their work?
    a. What
    b. Tracking Tool? How, when and why they are filling in case is the CBTS (Community Behaviour Tracking Survey)?
    c. What are the CRPs' job-aids and tools?
    d. What is the Enumeration sheets?
13. Flow diagram to represent the steps a CRP follows with job-aids and tools [we will construct]
14. Are CRPs giving their field observation input to government counterparts or the BCS and DCS? If yes, what sort of action is taken on their reports? Vice versa – are government stakeholders reporting or giving feedback on CRPs? How is it being recorded?
15. The nature of supportive supervision to community intervention implementation at different levels (interviews) – block, district and state, by both the UP-TSU and government.
16. How many joint visits are planned with the DCPM, BPM or any other government health officials for the supportive supervision?
    a. How does the district and block level public health system support the CRP implementation?
    b. How are the CRPs' planning meetings organised? Is the planning meeting done with close coordination of the DCPM or concerned government counterparts?
    c. Any observation on the government's role in supportive supervision of the CRP intervention
17. Any impact on beneficiaries, improvement in ASHAs' performances, or AAA coordination through the CRP's efforts (interviews – case studies or examples)
18. What is the role of the measurement, learning and evaluation partner Sambodhi in M&E of the CRP programme?

Questions to the BCS

1. What do you know about the CRP intervention programme? How were you recruited and trained?
2. Please tell us about your job duties and responsibilities.
3. How many CRPs are working under your supervision?
4. Tell us about your planning for hand-holding or supporting CRPs to do their work. How do you monitor CRPs? What tools are you using? To whom are you reporting?
5. Are you getting assistance from the BPMU or BPM in your work? If yes, please brief us. [Details on nature of interaction between the BCS and block level health officials]
6. What sort of impact of the CRP intervention are you observing on ASHAs' performances and AAA coordination?
7. What sort of difficulties are you getting in supervision and hand-holding? Do you have any suggestions for implementation of the CRP?

Questions to the BPM

1. What do you know about the CRP intervention?
2. Are you or the BPMU involved in supportive supervision of CRPs? Are block health officials supporting the CRP or UP-TSU community intervention in any way?
    a. If yes, how do you support it? [training / orientation / feedback / other tasks]
    b. Is there any format for supportive supervision from the BPMU? Are there any data that are shared with the BPMU on a periodic basis?
3. Were you involved in the CRPs' planning meeting? How many joint visits planned with the BPM or any other government health officials for the supportive supervision?
4. Does your government counterpart think CRPs are beneficial for RMNCH +A programme implementations?
5. Have you observed any impact on beneficiaries, improvement in ASHAs' performances, or AAA coordination through CRPs' efforts? If yes, please elaborate.

Questions to the CRP

1. Please tell us about your past work and background. [education, experience, social commitment]
2. How did you come to know about this job? Please brief us about your recruitment journey
3. How were you trained? Who conducted your training? What was the content of the training?

a. Are you being provided with a training module or any other documents for reference? Can you show us?

4. Are you receiving refresher trainings? How frequently? What kind of refresher training is there?
5. What are your key functions for each thematic area of RMNCH+A services? Can you please tell us about your job duties and responsibilities? If yes, please elaborate.
6. Have you observed any sort of social barriers in the community about RMNCH+A practices, specifically about maternal and child health care?
7. What is your understanding about AAA i.e. ASHAs, AWWs and ANMs? [probe – coordination, data sharing, joint visits, organising VHNDs, follow up and referral of high risk women and children]
8. What tools are you using for hand-holding or supportive supervision for AAA?
    a. What is the Enumeration Tracking Tool? [explain how it is used]
9. How are you helping AAA in VHNDs and VHSNC meetings? [role in strengthening VHSNC]
10. What is your role in the ANM meetings, held every Thursday?
11. How are you being supported by block and district health officials?
12. Have you observed any changes in the work of ASHAs, AWWs and ANMs after you have supported them? What do they (AAA) feel about your assistance in their work?
13. How are CRPs helping AAA in maintaining records?

Questions to AAA

1. What do you know about the CRP intervention programme?
2. How are CRPs helping/assisting/supporting you in your work?
3. What critical areas of RMNCH+A are you being supported in by the CRP?
4. Have you observed any sort of social barriers in the community about RMNCH+A practices, specifically about maternal and child health care?
5. How did the CRP educate you on maintaining records, diary and other work?
6. Do you feel that the CRP is helpful in making your work smoother and easier?
7. What sort of support you are getting from the CRP at VHNDs and VHSNC meetings?
8. Are you being supported by block and district health officials? How are you reporting? Have you observed any influence of the community intervention on your reporting?
9. Have you observed any changes in your work after being supported by the CRP? How best can you assess the support of the CRP?

Format 4 (Annex 1c): Guide for consensus building

Objective: To build consensus among all stakeholders on the implementation pathway, and to rectify errors, if any.

Potential respondents / stakeholders: Public health administration personnel at district- and facility-level, UP-TSU staff and CRPs involved in implementing the innovation. Specific to the CRP; Barabanki and Hardoi district staff involved in the CRP implementation - ASHAs, ANMs, AWWs, CRPs, BCS, UP-TSU district- and state-level staff.

Method of recording and synthesising information: For consensus building the process is to organise a focus group discussion with the above stakeholders (at least one from each category) as participants. Details of the implementation pathway are then described and consensus sought from all participants on each step.

The implementation pathway for the CRP intervention was shared. All the representations of implementation were described sequentially and consensus on each was obtained from all participants. Overall agreement was sought and any rectifications required were noted. In cases where there were differences among the participants, the opinion of the district-level senior public health official and at state level the Team Leader of the UP-TSU was considered final.

Format 5 (Annex 1c): Contextual information format

Date (dd/mm/yy)	Investigator's name	District name	UP-TSU zone name	District total population

1. CRP coverage

Block name	Total number of CRPs posted	Total number of SCs per block	Average number of ASHAs per cluster	Average number of villages per cluster	Number of VHSNCs per cluster
1.					
2.					
3.					
4.					

2. CRP background (*same block-wise order as previous table*)

Basic qualification	Previous work experience, if any	
	Nature of work (position)	Years of experience
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

3. Linkage with government

	How many government staff have been oriented and linked with the CRP in this district? Enter number for each type, zero if none |__|__| ANMs |__|__| Chief Medical office staff |__|__| Others (please explain) |__|__| Medical officers in PHC / CHC |__|__| NHM officials (block and district)
	Details of any training received by ASHAs and ANMs. And who provided these trainings? (government / private / non-governmental organisation) a. Skilled birth attendance b. Comprehensive Child Survival programme c. Other (please explain)……………………………………………….
	Details of records / registers maintained by ASHAs and ANMs [please collect photocopy]

ASHA		ANM	
Name of record	Key data elements	Name of record	Key data elements

4. Status of VHSNCs

	When were VHSNCs formed in the district? …………………………………………..
	Position holders: President:................................ Convener:................................. Cashier:................................ Remarks on the status of VHSNCs (whether functional or not): Nature of activities undertaken (if functional):

Annex 1d: Indicators for Community Resource Person implementation pathway

No.	Themes	Indicators	Frequency that indicator is collected	Data sources	Maintained by/ available at
1.1	UP-TSU- Developed implementation package	Number of components added to the strategy	Concurrent	Strategy documents	State TSU office
1.2	UP-TSU-Government- Permissions, facilitation and consultative implementation strategy	Number of collaborative meetings between government and TSU to facilitate implementation and discuss strategy	Concurrent	Minutes of meetings	State TSU office
1.3	UP-TSU- Recruitment and placement of CRPs	Number of CRP positions vacated Number of vacant CRP positions filled	Concurrent	Human resource records	State TSU office
2.1	UP-TSU- Design and revision of training manual and tools for CRP using government guidelines	Number of manuals, tools or job-aids added Number and/or name of guidelines used	Concurrent	Strategy documents and job-aids	State, zonal and district level- (community specialist)
2.2	UP-TSU-Government- 5-day training and refresher on RMNCH+A topics, health system, TSU goals	Number of refresher training sessions for CRPs Number of CRPs trained	Concurrent	Minutes of training/ training log	Zonal/district level- (community specialist)
2.3	UP-TSU- 5-day training on the role of CRPs and FLWs, use of job-aids, communication skills, HBMNC, VHIR, CRM	Number of CRP training sessions Number of CRPs trained	Concurrent Concurrent	Minutes of training/ training log	Zonal/district level- (community specialist)
3.1	UP-TSU – CRPs conduct CRM and identify areas for improvement	Number of areas of improvement for which an action plan was made	Monthly	DCS and BCS monthly reports	Zonal/district level - (community specialist)
3.2	UP-TSU-Government- Develop an action plan to fulfill needs identified through CRM and ETT summary	Number of village-wise action plans	Concurrent	Plan of action	Zonal and district level - (community specialist)

No.	Themes	Indicators	Frequency that indicator is collected	Data sources	Maintained by/ available at
3.3	UP-TSU-Government-Corrective measures for activation of services using currently available resources	Number of cluster meetings attended to understand corrective measures Number of VHNDs and AAA meetings supported	Monthly	DCS and BCS monthly reports	Zonal and district level-(community specialist)
4.1	UP-TSU- Priority focus on strengthening ANC-PNC, institutional deliveries, family planning, along with RMNCH+A services	Number of home visits made with ASHAs Number of VHSNC meetings supported Number of VHNDs supported	Monthly	DCS and BCS monthly reports	Zonal and district level-(community specialist)
4.2	UP-TSU –Strengthening coordination of FLWs in AAA forum to ensure service delivery and utilisation at VHNDs; assist FLWs in record keeping (in filling in VHIR/ETT and preparing due list), conducting home visits	Number of VHNDs and AAA meetings supported Number of ASHAs given support with VHIR (ETT) Number of ASHAs given support on updating due list Number of AAA meetings where ASHA-wise due list discussed Number of home visits made with ASHAs	Monthly	DCS and BCS monthly reports	Zonal and district level-(community specialist)
4.3	UP-TSU- Continued capacity building of FLWs through family focused communication skills	Number of home visits made with ASHAs	Monthly	DCS and BCS monthly reports	Zonal and district level-(community specialist)
5.1	UP-TSU- Support and supervision of CRPs by the BCS and DCS; supervision by zonal and state teams	Number of review meetings of CRP with the BCS Number of review meetings of the BCS with DCS	Monthly	DCS and BCS monthly reports	District level- (community specialist)
5.2	UP-TSU- Weekly cluster meeting to review FLWs'	Number of cluster meetings attended	Monthly	DCS and BCS monthly reports	Zonal and district level-(community specialist)

No.	Themes	Indicators	Frequency that indicator is collected	Data sources	Maintained by/ available at
	activities and provide feedback and corrective measures where required			Minutes of meetings	
5.3	UP-TSU- NM provides feedback on facility gaps and appropriate community behaviour around maternal and newborn care in monthly meeting of the CRP, NM and BCS	Number of meeting of NM, CRP and BCS at block facility Number of VHNDs, AAA forum and cluster meetings attended by CRPs and the NM	Monthly	DCS and BCS monthly reports Monthly facility report	Zonal and district level- (community specialist) Zonal Technical Specialist for monthly facility report
6.1	UP-TSU-Government-Programme review and revision of action plan with block and district officials	Number of review meetings of DCS and CMO officials or DPMU officials	Monthly	DCS monthly report	Zonal and district level- (community specialist)
6.2	UP-TSU- Concurrent monitoring through VHIR, ETT summary, Community Behaviour Tracking Survey and programme review	Number of ASHAs supported on VHIR and due list	Monthly	DCS and BCS monthly reports	Zonal and district level- (community specialist)
6.3	UP-TSU-Government-Techno-managerial support for strengthening and continuation of improved RMNCH+A services	Number of RMNCH+A review meetings facilitated Number of RMNCH+A review meetings attended at block level Number of ASHAs' coverage report	Monthly	DCS and BCS monthly reports	Zonal and district level- (community specialist)

IDEAS project

IDEAS (Informed Decisions for Actions) aims to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. Working in Ethiopia, northeast Nigeria and the state of Uttar Pradesh in India, IDEAS uses measurement, learning and evaluation to find out what works, why and how in maternal and newborn health programmes.

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