How to empower the community Health Workers

Dr. Tapan Jyoti Kalita
Piramal Swasthya
A Force to Reckon – “Community Health Workers”

• The use of community members to render certain basic health services to their communities is a concept that has existed for at least 50 years.

• We now know that CHWs can play a crucial role in broadening access and coverage of health services in remote areas and can undertake actions that lead to improved health outcomes.

• The World health report 2006: Working together for health recognizes shortages of professional health workers as one of the key ingredients in the growing human resource crisis, particularly in low-income countries. One strategy to address this crisis is so-called “task-shifting”.

• Community health workers are known by many different names in different countries. The umbrella term “community health worker” (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come. A widely accepted definition was proposed by WHO: “Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers.”
Community Health Workers in India

• The Primary Health Care in India focused extensively in Preventive care and hence the role of Community Health workers has been of paramount importance.
• ANM & ASHA: previously mostly confined to MCH & select CD related services, Since NHP (2017), their role got expanded to cover CPHC - 12 categories of clinical services
• Now they provide: Promotive, Preventive, Curative, Diagnostic, Rehabilitative & palliative services
• ANMs, ASHAs and AWWs constitute the three main pillars of Community Health in India
• ANM (Auxiliary Nurse Midwife) takes care of a Sub centre that covers a population of 5000 in plain areas and 3000 in hilly areas. Conducts VHND visits in 2 days a week and also takes part in the VHSNC meetings. Since 1960
• ASHA (Accredited Social Health Worker) constitutes core driving force of under NHM strategies and each well trained ASHA covers one village (1/1000 population). Since 1975.
• Angan-Wadi Workers are constituents of ICDS through which Government of India has been providing protection against childhood hunger and nutrition related problems. Since 2005.
How to empower Community Health Workers

**Roles and responsibilities**

**ANM** - Maternal and child health, family planning services, health & nutrition education and efforts for maintaining environmental sanitation, immunization, treatment of minor injuries, and first aid in emergencies and disasters.

**AWW** - Showing community support in executing ICDS, to conduct regular quick surveys of families, provide health & nutritional education, organize pre-school activities, promote family planning, promote child growth and development, assist in implementing Kishori Shakti Yojana etc.

**ASHA** - Identifying and registering new pregnancies, births and deaths, Mobilizing, counselling and supporting the community to demand and seek health services. Identifying, managing or referring cases of illness, Supporting health service delivery through home visits, first-aid and immunizations sessions, Maintaining data and participating in community-level health planning.

**AAA – The Magnificent Triad**
Some facts and figures

• In May 2015, India had a total of 12.96 lakh AWWs, who were running a total of 13.5 lakh AWCs, is paid around INR 4,000 per month, though this figure varies across states.

• In January 2017, there were a total of 8.82 lakh ASHAs. Each ASHA get monetary incentives for specific activities. For instance, they are paid INR 350 for every institutional delivery that happens because of them.

• As for ANMs, in March 2015 India had a total of 2.12 lakh. With 155,708 functioning health sub-centres and two ANMs per sub-centre.
Why Do we need to empower CHWs: Persistent reasons

a) **Low literacy makes tasks harder**: Many CHWs, specially ASHAs, have difficulty reading and writing, though their literacy levels differ widely across states. It not only affects their ability to discharge their daily activities, but also makes them less confident to deliver new ideas in group settings.

b) **Lack of role structure and definition confuses priorities**: The work of CHW is not always structurally defined; they can be pulled in for all kinds of government work—immunization, polio, helping with elections, and so on. While AWWs are paid an honorarium and ANMs are paid salaries, ASHAs are paid incentives. So they lack the institutional support structure that the others get. Further, only some of their duties are incentivized, which influences their priorities.

c) **Large workload and limited training impact quality**: CHWs are supposed to be the go-to resource at the village level, but they may not always be equipped or sufficiently trained to handle all their responsibilities.

d) **Community dynamics create cultural constraints**: They need to engage with all community stakeholders. There are huge challenges in terms of defying gender roles, navigating through racial, religious and socioeconomic factors, work-life prioritization.

e) **Overall Perceived Benefit**: the weightage of perceived benefit over perceived investment
Why do we need to empower CHWs: Imminent reasons

With the advent of CPHC of NHP, there is an urgent need to build capacity of CHWs in -

1. National health policy/ GOI & state level Programs
2. ICT advances & adaptations for Health care settings, Digital data entry & documentations
3. Newer ‘clinical care protocols’ & quality standards, POC diagnostics etc
4. Enhanced expectations & demands from the Community
What can we Improve for CHW empowerment?

Road map for Empowerment:
- Building advocates
- Empowering environment
- Selection
- Training
- Supportive supervision
- Motivation
- Ownership
- Identifying Barriers

How to empower Community Health Workers
Selection

• We need better selection criteria for CHWs
• Go beyond their education and age
• Basic skill assessment
• Work ethics
• Attitude
• Communication skills
• Propensity to learn
How to empower Community Health Workers

Training

• Periodic Need assessment
• Need based training on – Knowledge, skill
• Regular training impact Evaluation
• Training on soft skill
• Data orientation
• Documentation
• Leveraging use of Technology
• Feedback
Few Methods of effective Training

- Using Simulation Training
- Using interactive method
- Using participatory method
- Using engaging method
- Using on site training
Supportive Supervision

Most empowering Method of supportive Supervision.....
How to empower Community Health Workers

**Motivation**

- Perceived investment
- Perceived Benefit
- Satisfaction
- pride
- Community goodwill

**Extrinsic Motivation**
Motivated to perform an activity to earn a reward or avoid punishment

**Intrinsic Motivation**
Motivated to perform an activity for its own sake and personal rewards

**Intrinsic vs Extrinsic Motivation**
Ownership

“Once a CHW takes ownership of her vocation, there is no coming back”

How to build ownership?

• Involve in decision making process
• Give orientation and access to Data
• Encourage developing and sharing of opinions
• Appreciate and Encourage
• Positive competition
### One Example

A simple, easy to understand colour coded activity report format dramatically improved ANM’s practices and brought considerable amount of ownership.

#### Triggering factors
- Data accessibility
- Self monitoring
- Real time corrections
- Use of data for decision making

---

**Facility 606**

### OTIS Items

<table>
<thead>
<tr>
<th>OTIS Items</th>
<th>Times Observed</th>
<th>Success Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP1: Did BA take mother’s temp?</td>
<td>11</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP1: Did BA take mother’s BP?</td>
<td>11</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP1: Was a vaginal exam done?</td>
<td>11</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP1: If vaginal exam done, was water used to clean hands?</td>
<td>10</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP1: If vaginal exam done, was soap or alcohol rub used?</td>
<td>10</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP1: If vaginal exam done, were clean gloves used?</td>
<td>10</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP1: Did BA use checklist?</td>
<td>11</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: clean towel?</td>
<td>7</td>
<td>50.0%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: clean gloves?</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: pads for mother?</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: oxytocin 10 units in syringe?</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: sterile scissors or blade?</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: cord ligature/tie?</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: suction machine/mucus extractor?</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP2: Did BA prepare: neo-natal bag and mask?</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP2: Was water used to clean hands?</td>
<td>7</td>
<td>57.1%</td>
</tr>
<tr>
<td>PP2: Was soap/alcohol rub used to clean hands?</td>
<td>7</td>
<td>42.9%</td>
</tr>
<tr>
<td>PP2: Did BA use checklist?</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>PP3: Were gloves used at birth?</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>PP3: Was baby put immediately skin to skin?</td>
<td>8</td>
<td>93.8%</td>
</tr>
<tr>
<td>PP3: Was oxytocin given within 1 hour after birth?</td>
<td>6</td>
<td>87.5%</td>
</tr>
<tr>
<td>PP3: Did BA check for bleeding?</td>
<td>7</td>
<td>71.4%</td>
</tr>
<tr>
<td>PP3: Did BA take mother’s BP?</td>
<td>7</td>
<td>71.4%</td>
</tr>
<tr>
<td>PP3: Did BA take baby’s temp?</td>
<td>7</td>
<td>71.4%</td>
</tr>
<tr>
<td>PP3: Did BA take baby’s weight?</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>PP3: Was breastfeeding started within 1 hour?</td>
<td>7</td>
<td>71.4%</td>
</tr>
<tr>
<td>PP3: Was baby skin to skin still at 1 hour?</td>
<td>7</td>
<td>71.4%</td>
</tr>
<tr>
<td>PP3: Did BA use checklist?</td>
<td>7</td>
<td>71.4%</td>
</tr>
<tr>
<td>PP4: Did BA check mother for bleeding?</td>
<td>5</td>
<td>70.0%</td>
</tr>
<tr>
<td>PP4: Did BA check baby’s temp?</td>
<td>5</td>
<td>40.0%</td>
</tr>
<tr>
<td>PP4: Did BA check baby’s feeding?</td>
<td>5</td>
<td>80.0%</td>
</tr>
<tr>
<td>PP4: Did BA explain danger signs to mother/comp?</td>
<td>5</td>
<td>70.0%</td>
</tr>
<tr>
<td>PP4: Did BA discuss family planning with mother?</td>
<td>5</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

---

**Notes:**

- An OTIS Observation is defined by one OTIS form entered into the OTIS application regardless of the number of Pause Points coached. Data is shown for each Pause Point (PP) in chronological order independent of the OTIS Observation. Thus some PPs have more data points than others.

---

**One Example**

A simple, easy to understand colour coded activity report format dramatically improved ANM’s practices and brought considerable amount of ownership.

#### Triggering factors
- Data accessibility
- Self monitoring
- Real time corrections
- Use of data for decision making

**Courtesy—“Better Birth Program”**
How to empower Community Health Workers

Identifying Barriers

• It is important to identify what is the root cause of a non performed or poorly performed function

• It is important to classify the barrier into a genre or type

• e.g. the OAMS classification can be a good example

• Once identified, efforts should be made to directly address the barrier
Empowering environment

- Enabling environment
- Travel and logistics
- Tools and materials
- Safety
- Administration
Building Advocators

- Disinterest
  - Least empowered

- Interest

- Trial

- Maintain

- Advocacy
  - Most empowered

Adoption Stairway to Empowerment
Leadership is very important too

1. Empathetic
2. Inspiring
3. Dynamic
4. Walk the talk
5. Wisdom
6. Accessible
7. Visionary
8. Ethical
Few Important Points

- Have the District Annual Training calendar* prepared for ANMs & ASHAS (*Refresher/Reorientation/New skills etc.)
- Encourage PD-ICDS to get the ‘AWWs-training calendar ‘ prepared & made operational
- Create opportunities to attend in person Review meetings of ASHAs/ASHA facilitators, ANMs’ work at PHCs & AWWs’ review sessions at CDPO level.
- At MOs’ monthly meetings, include a short’ exclusive Review of performance of ANMs(Sub centers) & ASHAs.
- During every field visit to CHCS/PHCs etc. Visit one or two villages, en-route while coming back, just to meet and talk to a few ASHAs, ANMs & AWWs.(not in inspection mode)
- Institute and maintain ‘grievance redressal mechanism’ for ANMs & ASHAs at your dist. offices!(Hornets nest? But worth trying.)
- Organize half yearly Community events at Mandal level, for awarding ASHAs, AWWs with Citations, Certificates and Prizes from and by the Community leaders.
- Encourage PEER LEARNING and Mentoring by Senior CHWs.
1. 104 Health Information Helpline at 9 states – provide Health advisory services to nurses for institutional /non-institutional care

2. 75 seater Telemedicine centre run by ANMs at Himachal Pradesh, with Solan as the hub

3. Community Health Outreach Program for maternal Care and Nutrition hubs at ARAKU VALLEY, AP (ASARA Project). The ANMs travel long distances ranging from 3 miles to 10 miles or more on a bike sitting behind a male who is not her husband, then hikes hills and valleys to provide primary health care to mothers and children in the tribal areas of Vishakhapatnam, truly reflecting “SEVA BHAAV”

4. MCTS Call Centre engaging with ASHAs

5. More than 250 MMUs were operational in AP
**Ummeed Project** is a community-based cancer screening program started in July, 2019 in Moinabad Mandal, Telangana to reduce the proportion of late-stage diagnosis and mortality from breast, cervical and oral cancers by partnering with Care Hospitals to ensure end to end care to the beneficiaries and to increase awareness, improve knowledge, alter attitudes, and motivate and mobilize people to undergo cancer screening and treatment.

The community mobilisers and tele-counsellors attended a four-day workshop in Guwahati, Assam organized by the NGO Sangath where they received training in: eliciting history on sensitive topics, health promotion, community awareness activities regarding habit cessation, and providing one on one counselling to screened positive beneficiaries.

The project nurses have attended a three-day workshop on ‘Oral, Breast and Cervical Cancer Screening in low-resource settings using the Educate, Screen and Treat approach’ held by Christian Medical College, Vellore.

1920 Beneficiaries have been screened in past five months.

3253 Participants mobilized to attend awareness sessions.
One on One discussion with ASHA

Focus Group Discussions

Awareness Sessions
D.E.S.H is a community-based cancer screening program started in 3 blocks of Kamrup Rural in Dec. 2017, to reduce the proportion of late-stage diagnosis and mortality from breast, cervical, and oral cancers by partnering with Dr. B. Borooah Cancer Institute to ensure end-to-end care to the beneficiaries and to increase awareness, improve knowledge, alter attitudes, and motivate and mobilize people to undergo cancer screening and treatment.

The community mobilisers and tele-counsellors attended a four-day workshop in Guwahati, Assam organized by the NGO Sangath where they received training in: eliciting history on sensitive topics, health promotion, community awareness activities regarding habit cessation, and providing one on one counselling to screened positive beneficiaries.

The project nurses have attended a three-day workshop on ‘Oral, Breast and Cervical Cancer Screening in low-resource settings using the Educate, Screen and Treat approach’ held by Christian Medical College, Vellore.

16077 Beneficiaries have been screened since inception-Oct 2019

9568 Participants mobilized to attend awareness sessions since inception – Oct 2019
Generating awareness in the community – IEC Tools

Community Awareness Sessions

One on One discussion with ASHA
Project Description:

Preventive: It is an integrated model covering ANCs (antenatal care) and NCDs (Diabetes and Hypertension) along with community mobilization & awareness sessions with an objective towards encouraging trimester checkups, institutional deliveries and early checkups regarding NCDs (Diabetes and Hypertension).

Curative: It provides pharmaceutical support for common ailments.

36812 Beneficiaries have availed MMU services in past 10 months
Ujjivan - we have 5 MMU, two at Bangalore and three at Maharasthra (Mumbai, Pune and Nasik). Each of these MMU has one Community Mobiliser. They are either GNM/MSW. Their job responsibility include visiting the houses near the service point and mobilising the people to our MMU by informing them about the services. Visiting the local anganwadis and identifying the vulnerable groups with the help of the Anganwadi worker. These MMU operate in Urban slums and our Community Mobiliser engage commonly with Anganwadi workers.

Asian Paints Project: As of now we have four static clinic operational in four states.
   a. Thandavapura, Mysore, Karnataka- launched on July 13th 2019
   b. Beeramguda, Hyderabad- Launched on 22nd September 2019
   c. Ghongola, Kasna, Uttar Pradesh- Launched on 1st October 2019
   d. Sangvital, Khandala Satara, Maharasthra- Launched on 27th November 2019

• Bokaro Power Project: Swasthya Kiran
   Has one community Mobiliser who works in co-ordination with ASHA and Anganwadi worker.
The time is Ripe for a change

1. Focus on Quality, Equity and Dignity in maternal care, Respectful maternal care is the need of moment

2. Govt focussing on de-medicalizing maternal care

3. Shifting Role of ASHA from Demand side to Supply side

4. AP is the state to have taken a lead in rolling out ANMOL for ANMs and it needs to further improve its use.

5. 292 MMUs and now the state is planning to have 600+ MMUs.

6. AP has also started giving a lump sum amount to ASHAs which few states has done
Exercise -

Each trainee will be handed over a card and will be asked to write two perceived investment and two perceived benefit in CHW perspective and System perspective. All cards will be collated and final points noted down. The whole group then be asked to come up with a plan for addressing the threats perceived threats and how they would be taken care of.
Thank You