



# GUIDEBOOK

## for Enhancing Performance of Auxiliary Nurse Midwife (ANM) in Urban Areas

March 2017



NATIONAL URBAN HEALTH MISSION

Ministry of Health and Family Welfare  
Government of India





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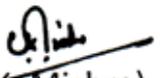
## **PREFACE**

The National Urban Health Mission was launched to address the primary healthcare needs of the urban population, and in particular, the specific health needs of the urban poor and vulnerable. Addressing these needs requires a deep understanding of their living situations and everyday challenges, and how the external environment impacts their physical and mental wellbeing.

The frontline health workforce such as the ANMs and the ASHAs have very crucial role in helping the people living in slums and slum-like habitations, not only for their health needs but also for various social and environmental factors affecting their health. The Mission envisages them to connect the marginalized with the public health system, to enhance the responsiveness of the system towards their health needs, to deliver certain services and to be champion of their rights and entitlements.

This training module will help the ANMs in understanding their roles, responsibilities and duties within the Urban Health Mission. It will also provide them with the necessary perspective to develop awareness and empathy towards the plethora of social and economic challenges faced by the population, which shape their health seeking behaviour and health outcomes.

I appreciate the efforts undertaken by the Urban Health Division of the Ministry, NHSRC and other experts in bringing out this document, which will be a good resource not only for the ANMs but also other personal working under NUHM.

  
(C.K. Mishra)





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## **FOREWORD**

Providing healthcare to the vulnerable and disadvantaged groups in the urban area is the core focus of the National Urban Health Mission, in addition to serving the larger urban population. It is well established that urban health issues are distinct and require new skills and capacities to understand and respond to the differential health needs.

The role of the ANM is critical to the success of the Mission. ANMs are the crucial component which connects the ASHAs and the communities with the public health system. In view of the emerging disease burden, the ANM's role has been expanded to enable her to address communicable and noncommunicable diseases, in addition to her traditionally RCH centric functions. Thus, under NUHM, ANM is a health worker whose clinical role is as significant as her presence in the community.

With the ANMs playing the role envisaged for them, it is hoped that the Mission will get the necessary fillip and reach out to the vulnerable groups in the urban areas. A well trained and well performing ANM will ensure that her allocated 10,000 population is being reached out with the defined basic primary healthcare including NCD services either through her or the ASHAs under her. This, when operationalized, will be a significant achievement under the Mission, taking it closer to its objective.

I hope the states will implement training based on this module, and utilize this document for bringing about all-round development of the ANMs.

  
(Arun K Panda)

**Healthy Village, Healthy Nation**







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## Foreword

Under National Urban Health Mission, it is very important for the ANM to understand the demography of her population so that she does not miss the vulnerable households who require her services. While NUHM is under the larger umbrella of the National Health Mission, the purpose of creating a separate training module for ANMs was felt so as to communicate to the ANMs their role enlightenment in the urban context. While NUHM does not expect ANMs to have different skills from their rural counterpart, they surely need a new perspective and orientation to understand and cater to the needs of the urban poor.

In a rapidly changing urban environment leading to diverse health needs of the population, the UPHC team and the ANM in particular needs to be ready to address diverse health seeking behaviour with interventions. In this context, she needs to possess skills to understand and adapt to her specific context and respond effectively. She needs to be sensitive enough to empathize with diverse urban groups such as the elderly, differently abled, transgenders, people living with HIV and AIDS, various other social and occupational groups. She also requires skills to guide the ASHAs under her supervision to help the urban vulnerable in need of their services.

This document aims to sensitize the ANMs to the issues of the urban poor, help her understand her roles and responsibilities and provides her and the MO-IC of the UPHC plan her work schedules. This document also helps the MO and the ANMs to analyse the performance of the ANMs and help her reach her full potential while serving the community.

I hope these guidelines will help to bring clarity not only for the functioning of the ANM but also helps in the implementation of the programme at the UPHC level.

**(Dr. K. Rajeswara Rao)**





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# INTRODUCTION



The National Urban Health Mission is a sub-mission under the National Health Mission, which aims to cater to the unique and diverse needs of the urban poor and vulnerable population. To reach out to the urban marginalized population – a key priority for NUHM – a well-trained and motivated frontline health workforce is essential. In particular, the Auxiliary Nurse Midwife (ANM) is the backbone of the urban health care delivery system. They form an important link between the Urban Primary Health Centers and the community, ensuring no one is left without access to basic primary health services.

The role of the ANM under NUHM encompasses provision of not only RCH related services but also basic services for communicable and non-communicable diseases including disease surveillance. Depending upon the specific needs of the population, her role will include:

- Identifying vulnerable populations and health needs
- Responding to area specific endemic diseases
- Supporting national and state program activities
- Supervising and facilitating ASHAs
- Supporting formation of Mahila Arogya Samitis (MAS)
- Conducting outreach sessions, patient record maintenance and follow up for continued care
- Participate in Inter-sectoral collaboration with Urban Local Bodies (ULB) including non-health departments (such as water and sanitation) and programs such as ICDS.

While urban areas offer proximity to high level health facilities, there are many barriers to actually accessing the care that is available. These barriers include:

- High costs of drugs and diagnostics leading to out of pocket expenditure
- Inconvenient OPD timings
- Apathetic behaviour of health providers
- Distance and overcrowding

Also, primary health care under the public sector remains inadequate and limited in urban areas. **The ANM through her services shall aim to overcome these barriers and provide accessible primary health care facilities** to those who are unable to physically, financially and 'socially' access them.

This guidebook provides clarity on the roles and responsibilities of the ANM against the backdrop of urban vulnerability and health, and in the context of NUHM programme components and processes. It is important that the ANM is oriented on important skills required to enable delivery of her duties in an effective and compassionate manner. This includes administrative, managerial and other soft skills such as leadership, team working, effective communication (both with patients and other health functionaries), enabling community participation, and developing community linkages with other departments and urban local body representatives.

To this end, this guidebook is designed to orient the ANM on the following broad areas:

1. Vulnerabilities and marginalization of the urban poor and their diverse health needs
2. Components and processes of the NUHM
3. Roles and responsibilities of the ANM
4. Interpersonal skill development of the ANM
5. Performance Assessment of the ANM

**Section 1** aims to develop an understanding of **urbanization and its effect on health status**, and of the everyday vulnerabilities and challenges faced by the urban poor. This section aims to develop a perspective on urbanization and provide information on the hardships faced by the urban poor. After reading this section, the ANM will have a better understanding of the context of urbanization and urban poverty – and this will help her better identify and meet their needs.

**Section 2** details out **program components** such as program structure, staffing patterns, formation of MAS, role of urban local bodies and other stakeholders. After reading this section, the ANM will better understand the programmatic structure of the NUHM, and where she fits in it. This will help her understand her workplace and therefore help her perform her job role with confidence.

**Section 3** provides a detailed description of **roles and job responsibilities of the ANM**. Besides RCH services, the section covers her role in communicable and non-communicable diseases, disability, mental health and in developing community based linkages with Urban Local Bodies and other urban stakeholders. It also identifies her administrative and supervisory/management responsibilities. After reading this section, the ANM will understand her job responsibilities.

**Section 4** elaborates on the **soft skills** required for the ANM to perform her duties. The various topics of interpersonal skill development include leadership, management, decision making, effective communication, negotiation and coordination, without the use of which achieving the desired outcomes may be difficult. After reading this section, the ANM will have an understanding of the soft skills required to effectively perform her role.

**Section 5** describes the process of **performance assessment** of the ANM, which is to be done both by the ANM herself and by her supervisor.

Technical information on different health programs like NCDs, disease control programs, MCH and other relevant initiatives is already available in various MoHFW approved guidelines. However, if the need for a comprehensive integrated training package is identified by states, this can also be developed subsequently.

This guidebook will enable the ANM to be an empowered, aware and sensitive health worker at the UPHC. The content is tailored to provide technical details on knowledge, skills and attitude required for efficient service delivery. They will be able to develop skills in identifying and responding to the needs of the urban poor and vulnerable, provide leadership to the team of ASHAs supervised by them and skillfully execute and implement the National Urban Health Mission.

## SECTION

## 1

## THE URBAN CONTEXT

Understanding the extent of vulnerability in the urban population is the foundation of NUHM. For this reason, details about the socio-economic context of the urban poor are provided below. Understanding vulnerability helps us to understand how to target the services to those most in need.

## 1. Defining Urban Areas

Urban areas are characterised by high economic activity, diversity of livelihood opportunities and high population density. While in rural areas, people mainly work in agriculture, in cities people are engaged in many jobs. Cities are centres of business, commerce and economic activity and have more employment opportunities. Generally, a city has more well developed and structured infrastructure, schools, buildings, residential complexes, roads and transport facilities compared to rural areas.

An important distinction between an urban and a rural area is the density of population. An urban area is one where the density of population is high, as compared to rural areas. For example, the density of population of Bangalore Urban district is 4378 people per square km, while that of Bangalore Rural district is only 431 persons per square km.

For the Census of India 2011, the definition of urban area is as follows:

1. All places with a municipality, corporation, cantonment board or notified town area committee, etc.
2. All other places which satisfy the following criteria: i) A minimum population of 5,000; ii) At least 75 per cent of the male main working population engaged in non-agricultural pursuits; and iii) A density of population of at least 400 persons per sq. km.

An urban area is typically surrounded by rural areas. Due to increasing urban population and expansion of city infrastructure, cities have started to expand, leading to even larger cities.

## 2. Urbanization

Urbanization, in simple terms, means the increase in the proportion of people living in urban areas, as compared to rural areas. The increase in population is accompanied by a physical increase in urban areas and the growth of infrastructure, including commercial and residential structures. India is becoming more urbanized, with the proportion of urban population increasing from 11.4% in 1901, to 28.53% in 2001 and 31% in 2011, and is expected to increase to 50% over the next few decades. The increase in the last couple of decades has been particularly rapid.

Urban growth in India is influenced by three factors:

- Natural population growth

- Migration from rural to urban areas, and
- Transformation of rural or peri-urban areas into urban areas.

While the biggest addition to the urban population is due to the natural population growth, migration plays a significant role in the increase of urban populations.

India has cities of various sizes and populations. New Delhi and Tumkur (in Karnataka) are both cities but vary greatly in terms of population, area, infrastructure, facilities and resources available. India has 75 cities with a population of one million or above as per Urban Development Ministry, Govt. Known as Million Plus cities, these are the major urban centers in the country. Among the Million Plus Cities, there are three very large urban agglomerations (UA) with more than 10 million persons in the country, known as Mega Cities. These are Greater Mumbai (18.4 million), Delhi (16.3 million) and Kolkata (14.1 million). The largest UA in the country is Greater Mumbai UA followed by Delhi UA. These and other major cities in India like Ahmedabad, Bangalore, Chennai and Hyderabad, are also called metropolitan cities.

## Implications of Urbanization

The rapid increase in urbanization has led to more people living in cities, than the resources available to sustain a safe and healthy living environment for all. Urbanization often leads to overcrowding, an increase in slums and poor quality housing, competition for resources, air, water and noise pollution and an increase in traffic. Most Indian cities lack the necessary infrastructure in terms of housing, water and sanitation, employment opportunities, and basic services such as health care and education to accommodate the needs of the urban poor. This has implications for their health, wellbeing and productivity.

### Urbanization: Good or Bad?

Urbanization is a demographic trend that many countries are witnessing today. Urbanization and globalization go hand in hand, and are considered inevitable in today's rapidly developing world. While urbanization has very clear advantages, it also has some undesirable side-effects. Think over the positive and negative impacts of urbanization. What can be done to mitigate the negative impact of urbanization? What can the government and we, as a society do?

This increases inequality – with large gaps between the rich and poor. Thus, cities present two stark extremes – one with extreme poverty and deprivation of basic needs and the other with extreme wealth and prosperity. In a typical city, there may be areas where residents are extremely wealthy, and areas like slums where families cannot even afford meals for their family. Further, unlike in rural areas where food and other items may be obtained from nature free of cost, in urban areas everything needs to be purchased.

The root cause of the problem is not with urbanization as such, it is with the lack of appropriate planning to accommodate the increasing population in the urban space, and to generate or procure adequate resources for decent living for all.

## Migration

Migrants are drawn to urban areas for employment opportunities and to establish a better life for themselves and their families. Rural to urban migration involves both 'urban pull' and also 'rural push' factors. Factors such as lack of land-holdings, lack of viable economic opportunities, difficulty in sustaining profitable agricultural practices, and inadequate amenities and infrastructure often 'push' rural families or head of households out of rural areas towards urban areas in search of better opportunities.

People migrating to cities are often employed on daily wages in the unorganized sector as rickshaw pullers, construction workers, factory workers, head loaders and other similar vocations. Safe, affordable and good quality housing is limited in cities, and migrants often live on the margins in slums or slum-like housing, with poor sanitation, water supply and inadequate space. The next section expands on some of these issues and helps develop an understanding of 'urban vulnerability'.

### 3. Challenges Faced by the Urban Poor and Vulnerable

Although the urban poor share the same spaces and resources as the wealthy populations, they are more vulnerable to the harsh living environment of the city. A range of factors including their economic and social status, location and type of their home and work increases their vulnerability by exposing them to a number of health hazards.

#### Types of Vulnerability

The urban poor live a socially and economically insecure life, which may directly or indirectly impact their health. Their vulnerability comes from a range of factors:

1. **Residential Vulnerability:** This includes persons and households that are vulnerable because of their location, nature and type of residence. This includes those who are homeless, live in slum or slum like habitations, face insecurity of tenure and are unserved or under-served with basic public services like sanitation, clean drinking water and drainage.
2. **Occupational Vulnerability:** This includes persons who are subject to unsanitary, unhealthy and hazardous work conditions, have irregular or unpredictable incomes or are unemployed. For example, those working in the informal sector, daily wage labourers, factory workers working without adequate safety equipment, sanitation workers without adequate protective equipment and, bonded labour are occupationally vulnerable.
3. **Social Vulnerability:** This includes those who face problems due to their social circumstances in terms of caste, class, gender, physical abilities and age. For example, widows, the transgender community, the elderly, the disabled and those belonging to scheduled castes and tribes face discrimination in their everyday life because of their disadvantaged social status. Social vulnerability and discrimination hinders access to resources such as health services, education and access to government schemes and programs.

The above-mentioned vulnerabilities do not exist in isolation. Most individuals and families living in urban areas face multiple and overlapping vulnerabilities, which exacerbate the impact of other factors – those in unhygienic and unsafe slum housing often work in hazardous conditions and may also be socially excluded. The combined effect of all vulnerabilities on one family or individual has a negative impact on their well-being and health. This increases their risk of disease and/or injury, while reducing their opportunity to access affordable health care when needed.

#### Factors Contributing to Urban Vulnerability

The vulnerability of the diverse urban poor population derives from four interconnected factors:

1. The harsh urban environment
2. Lack of social networks /supports
3. Monetization of basic needs
4. Limited access to social security schemes

## 1. The Harsh Urban Environment

Pollution, makeshift housing and high population density all contribute to a harsh and unsafe environment, especially for the poor. Living in makeshift, temporary constructions of plastic, brick, tin, and other waste materials (that may be unsafe and hazardous) or on roads, under flyovers and railway platforms, they are **exposed to extreme weather** conditions of heat and cold. During rains, such housing may experience flooding, exposing residents to drain water and sewage material, making them susceptible to outbreaks of infectious diseases and injuries. They are also **easy targets of crime**, physical assault, theft, kidnapping, abduction and accidents. Children, adolescent girls and women are particularly at risk of sexual violence. The general living environment is unsafe and hazardous – with unprotected electricity wires, open pits and drains and fragile construction, as a part of their surroundings. Many urban poor live on or near landfills, garbage dumps, factories, open drains, construction sites and are at risk of floods, infections, pollution and effluent exposure.

Some of the specific challenges include:

- Basic services such as safe and adequate drinking water, electricity, garbage disposal, sanitation facilities are either lacking or of very poor quality.
- Toilets, where present, are often shared by a large number of people, and may even be unaffordable (pay-per-use) in cases of large families.
- Congested living conditions exacerbate the risk of fecal contamination and infectious diseases such as tuberculosis, acute respiratory infections, and various skin disorders.
- People living in temporary or *kutchra* housing live under the constant threat of eviction and demolition of their housing, as part of city 'clean-up' drives.

Like their living environment, **their work environment too is often hazardous**. Laborers and construction workers work at minimum wage and generally without adequate safety equipment. Due to lack of extended family or social support, women workers often have to take their children along to factories or construction sites, exposing them to a hazardous and unprotected environment.

## 2. Lack of Social Networks

Social networks play a critical role in urban residents' living experience and also influence their health behaviors and health outcomes. **Strong social networks promote emotional wellbeing**, through different kinds of support – emotional, financial or practical. The lack of such networks and support structures, strained social relationships and marginalization place urban dwellers at risk for common mental disorders, including depression, schizophrenia, substance abuse, alcoholism and crime.

Certain communities also face marginalization because they belong to a particular group such as sex workers, rag pickers or waste workers, transgenders, homeless, mentally ill etc. These groups are often *excluded from* accessing and participating in various aspects of urban life including health care, education, employment, and even basic amenities such as housing, sanitation and food.

## 3. Monetization of Basic Needs

The cost of living in urban areas is much more than that of villages. Sharing of resources in rural areas such as farm animals, fuel, each other's harvest and other commodities is common. In contrast, in urban areas, most commodities have to be paid for - including the use of bathrooms and toilets. Blankets and mattresses in winters and fans and coolers in summers are rented out per night for the homeless.

This makes access to even basic amenities unaffordable for the urban poor. Regular expenditure on rents for housing, fruits and vegetables, food items, clothing and other basic necessities makes living in the urban area prohibitive for the poor.

#### 4. Limited Access to Social Security Schemes

Most of the urban poor, typically migrants, are not considered 'legitimate' citizens of cities. Their *kutcha* housing is often declared 'illegal' and under threat of demolition. Although the government has many schemes for populations Below the Poverty Line (BPL), accessing services for the urban poor is complicated as they may live in areas that are not officially recognized and proving their identity or providing official documentation is often a challenge.

For example, children from many urban poor and migrant populations are not entitled to admission in schools due to lack of proper identification documents with their parents. Similarly proving their entitlements to various subsidies and accessing basic services such as the public distribution system (PDS) remains a challenge.

#### Barriers to Accessing Care in Urban Settings

Barriers to accessing health in urban areas are distinct from those in rural areas. With shorter distances and availability of public transport, geographical access is not as big a barrier in urban areas. There are also many qualified doctors and nurses working in cities. However, there are other barriers to accessing care:

- **Limited availability of government primary health care services:** Primary health care facilities in urban areas are limited in number; where they exist they offer a limited range of services. Most urban residents thus access 'larger' or secondary/tertiary hospitals even for minor ailments.
- **Overcrowding in public hospitals:** Secondary and tertiary public hospitals are generally too crowded to provide timely and adequate care to all. Shortages of drugs, supplies and diagnostic facilities are common, and many patients are forced to procure products and diagnostic services from other private providers due to lengthy waiting times. There are reports of patients lining up at OPD queues in the early hours of the morning for counters that open at 8 am.
- **Unprofessional and rude behaviour towards the urban poor:** The poor and vulnerable are often treated with disrespect and hostility by service providers, and at times even refused treatment. Special needs groups such as elderly, disabled and transgender have a very difficult time navigating the system.
- **High cost of drugs and diagnostics:** Accessing both public and private care can involve high costs and out of pocket expenditure, which can be unaffordable for the urban poor.
- **Out of physical reach:** Navigating the city and its hospitals may be physically impossible for the disabled and the elderly, as most are not disabled friendly. Dependence on care givers further limits their access.
- **Inconvenient timings:** As most public health services open in the morning hours, consulting a doctor may mean the loss of a day's wage for the poor. The alternative is to go to private doctors during evening hours, even though they have to pay for their services.

Thus the urban poor face physical, social, and economic constraints to accessing public health care. As a result, many seek health care from a range of licensed and unlicensed providers, or seek health care only

when their health condition becomes severe - or do not seek health care at all. The out of pocket expenses are substantial and cause severe financial strain.

The NUHM attempts to address some of these challenges and provide accessible and affordable quality health care services for the marginalized and disadvantaged urban poor. It has developed a systematic institutional structure for addressing their diverse needs. The next section provides details of the program components of NUHM.

## SECTION

## 2

## NATIONAL URBAN HEALTH MISSION



The National Urban Health Mission builds on the principles of the National Rural Health Mission; it has been tailored to the urban context and certain specific aspects have been built into the Mission to reach out to the most marginalized. According to the NUHM Framework for Implementation, the NUHM will focus on:

- The urban poor population living in listed and unlisted slums
- All other vulnerable populations such as the homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers and other temporary migrants.
- Sanitation, clean drinking water, vector control and related issues
- Strengthening the public health capacity of urban local bodies

## 1. Institutional Framework

For the implementation of NRHM, State Program Management Units and District Program Management Units were created in all states and districts. For NUHM also, the same structures shall be utilized, but with additional staff added. Only cities where no prior comprehensive health system was in place, shall have new program management units, called as 'City Program Management Unit', placed under the Urban Local Bodies.

The implementation of NUHM is to be done jointly by the Health Department and the Urban Local Bodies such as Municipal Corporation and municipalities. In large cities such as Mumbai, Bangalore and Chennai, the implementation shall be done by Municipal Corporations, and in smaller and non-metro cities, the implementation shall be done by the Health Department, but with close collaboration and help of the ULBs. The involvement of ULBs thus is very important for all types of cities and at all levels. This is because the ULBs are responsible for basic services such as water, sanitation, vector control, housing which directly impact health outcomes of the population.

The key features of the NUHM include:

- **Facilities** such as the Urban Primary Health Center (UPHC) and Urban Community Health Center (UCHC).
- **Structured outreach activities** in the form of Urban Health and Nutrition Days (UHND) and Special Outreach Camps.
- **Community Groups** of women from slum and slum like housing in the form of **Mahila Aarogya Samitis**.
- **Working Jointly (known as 'Convergence')** with other departments such as ICDS, Municipalities, Water, Sanitation and others related to health.

The National Urban Health Mission includes the following services, health workers and community structures based on the population served:

Population Served		Health Facility/Worker
2.5 lakh population (5 lakhs for metros)	→	1 UCHC (30-50 bedded in-patient facility)
50,000 population	→	1 UPHC (OPD facility)
10,000 population	→	1 ANM
1000-2500 population (200-500 households)	→	Community Health Volunteer (ASHA)
250-500 Population (50-100 households)	→	Mahila Aarogya Samiti

## 2. The Urban Primary Health Center

Unlike in the National Rural Health Mission, there are no sub centers envisaged under the NUHM plans as geographical distances in accessing health services are not as great as in rural areas. The first point of contact under the NUHM is the Urban Primary Health Center. This is where the ANM will be posted. Key characteristics of the UPHC include:

- a. **Population coverage:** Depending on the spatial distribution of the slum population, the population covered by a UPHC may vary from 30,000 to 50,000 for cities with sparse slum populations to 75,000 for highly concentrated slums.
- b. **Timings:** The hours of operation must enable the urban working population to conveniently access the UPHC. States may opt for any suitable timings, provided the UPHC provides 8 hours of service, which are convenient to the community, with evening OPD (for eg. 8am to 12pm and 4pm to 8pm). Dual shift timing of UPHC should be flexible with the ability to be modified according to the convenience of vulnerable and marginalised communities.
- c. **Location:** The UPHC should be located in close proximity to slums e.g. about half a kilometre from a slum or slum-like habitation. If more than one slum exist in the catchment area, the slum with largest population could be considered as reference point for the location of UPHC.
- d. **Service provision:** The UPHC's key responsibility is to provide comprehensive preventive, promotive and non-domiciliary curative care. Services provided by U-PHC include:
  - i. OPD (consultation)
  - ii. Basic lab diagnosis (List attached as Annexure 2)
  - iii. Drug /contraceptive dispensing

- iv. Delivery of Reproductive & Child Health (RCH) services
- v. Preventive, promotive and where appropriate, curative aspects of communicable and non-communicable diseases.
- vi. Minor surgical procedures
- vii. Counselling and Help Desk
- viii. Organize outreach services (routine UHNDs and special outreach)
- ix. Patient referrals and follow up

To strengthen the delivery of specialized OPD care, UPHCs can utilize the services of specialists on a weekly basis. As per the NUHM framework, the UPHC does not have provision for in-patient care. However, some states may include in-patient care, if it emerges as a need for the community.

- e. **Staff Structure:** There is a team of about 15 personnel at the UPHC and the staff structure is as follows:

Cadre	Number at UPHC
Medical Officer In-Charge (MO I/C)	1
2nd MO (part time)	1
LHV	1
Nurse	1
Lab Technician	1
Pharmacist	1
ANMs	3-5
Public Health Manager/ Mobilization Officer	1
Support Staff	3
Monitoring & Evaluation Unit	1

At the UPHC, every ANM will be responsible for a population of approximately 10,000. Since a UPHC covers an average 30,000-50,000 population, it will have 3-5 ANM.

#### f. Mapping and Vulnerability assessment of UPHC catchment area

**Understanding the extent of vulnerability in the urban population is the foundation of NUHM.**

In order to plan services such as outreach session, special outreach camps and screenings, it is important to understand: which are the vulnerable groups in your UPHC catchment area? What is their population? Where do they live? What is their occupation? What are their special health needs? Are they at risk of specific diseases because of their location, type of housing, occupation or their social status? Answers to these questions will tell us what services should be provided and how best they can be reached. This is called vulnerability assessment.

For this, the UPHC should **prepare a map of its catchment area and identify locations of slums and other locations where the urban vulnerable reside**. Further, as directed by the state, a **house to house survey** needs to be done to find out the above information. The survey tool for such a survey shall be provided by your state.

The urban ASHAs are also required to conduct a basic vulnerability assessment for their specified households. Areas that are not under any ASHA should also be covered by the ANM.

## Role of ANM in UPHC Mapping and Vulnerability Assessment

### UPHC Mapping

1. Find out from your Public Health Manager or Medical Officer about how vulnerability assessment shall be conducted for your UPHC. This decision would be taken by your state and communicated to your UPHC. Further ask your supervisor about your role in the vulnerability assessment in your population.
2. Along with other ANMs and Public Health Manager (if present), create a map of the UPHC catchment area for your UPHC, with the help of your supervisor on a big chart paper. You can also check if GIS maps are available in your state, and how you can refer to them from your supervisor.
3. While making your map, clearly mark all slums, low income housing, your UPHC, anganwadi centers, and all other landmarks such as schools, water bodies, large drains, landfill sites, other health facilities etc. Areas of each ANM should also be marked on the map.
4. The map will help you in identifying if any areas or pockets of poor and vulnerable houses are being left out from coverage of any ASHA or ANM.

### Vulnerability Assessment

5. Guide the ASHAs under you in conducting the Vulnerability Assessment as per the tool given in the ASHA Training Module, in her households. Make note of the most vulnerable families and individuals identified from her survey, and ensure delivery of the needed services to them. Assist her in recording the survey data and understand the findings to improve her service delivery.
6. There may be some areas in your population which are not under any ASHA. Special attention must be given to such areas by you in identifying and serving the vulnerable in those areas. It may be ensured that the entire population is covered and special provision may be made so as to reach the whole population. From the above assessments and mapping, make sure you have identified the persons needing special services in your area. Make lists of: all 30+ persons for NCD screening, all eligible couples, all pregnant women, under 5 children, elderly, persons with special needs, disabled, at risk of TB, in contact with leprosy patients etc., and ensure service provision to them through home visits, outreach and other services.

### g. Innovative approaches

Depending on the health care needs of specify communities and existing resources, state may wish to consider innovative and alternative approaches for more effective and efficient service delivery. While there are many ways in which states can innovate delivery of urban health services, an example of health kiosk is briefly descried below:

#### Health Kiosks

As the NUHM does not have a provision for sub-centers, Health Kiosks (or nursing stations) can provide alternative infra-structural support. This alternative/innovative approach can be considered depending on the availability of adequate funds and existing human resources. These are prefabricated structures that can help ANMs in conducting outreach services. These can be set up where slums under a UPHC are distant, and it is not possible to create another UPHC, or where there is no adequate space within or near a slum to establish a UPHC. These may also be considered in unauthorized slums or in areas inhabited by communities at high risk of adverse health outcomes, e.g. commercial sex workers, street children, rag pickers, nomads etc.

These health kiosks will act as the first point of contact between the community and the health system and will be attached to the nearest Urban PHC. The services provided at Health Kiosks could include: Immunization services, Antenatal and postnatal care, Family planning - counselling and contraception services, Screening for anaemia and other non-communicable diseases such as BP, blood sugar, cancers, Sputum and Blood smear collection for detection of TB and Malaria, Health promotion activities.

### 3. Community Processes

Community processes under the NUHM are important for service provision, community mobilization and raising awareness about individual and community rights and entitlements. The **Urban ASHA** and **Mahila Aarogya Samitis** form the foundation of community processes under NUHM.

#### A) Urban ASHA

The role of an ASHA includes a mix of many tasks: facilitating access to health care services, raising awareness about health care entitlements especially amongst the poor and marginalized, promoting healthy behaviors, mobilizing for collective action for better health outcomes and providing curative care as appropriate to the organization of service delivery in that area and compatible with her training and skills. The role of the urban ASHA has similarities to that of the rural ASHA; she fulfills her role through five activities:

1. Home visits
2. Attending the Urban Health and Nutrition Day (UHND) and supporting outreach activities
3. Visits to the health facility (to accompany pregnant women, sick child or others needing facility based care).
4. Promotion of Mahila Aarogya Samitis
5. Maintaining records

The broad role of the ASHA is to:

1. **Awareness generation:** Create awareness on factors that determine health status and entitlements related to health and other related public services. She provides information to the community with a special focus on vulnerable groups - on the determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and facilities and the need for timely access to health services.
2. **Counselling:** Counsel women, families and adolescents on birth preparedness, the importance of safe delivery, breast feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infections and Sexually Transmitted Infections (RTIs/STIs), care of the young child, substance misuse, prevention of domestic violence and sexual violence.
3. **Curative care and supplies:** ASHA provides community level curative care for ailments such as diarrhoea, fevers, care for the normal and sick new-born, childhood illnesses, nutrition counselling and first aid. In some states, where trained, she also measures blood pressure and blood and urine sugar. She ensures compliance with Directly Observed Treatment Short-course (DOTS) under the Revised National Tuberculosis Control Programme and will provide appropriate community level care for other communicable diseases like malaria, Japanese encephalitis, chikungunya and leprosy. She also acts as a depot holder for essential health products like ORS-Zinc, Iron and Folic Acid tablets, Chloroquine, condoms, oral contraceptives, sanitary napkins and other products as appropriate to local community needs. Each ASHA is provided a Drug Kit.

4. **Community mobilization:** ASHAs mobilize the community and facilitate people's access to health services available at the AWC, Primary Urban Health Centres urban secondary and tertiary health centres for services including institutional delivery, immunizations, ante natal care (ANC), post-natal care (PNC) and related activities. She will arrange an escort or accompany pregnant women and children requiring treatment or admission to the nearest pre- identified health facility i.e. Urban Primary Health Centre, Community Health Centre, First Referral Unit (CHC/FRU). This escort role is important if the beneficiary is homeless or belongs to a marginalized community.
5. **MAS coordination:** She will work with the Mahila Aarogya Samiti to promote convergent action by the committee on the social determinants of health and take action to improve access of vulnerable groups to various public services. With the support of MAS, ASHAs will assist and mobilize the community for action on gender based violence, alcohol and drug misuse, mental health issues and raise awareness about irrational drug use and the sometimes exploitative practices of private health practitioners. She will work on issues of water and sanitation in coordination with Mahila Aarogya Samitis and enable construction and use of household/community toilets and promote sanitation and hygiene in the community.
6. **Information:** The ASHA will provide information on births and deaths in her area and any unusual health problems/disease outbreaks in the community to the Urban Primary Health Centre.

## B) Mahila Aarogya Samitis

Mahila Aarogya Samiti (MAS) are local women's collectives that are expected to champion and take proactive action on issues related to health, nutrition, water, sanitation and other social determinants for their local community at the slum/ward level. MAS are intended to be a leadership platform for local women to raise awareness, improve health seeking behavior, advocate for optimal utilization of services, increase community ownership and establish a community based monitoring system.

### Mahila Arogya Samiti (MAS)

- Local women's collective with an elected Chairperson and a Secretary
- Covers approximately 50-100 households in slum and slum like settlements. Addresses local issues related to Health, Nutrition, Water, Sanitation and social determinants of health at slum level.
- Facilitated by the ASHA who acts as the Member Secretary

### Objectives and Goals of MAS

1. To provide an institutional mechanism for the community to be informed about health and other government initiatives and to **participate in the planning and implementation of these programmes for better outcomes.**
2. To organize or facilitate community level services and improve referral linkages to health services for Maternal, New-born, Child health and Nutrition (MNCHN) issues and other related services for improved water, sanitation and hygiene (WASH), adolescent health, communicable and non-communicable disease control.
3. To provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
4. To provide a mechanism for the community to voice health needs, experiences and issues with access

to health services, such that institutions of local government and public health service providers can take note and respond appropriately.

5. To generate community awareness and coordinate action on MNCHN, WASH and locally relevant health issues and to promote the acceptance of best practises in health by community members.
6. To focus on preventive and promotive health care and promote positive health behaviour.
7. To manage MAS's untied funds.
8. To provide support and facilitate the work of community health workers like ASHA and other frontline health care providers that form a crucial interface between the community and health institutions.

**Composition of MAS:** Mahila Arogya Samiti should have 10-12 members, depending on the size of the slum, but the group should not be less than 8 and not more than 20 members. In case the MAS is formed in a slum with different social groups, representation should be ensured from all groups and from all pockets of the slum. The Urban ASHA will be the Member secretary of MAS.

**Characteristics of members of the MAS:** Local women willing to contribute to the 'well-being of the community' with a sense of social commitment and leadership skills should volunteer for the MAS. Members could include:

- Service users like pregnant women, lactating mothers, mothers with young children and patients with chronic diseases using public services should also be on the MAS.
- If the slum has self-help groups, Development of Women and Children in Urban Areas (DWCUA) groups, Neighborhood groups under SJSRY, thrift and credit groups etc., women from these groups should also be encouraged to participate in the MAS.

**Coverage of MAS:** The MAS is to be formed at slum level and is expected to cover approximately 50-100 households. However, this can be modified based on the circumstances in each slum e.g. small slum of less than 50 families can still form a MAS. In case there are Anganwadi Centers in the slum, the coverage of each MAS should be aligned with the coverage area of the Anganwadi Centre and should cover all pockets of the slum.

### Formation of the MAS

- a. **ASHA selection:** The selection of an ASHA for a designated "slum or vulnerable cluster" will be carried out by a women's group which can later potentially serve as the Mahila Arogya Samitis in that area.
- b. **Constitution of a team at slum level:** The ASHA, ASHA facilitator/Community organizer with support of NGO field functionary (if any), AWW and ANM will constitute a team for selecting the MAS members. As far as possible the community women's group involved in the selection of ASHA should be part of MAS. Each ASHA will supervise the formation of two-five MAS.
- c. **Meetings with slum women:** The team (ASHA and others) should conduct a series of meetings with women from the slum to understand their health issues and to sensitize these women about improving the health of the men, women and children in their slum. It is generally observed that the initial meetings attract a large number of slum women often out of curiosity or perhaps with expectations of some sort of monetary benefit.
- d. **Identification of active and committed women:** A period of 1-2 weeks is given for women to reflect, discuss with others and determine their commitment to serve their slum community on the MAS. Generally towards the 3rd or 4th meeting, the attendance falls and only the committed

continue attending. Each community responds differently and takes its own time to crystallize. Social acceptance is enhanced by talking to family members.

### MAS Grant

The NUHM provides an annual grant of Rs.5000 to the MAS. This amount can be used for conducting fortnightly/monthly meetings of MAS, sanitation and hygiene drives etc. To build the capacity of MAS, quarterly orientation workshops on issues such as the group organization, governance and management of the group, leadership skills etc. should be organized in the first year, and thereafter once every year.

## 4. Role of the Urban Local Bodies in NUHM

Urban Local Bodies (ULBs) are the local governance bodies in urban areas, similar to the Panchayats and Zila Parishads in rural areas. A ULB is classified into the 3 major categories:

- Mahanagar Nigam (Municipal Corporation)
- Nagar Palika (Municipality)
- Nagar Panchayat (Notified Area Council, City Council)

The municipal corporations and municipalities are representative bodies (meaning members are elected), while the notified area committees and town area committees are either fully or partially nominated bodies (meaning members are appointed). Currently, only large Municipal Corporations in large cities play an active role in providing health and medical services in their cities. In smaller cities, municipalities have little contribution in the health sector. However, **ULBs are responsible for services such as providing water, sanitation, waste disposal, education and other services, which have a direct impact on the health of urban populations.** Therefore, it is very important for the ULBs to be involved in the public health services of the city.

NUHM aims to increase the participation of ULBs in planning and implementation of health services. For larger cities, including metro cities, the NUHM is to be implemented through the Municipal Corporation. For smaller cities, NUHM will be implemented by the Health Department, with active involvement of the ULBs. In either case, there are some critical functions, which require close collaboration between NUHM and ULBs to positively influence the wider determinants of health, as follows:

1. Epidemic control (including control of vector borne diseases)
2. Disease surveillance
3. Treatment and disposal of sewage
4. Solid waste management including carcass disposal
5. Drinking water supply
6. Sanitation and prevention of public health nuisances
7. Dangerous and offensive trade, licensing (in particular slaughter house management, health safety in cinemas, restaurants etc.).
8. Food safety
9. Road safety, including street lighting
10. Birth and death registration
11. Management of cremations and burials
12. Control of stray dogs, and rabies control

13. Air pollution
14. Convergence of slum redevelopment and affordable housing
15. Implementation of welfare schemes for vulnerable populations, especially the homeless

### ANM and the ULB

ANM must be aware of the ULB's specific role in her catchment area. She should be clear on the demarcation of responsibility between the Ministry of Health and ULBs. ANMs must be aware of the ULB departments and members – both elected and non-elected – who are responsible for providing services in the UPHC area.

She should develop community linkages with ULB functionaries to help the community address their concerns such as water, sanitation, waste management and disposal, vector control, stray animal nuisance etc. She should be able to guide the ASHA in developing her linkages with the community.

It is also her role to identify/take note of issues from the community which are to be addressed by ULB, and are not being implemented properly and report to the PHM/MO. The PHM/MO shall then take it up with the ULB officials and advocate for expedited redressal.

## 5. Outreach Activities under NUHM

Outreach is a critical component of primary health care. It serves to expand the reach and coverage of health services to the urban poor population living in listed and unlisted slums and other vulnerable groups such as the homeless, rag pickers, street children, migrants, men and women suffering from physical violence, discrimination and exploitation. A strong outreach program is critical to connect with the most marginalized and vulnerable populations. Community based outreach sessions in the slums are the first step in the continuum of care linking primary to secondary and tertiary care services. Operational guidelines for conducting outreach camps under NUHM have been prepared. The ANM should refer to these guidelines for smooth conduct of these activities. As per the guidelines, under the NUHM, two types of Outreach Services are envisaged:

### I. Outreach through Urban Health and Nutrition Days (UHND)

The UHND is a platform for people to access services for a package of preventive, promotive and basic curative care. It is held at the Anganwadi Centre (AWC), primary schools or a suitable community space where these services can be provided on a regular basis. Beside the above, community structure constructed under the schemes of the various Departments e.g. UD, HUPA, WCD, Social Welfare i.e. RAY, IHSDP and JnNURM etc could be utilized as fixed points for providing periodic outreach services.

ASHA and MAS members are responsible for mobilizing the community to the UHND which is intended as a convergence platform for services to be provided by the ANM and the Anganwadi Worker (AWW). The UHND is also an occasion for health promotion on a number of key health related issues.

#### Organizing a UHND:

Organizing a UHND is based on the spread and distribution of the catchment area of each Urban PHC and should be organized closer to the marginalized and vulnerable population settlements

- In order to minimize barriers to geographic access, the UHND should be organized in areas which are distant from the Urban PHC or other primary care facilities provided by the government.

Its timings should be flexible and take into account the occupation of its inhabitants, especially being sensitive towards daily wage earners.

- The space for the UHND is to be facilitated by the Urban PHC, City Health Society, Urban Local body.
- The MO-IC of the Urban PHC is responsible for ensuring the development of an annual calendar for the UHND in their catchment area, and reviewing the coverage and quality of UHND services and ensuring the timely submission of monthly and quarterly reports by the ANM.
- The ASHA with the support of the MAS will prepare a list of people requiring services at the UHND and make a special effort to include marginalized individuals and families such as new migrants and the homeless and those living in distant areas.
- She will also inform the community and the MAS members about the date and timing of the UHND to ensure improved coverage and access.
- It will be the responsibility of the ANM to provide services to UHND clients, including pregnant women, newborn and sick children, adolescents and eligible couples and a basic level of curative care for minor illness/injury - with appropriate referral where needed.
- If more than one AWC exists in the catchment area of the ANM, the feasibility of merging UHND sessions for two or more AWCs should be explored while ensuring that there is minimum inconvenience to the community.
- If this option is not feasible, then a rotational plan should be introduced covering one AWC at a time on a pre-agreed fixed day basis. In such cases two days in a week may be chosen to organizing UHNDs.
- For screening and management of chronic diseases particularly common cancers, diabetes and hypertension, the ANM will undertake screening, including blood pressure and blood glucose measurement at the UHND.
- Those with abnormal findings will be referred to the appropriate facility for confirmation and initiation of treatment plans. The UHND can also be used for the follow-up management of these patients.

### Role of ANM in Organizing a UHND

- **Microplanning of UHND:** With approval/supervision of MO and PHM, the ANM must prepare UHND microplans, ensuring coverage of all vulnerable areas in her 10,000 population.
- **Ensure adequate awareness about the UHND:** Along with ASHA, Anganwadi worker, MAS groups, local NGO workers, ULB members, she must ensure that the target population is aware of the location, day and timing of the outreach session. The PHM or MO must provide support for making public announcements, printing of pamphlets etc. for the same.
- **Ensure attendance:** ANM must ensure that all due list patients and the highly vulnerable (as per assessment) attend the UHND, coordinating with the ASHA for the same.
- **Supply and logistics:** ANM must ensure that the location is appropriate and all vaccines, supplies and equipment are taken to the site on the day of the UHND.
- **Ensure that all services defined** for the UHND are delivered as per protocol. (Refer Operational Guidelines conducting Outreach Sessions in Urban Areas, 2015, MoHFW)
- **Systematic reporting:** Ensure that there is systematic recording of all attendees of the UHND, and that prescribed formats for UHND reporting all filled and submitted
- **Referral:** Ensure that all patients requiring a referral or medical attention are referred, and are followed up. Refer all 30+ attendees for NCD screening also.

## II. Special Outreach Sessions

Special Outreach Sessions are designed for hard-to-reach groups and communities. These sessions are in addition to the routine outreach services provided through the UHND. Special outreach sessions could focus on specialized services such as chronic diseases screening, detection of developmental delays, childhood disability, geriatric care, dental services, etc. Though the special outreach sessions are not designed to provide routine RCH services, these sessions/camps should not miss the opportunity to provide these routine services to the needy.

### Organizing a Special Outreach Session

Special Outreach Sessions may involve provision of services by specialists (including Gynecologists, Dermatologists, Ophthalmologists, Psychiatrists, Dentists, ENT surgeons, Orthopedic Surgeons) and other health professionals such as nurses, laboratory technicians, physiotherapists, occupational therapists, optometrists, clinical psychologists, medical social workers and pharmacists.

The steps in organizing a special outreach session are given below:

- ASHAs and MAS, facilitated by the ANM have a key role in mapping their populations, to identify vulnerable subgroups and understand their health needs.
- Based on the needs identified, the UPHC will plan services to be provided through Special Outreach Camps.
- The local UPHC should develop a calendar of services to be provided each month, which could offer different specialist services, rehabilitation and other curative services.
- Point of care diagnostics will facilitate management and initiation of treatment (e.g. for blood glucose, urine protein, Hb, Malaria). Test results must be reported back promptly to ensure timely management.
- The ASHA could serve as the focal point person for both communicating the test report and enabling follow up action. The use of mobile phones would facilitate this process.
- There must be a mechanism for the UPHC to follow up after these special sessions. Such follow up should be facilitated by the ANM/ASHA to ensure patients receive the follow up care required.
- Planning and implementation of such special outreach sessions should engage with relevant departments and NGOs to ensure that social support services are made available e.g. access to food, clothing, shelter, prosthetic support etc. Special Outreach Sessions for the homeless population should involve engagement with de-addiction centres if this is identified as an issue with this population.
- Planning and implementing UHNDs and Special Outreach sessions is summarized in the table below:

	Urban Health & Nutrition Day (UHND)	Special Outreach Sessions
<b>WHERE: Site of providing the Service</b>	Anganwadi Centre (AWC) or any other community level structure in slum	Space or structure at the community level in slum/near vulnerable population (Community Centre, School which may be near Railway Station, railway tracks, city outskirts, Bus Stand, underpasses, outside place of worship, etc.).

	Urban Health & Nutrition Day (UHND)	Special Outreach Sessions
<b>WHO: Population coverage</b>	Slum and vulnerable population (women and children) in the catchment areas of the UPHC. The already identified patients needing follow-up may be catered to by providing medicines.	Vulnerable groups; emphasis on the most disadvantaged and hardest to reach (migrant labourers, homeless, etc.).  Target population for the specific services ie. All women in a special outreach session being conducted for screening for breast/cervical cancer.
<b>WHAT: Service Coverage</b>	ANC, Immunisation, Health Education, Child Growth Monitoring, Nutrition Supplementation, Nutrition Counselling, education on Water Sanitation and Hygiene, Use of RDK, Drug Dispensing.	Health check-up (routine, for locally endemic diseases and population sub group specific problems), screening and follow-up (for chronic and non-communicable diseases), basic laboratory investigations (using portable /disposable kits), and drug dispensing
<b>BY WHOM:</b>	ANM supported by team of ASHA, AWW, and MAS members	Doctors/Specialists, Lab Tech, Pharmacist, physiotherapists, social workers etc.  Supported by MO-UPHC, with ANM and ASHA, MAS members and community volunteers
<b>WHEN: Frequency</b>	Monthly	Periodic (as per the local needs in community).

### NCD Screening Sessions:

The Ministry of Health & Family Welfare guidelines on NCD screening recommend a population based screening approach to ensure maximum coverage in a systematic manner. Until such arrangements can be scaled up across states, any occasion for opportunistic screening should not be missed especially for conditions like hypertension, diabetes and common cancers. This could be provided at the facility or through outreach activities. (e.g. screening camps). It is also recommended that fixed days are designated for such screening camps.

### Role of ANM in organizing Special Outreach Camps

- Ensure awareness about the camp: Make all necessary arrangements for creating awareness about the location, time, specialty of the camp. Special attention to mobilization of the vulnerable groups should be paid, in coordination with ASHA and AWW.
- Ensure attendance: In coordination with the ASHA, ensure that all listed, at-risk, and vulnerable patients attend the camp.
- Ensure that the supply of diagnostic kits, equipment, drugs and consumables reaches the site well before the day's activities begin.
- Ensure appropriate health promotion materials are in place
- Ensure reporting of the special outreach session to the MO in charge of the UPHC
- Assist the Medical Officer and Public Health Manager during these special outreach camps
- Follow up with patients referred to higher facilities on their treatment and compliance

## SECTION

## 3(A)

## JOB RESPONSIBILITIES OF THE ANM UNDER NUHM

The roles and responsibilities of an ANM under NUHM can be broadly divided into six categories:

1. Services delivered through outreach sessions and camps
2. Services delivered during home and community visits
3. Responsibilities at the UPHC
4. Supervision and mentoring of Urban ASHAs & handholding of MAS
5. Management and community level promotion and preventive activities of Communicable and Non Communicable Diseases.
6. Administrative responsibilities, including listing of beneficiaries in the catchment area, creation of family folders and maintenance of records and reports.
7. Other activities assigned by MO I/C (UPHC)

Each ANM is expected to provide services for a population of 10,000 (or 2000 households). She will have 4-5 urban ASHAs under her supervision, each responsible for a population of 1000-2500 (200-500 households). She will work closely as part of a team, which will include the MO, staff nurse and other functionaries at the UPHC, the Urban ASHAs she supervises and the AWWs in her catchment area. This will also help ensure continuum of care from the community and primary care facilities to higher referral centers, where appropriate.

## I. Services Delivered through Outreach Sessions and Camps (UHND and Special Outreach Camps)

Each ANM is expected to conduct a UHND in her area every month. Special outreach camps will be conducted based on the specific health needs and requirements of the community on a periodic basis. (Operational guidelines on conducting UHNDS and Special Outreach Camps have been prepared which provide further details). ASHAs, UPHC staff and MAS members are expected to assist the ANM in organizing these camps. The activities to be conducted by the ANM during various outreach sessions include the following:

### A. Urban Health and Nutrition Day

1. Antenatal care and Post natal care (all components such as ANC registration, PNC Checkup etc)
2. Routine Immunization session conduction with cold chain maintenance
3. Provision of essential medicines such as paracetamol, chloroquinone, IFA tablets, iron syrup, ORS with zinc etc.
4. Counselling and awareness raising for family planning and delivery of contraception
5. Symptomatic Treatment of patients with minor illness e.g. cut, boils, first aid etc.

6. Follow-up visit for chronic illnesses, including diabetes and hypertension
7. Blood slides/RD tests for patients with fever and providing treatment where required as per protocol.
8. Growth monitoring and counselling on nutrition and breast feeding
9. Ensure availability of necessary consumables, equipments and health promotion material for outreach sessions.
10. Referral to UPHC/UCHC and do follow up
11. Record maintenance with appropriate registers

## B. Special Outreach Camps:

1. Supporting Special Outreach Camps as directed by the MO
2. Maintenance of line listing of vulnerable & marginalized population
3. Services delivered through the Special outreach camps shall vary depending upon the specialist providing services at the camp.
4. In terms of organizing the session i.e., raising awareness, publicity, ensuring participation of the target group, coordinating with ASHAs and ULB members, setting up the site to receive patients, the role of the ANM shall be same as that in the UHNDs.
5. Her specific clinical role shall be defined by the MO and the specialist attending the camp

## C. NCD Screening Sessions: (MoHFW Guidelines for NCD Screening, 2017 to be referred)

As directed by the MO, the UPHC shall also hold NCD screening on specific days as an outreach activity. For this the ANM should perform the following activities:

1. Create a database/list of all individuals aged over 30 (30+) in her catchment area. This may be done with the help of ASHAs. ASHAs may also ask screening questions to identify at-risk population among the 30+ individuals in her population (Questionnaire attached as Annexure 3).
2. Ensure all 30+ individuals are aware of the NCD Screening Day, time and location and are encouraged to attend the same, by the ASHAs.
3. Plan to conduct NCD Screening Days once a month, or as decided by the MO/PHM in as an outreach activity. Choose an appropriate site for the Screening. It may be same at the UHND site, if found appropriate.
4. During the Screening session, screen for hypertension (BP), diabetes (Blood sugar) and cancers (oral, breast and cervical).
5. Clinical breast examination must be conducted only with proper training and in adequate privacy. If outreach site does not allow, this should be done at the UPHC.
6. Cervical Cancer screening with acetic acid should also be done at the UPHC, with adequate training.
7. Specific day may be fixed for Breast and Cervical Examination Screening at the UPHC, for which women may be referred from the NCD screening Day.
8. All suspected cases must be referred to the UPHC for further confirmation and treatment

## II. Services Delivered During Home and Community Visits

ANMs conduct home visits for patients as indicated or referred to by the ASHA. Her responsibilities include:

1. Follow-up and ensure compliance with treatment for non-communicable diseases e.g. diabetes and hypertension.
2. Encourage patients with chronic illnesses to attend UPHC and/or special-day clinics
3. Raise awareness and provide relevant health services under national initiatives such as PMSMA, MAA, RBSK, RKSK.
4. Collect blood smears or perform RDTs from suspect malaria cases, especially in areas with no Fever Treatment Depots. Provide treatment to positive cases. Facilitate distribution and utilization of LLIN bed nets; quality spray in households and insecticide treatment of community-owned bed nets.
5. Identifying suspected cases of TB, leprosy etc. and providing follow-up care after confirmation of diagnosis and initial management. Ensure the provision of DOTS and MDT (Multi drug therapy) as appropriate.
6. Disease Surveillance, documentation and reporting under IDSP to the MO. The 'S' (syndromic) form under the Integrated Disease Surveillance Program is to be filled by the ANM. Identify cases of fevers, cough, rashes etc. and refer to the UPHC.
7. Identify and refer all cases of blindness, deafness, mental illness, seizures/epilepsy, developmental delays and disability, including in children to the facilities.
8. Ensuring RCH services like ANC, PNC, immunization, family planning and safe abortions are delivered to all eligible beneficiaries, with particular emphasis on the marginalized and hard-to-reach communities.
9. Pregnant women: Women with high risk pregnancies, those in the ninth month of pregnancy and those who missed their ANC during UHNDs should be prioritized and motivated for institutional delivery.
10. Support ASHAs to ensure home based new born care for all home deliveries.
11. Midwifery services for pregnant women delivering at home
12. Home based care for post-partum mothers as indicated by ASHA or due to failure to attend UHND
13. Review, and refer where appropriate, sick new born/low-birth weight babies and malnourished children
14. Motivate families and ensure that unprotected children receive vaccination during subsequent immunization sessions.
15. Motivate families to improve health-seeking behaviours, adopt family planning methods and attend UHND. A cluster of families could be assembled together for these sessions.
16. Conduct a preliminary inquiry or preferably a verbal autopsy for maternal and infant/child deaths. Document and inform MO whenever there is death in the community.
17. Update RCH registers, HMIS, MCTS and other health registers and records

## III. Responsibilities of the ANM at the UPHC

1. Assist and support the MO during OPD as required
2. Conduct facility based ANC check-ups and refer high risk cases
3. Provide facility based immunization on the weekly fixed day/s for this activity
4. Facility based family planning counselling and provision of contraceptive services (IUCD, condoms, OCPs, emergency contraception).
5. Support the MO in the planning of outreach activities such as special outreach clinics, UHND and screening camps.

6. Assist in 'Special Day Clinics' e.g. Adolescent Health, Family Planning, Chronic Illnesses, Elderly care etc.
7. Provide midwifery services if the UPHC is a delivery point. In Delivery Points when a pregnant woman is in labour, it is mandatory for the ANM to be with her, until at least 4 hours after the 3rd stage of labour is completed.
8. Screening for NCDs – diabetes and hypertension for those above 30 years of age; support the risk assessment for breast, cervical and oral cancer screening.
9. Blood pressure/blood glucose and treatment compliance for follow-up patients of hypertension and diabetes.
10. Visual inspection of cervix with acetic acid (where trained)
11. Assist the MO or Staff Nurse in minor surgical procedures
12. Examine patients referred by the ASHA from the catchment areas
13. Maintaining of ILR & Deep Freezer in case of non availability of other staff
14. Other task assigned by MO I/C of UPHC

#### IV. Supervision and Mentoring of Urban ASHAs

The contribution of ANMs in supervising ASHAs will depend on the availability of ASHA facilitators and other ASHA support structure in the state. The state will allocate the task of ASHA mentoring and supervision between the ANMs and ASHA Facilitators. Each ANM will have 4-5 urban ASHAs in her area. The ANM will guide, supervise and mentor the ASHA in the field level. She will supervise the following area of activities of the ASHA in urban areas:

1. Ensure complete population and household coverage
2. Guide in regard to specific activities to be conducted during field visits, home visits, UHNDs and MAS meetings.
3. Ensure maintainence of accurate and timely records and review these periodically
4. Replenishment of ASHA kits regularly
5. Tracking of new-borns and making appropriate home visits, especially for high risk pregnancies
6. As indicated by the ASHA, the ANM will make home visits for cases needing special attention
7. Support the ASHA in facilitating MAS meetings and addressing issues raised
8. Encourage and facilitate the ASHA to ensure her knowledge and skills are up to date
9. Orient ASHAs on her role in mobilizing beneficiaries for NCD screening
10. Guide ASHA in conducting household vulnerability assessment, as per the tool provided in ASHA Induction Training Module.
11. Guide ASHA in coordinating MAS meeting, hold interactive discussions and involve them in generating awareness on outreach activities.
12. Ensure ASHA is aware of the wider determinants of health, including the importance of potable water, sanitation, and the adverse health effects of open drains, open defecation etc.
13. Hold weekly meeting of all ASHAs in her area to discuss and resolve key issues, provide mentoring and support.
14. Address problems faced by the ASHA in her community, specially security issues - and escalate this to the MO or Public Health Manager as appropriate.
15. Support and facilitate timely payments of ASHA incentives, including reviewing the record of payments

## V. Role in Preventing and Managing Communicable and Non-Communicable Diseases

### 1. Role in Identifying and Managing Communicable Diseases

- Contact ASHA, AWW, community volunteers in her area for active case search for vector borne diseases (malaria, dengue, chikungunya), TB, Leprosy, other communicable diseases and season specific or locally endemic diseases (measles, diarrhoea).
- Identify cases of fever during field visits in her area and maintain a record as per programme guidelines
- Provide information about diagnosis and treatment of these diseases
- Investigation, management, follow-up, compliance with treatment and referral where appropriate – according to programme guidelines for relevant communicable diseases, including vector borne diseases, TB and Leprosy.
- Acutely ill patients must be referred to an appropriate referral facility
- Inform the UPHC MO about the occurrence of communicable diseases in the community
- Actively participate and mobilise the community in elimination of breeding places for mosquitos
- Educate the community about the signs and symptoms of prevalent vector borne diseases; methods of prevention such as the use of bed-nets; treatment and control measures; provide information about spray schedules to the community.
- Maintain accurate and timely records

### 2. Role in Identifying and Managing Non-Communicable Diseases (NCDs)

- The ANM should raise awareness and provide information on the lifestyle and risk factors for common NCDs.
- She should sensitize and mobilize different stakeholders, Self Help Groups, opinion leaders, ULB representatives and trade associations and provide advocacy for health promotion activities such as developing parks and discouraging the use of alcohol and tobacco.
- Provide information about the adverse health effects, prevention, diagnosis and management of diabetes, hypertension and common cancers – and their complications.
- Participate in the screening for diabetes, Hypertension, Breast cancer, Oral cancer and Cervical cancer where trained and introduced by the state.
- Raise awareness about healthy school and healthy work place practices
- Maintain records and registers of NCD data
- Raise awareness about mental health issues and mental health service providers – and help integrate mental health into child health, school health and women's health.
- Under guidance of Medical Officer, identify and refer cataract and common refractive errors
- Encourage school children to use corrective glasses
- Raise awareness about good oral hygiene
- Roles as defined for ANM under the Programme specific guidelines for communicable & non communicable diseases to be referred.

## VI. Administrative Responsibilities

ANMs administrative role will not only be accurate and timely maintenance of reports and records but also submission of the reports. Maintenance of various registers may vary between states and include the following:

1. Listing of beneficiaries in the community– working closely with the ASHA, the ANM will ensure complete enumeration of the coverage population. This may take the form of individual health cards placed within a family folder. While initially register based, it is expected that these cards will be converted to an electronic format.
2. Stock and inventory register, where appropriate
3. ANC and PNC register
4. Immunization register
5. Outreach Registers
6. Family Planning – and eligible couples – register
7. Disease surveillance including IDSP notifications
8. NCD screening register
9. Registration of vital events, e.g. births and deaths
10. ASHA supervision and mentoring notebook
11. Registers for the HMIS and MCTS portal: where appropriate and available, the Data Entry Operator will upload this data on to the portal.

### Topics for Raising Awareness and Discussion with Community for the ANM

The following priority topics can be suggested for discussion and dissemination of relevant information during home visits:

1. Danger signs during pregnancy
2. Importance of institutional delivery and public facilities offering these services
3. Importance of ante-natal and post-natal care
4. Nutritional augmentation for pregnant mothers, infants and young children
5. Exclusive breastfeeding
6. Weaning and complementary feeding
7. Care during diarrhoea; use of ORS with zinc; signs of dehydration
8. Care during acute respiratory infections - signs of pneumonia and respiratory distress
9. Prevention of malaria, TB, leprosy and other communicable and locally endemic diseases (e.g. Kala-Azar, encephalitis).
10. Prevention of RTIs, STIs, HIV/AIDS
11. Importance of safe drinking water
12. Family planning and various contraception choices available to women and men
13. Personal hygiene and household sanitation
14. Dangers of sex selection; legal and appropriate age for marriage
15. Adolescent health issues (e.g. adverse effects of early marriage)
16. Disaster management or appropriately responding to urban disasters

17. Disadvantages of open defecation; importance of using toilets
18. Spread of vector borne diseases such as dengue, malaria, chikungunya and use of bed nets, prevention of mosquito breeding (e.g. in stagnant water), use of mosquito repellents.
19. Lifestyle and risk factors for prevention of non-communicable diseases
20. Signs of mental illnesses; importance of community support, elimination of discrimination and stigmatization of mental illness; information on mental health services and their availability.
21. Information on health, social and financial effects of alcoholism, substance misuse and tobacco - smoking and chewing.
22. Occupational health hazards relevant to the local community e.g. rag pickers, rickshaw pullers, factory workers, beedi makers, commercial sex workers, sanitation workers, firecracker makers, construction workers etc.
23. The social, legal and health implications of child labour
24. Promoting childhood education

### Responding to Urban Hazards: Role of the ANM

The living conditions of the urban poor make them highly susceptible to injuries and other hazards. Incidents of electric short circuits, fires, collapse of poorly constructed or old buildings and bridges, injuries in construction sites, falls in pits and manholes are not uncommon in dense urban settlements. Moreover, natural calamities such as earthquakes and floods affect the urban areas more adversely than the rural areas.

Working in the most vulnerable population, it is the responsibility of the ANM to understand and respond to urban hazards. The ANM as the frontline health worker must act as the eyes and ears of the Health Department to prevent and support the mitigation of urban disasters. In the unfortunate event of a disaster, she should be able to provide support. For this, States may plan for disaster management trainings for all health staff, including the ANMs.

Some of the actions to be taken by the ANM for such situations are:

- Generate awareness among her population on possible disasters such as earthquakes and floods and to educate them on how to act during these situations to minimize harm. Earthquake and flood prone areas may be identified in advance and the ANM guided on the topics of awareness generation by the MO.
- Educate communities on safety mechanisms to minimize hazards such as fires, electric shocks, animal bites, falls and injuries.
- Be vigilant during field visits to identify potential health hazards such as open pits, manholes, naked wires, rabid dogs, overflowing drains etc. These must be pointed out to the appropriate authority such as the ward member, community leader, Medical Officer, Public Health Manager urgently.
- Provide first aid at the site or health facility in case of an accident
- Be pro-active in rescue efforts during a natural calamity and provide support as needed
- In the aftermath of a calamity (such as floods), follow up with the affected victims to identify any adverse health impact such as spread of infection etc.
- Ensure proper distribution of medicines and other supplies to the affected population



## SECTION

## 3(B)

## WORK PLANS AND SCHEDULES



One ANM is recommended to cover a population of 10,000 people. According to this norm, there will be **5 ANMs for each UPHC covering a population of 50,000**. However, if the UPHC population is less or more than this norm, the number of ANMs shall vary accordingly. For example, if the UPHC caters to 30,000 or 70,000 population, the number of ANMs required shall be 3 and 7 respectively.

The working hours and timings of the ANM will depend upon those of the UPHCs. While some will open only during a morning-afternoon shift, others may have both morning and evening shifts. The daily and weekly work-plans would have to be scheduled accordingly.

The **ANM will spend at least 2 days of the week in the field with her community**. For conducting home visits, she will visit all cases flagged by the ASHAs, high risk pregnancies, service resistant households, families facing acute or chronic illness and unable to come to the UPHC. She will also attend outreach sessions and MAS meetings. She will need to collaborate with Anganwadi workers for conducting UHNDs, meet with local NGO workers, community leaders, and other health providers for purposes of collaboration for routine and special outreach camps, information dissemination and awareness generation regarding various issues.

## Work Load Estimation

The **ANM may calculate her workload** by estimating the number of pregnancies, estimated live births and children due for immunization to plan her activities accordingly. To calculate these numbers:

- You must know the birth rate and population size of the area under your jurisdiction (the state or district birth rate may be used).
- The birth rate of your area can be obtained from the MO at the PHC or you can consult the available district/state/national figures. It is advisable to use the available local figures for the birth rate for correct estimation. To know the exact population of the area under your jurisdiction, use the latest demographic data/census reports.

Some points to be kept in mind:

- Specific pregnancy load in urban slums and vulnerable areas may be higher than the general population, assuming higher fertility among vulnerable groups.
- The ANM, with the help of Public Health Manager and MO should plan for outreach and other health services keeping the patient load for her area in mind. More specific calculations and projections may be done with state/district specific birth rates and figures. Depending on the geographical spread of the community and the population of the catchment area, the number of outreach sessions (or UHNDs) needed to cover this catchment area will be variable.

- There may be a situation where there are more than 4 UHNDs in your area, in that case you need to mark additional day of the week for completing the coverage of all UHNDs in that month. The weekly schedule can be revised accordingly in consultation with MO or PHM of the UPHC.

## Calculating Expected Number of Live Births and Pregnancies in a Year

$$\text{Expected Number of Live births per year} = \frac{\text{Birth rate (per 1000 population)} * \text{Population of the area}}{1000}$$

As some pregnancies may not result in a live birth (i.e. abortions and stillbirths may occur), the expected number of live births would be an under-estimation of the total number of pregnancies. Hence, a correction factor of 10% is required, i.e. add 10% to the figure obtained above.

*Expected Number of pregnancies per year*

$$= \text{Expected number of live births} + 10\% \text{ of expected number of live births}$$

As a thumb rule, in any given month, approximately half the number of pregnancies estimated above should be in ANM's records. This is explained using the National Crude Birth Rate of 21 per 1000 population.

Birth Rate	= 21 per 1000 population (All India figure)
Population under ANM	= 10,000
Expected number of live births	= (21 x 10,000)/1000
	= 210
Correction Factor of 10%	= 10% of 210 = 21
Therefore, total number of expected pregnancies in a year	= 210 + 21 = 231

In any given month, the ANM should have about 115 pregnancies registered. Around 15-20 % of these pregnancies will be high risk, i.e., around 45 women, to which the ANM needs to pay special attention and make home visits. You can also estimate the number of children under 5 to be immunized in your population.

## Estimating the Immunization Load

*Expected Number of pregnancies per year*

$$= \text{Expected number of live births} * \text{Proportion of population under 5 years of age}$$

For example, for the state of Assam the estimated mid-year population for 2016 is 329,64,513. The proportion of population Under 5 years of age is 10.30 % for this population (mid-year population is calculated using RGI midyear population projections and proportion of children is taken as per Census 2011).

The Under 5 population for Assam would be = 329,64,513 \* 10.30 / 100 = 33,95,345

For a 10,000 population in a city in this state, the number of Under 5 children would be = 33,953

Keep in mind that the number of children calculated above will be an **underestimation**, as fertility among women in slums is higher than the overall population, resulting in a higher number of children.

## Suggested ANM Weekly Schedule:

Depending on the population of the catchment area and the service delivery requirement, **weekly schedules for ANMs**, assuming a UPHC with 5 ANMs, have been provided below. These may be modified as per the specific workload and needs of the UPHC. The ANM schedules can be divided into two sessions- the first half and the second half of the day wherever appropriate. These can be adapted depending on the UPHC timings, which may vary from state to state.

	ANM 1	ANM 2	ANM 3	ANM 4	ANM 5
Day 1	Plan for UHND	Field Visit	Facility Based Services	Sp. Outreach/ NCD Screening	Facility Based Services
	Record Keeping		Field Visit	Record Keeping	ASHA Meeting
Day 2	UHND	Plan for UHND	Field Visit	Facility Based Services	Spl Outreach/ NCD Screening
		Record Keeping		Field	Record Keeping
Day 3	Facility Based Services	UHND	Plan for UHND	Field	Facility Based Services
	ASHA Meeting		Record Keeping		Field Visit
Day 4	Spl. Outreach/NCD Screening	Facility Based Services	UHND	Plan for UHND	Field Visit
	Record Keeping	ASHA Meeting		Record Keeping	
Day 5	Facility Based Services	Spl Outreach/ NCD Screening	Facility Based Services	UHND	Plan for UHND
	Field Visit	Record Keeping	ASHA Meeting		Record Keeping
Day 6	Field Visit	Facility Based Services	Spl Outreach/NCD Screening	Facility Based Services	UHND
		Field Visit	Record Keeping	ASHA Meeting	

Note: Field visit also includes visit to schools.

As per the above schedule, each ANM has the following activities:

1. Providing Facility Based Services (2 half days): Being present during OPD hours to provide immunization, ANC, conducting opportunistic NCD screening, and other services as directed by the MO.
2. Field Visit (2 full days): Home visits, MAS meetings, liaising with ULB functionaries or local NGO members.
3. Planning a UHND (one half day): Coordinating with AWW and ASHA, ensuring all supplies, publicity materials etc. (If more than one UHND is required to cover the target population, the ANM work plan and schedule be worked out accordingly).
4. Organizing a UHND (one full day)
5. Special Outreach or NCD Screening (one half day): assisting during special outreach or conducting NCD screening in her area.
6. Record Maintenance (2 half days): Updating records, HMIS, creating due lists,
7. ASHA Meeting (one half day)

Note: The above work plans and schedules are just an example to demonstrate how the activities need to be distributed among the ANMs. For your UPHC, the plans would have to be worked out depending on population to be covered, number of ANMs available, needs of the community etc.



## SECTION

## 4

## INTERPERSONAL SKILL DEVELOPMENT

## Management Skills

These will be an important adjunct to deliver services in an efficient, effective and compassionate manner. The section below provides information on some of these components – it includes the areas of leadership, communication, decision-making, negotiation strategies and coordination skills.

### Leadership

Leadership as an ANM involves mobilising people and resources towards achieving positive health outcomes. You will often have to play the role of a leader. Hence it is important to understand the meaning of leadership and the qualities required for being an effective leader.

#### What is leadership?

To be a leader, means to be:

- Responsible
- Set an example for others to follow you
- Inspiring - provide optimism and confidence in people
- Non-judgemental with people and transparent in your actions
- Confident, assertive, enthusiastic, passionate and accountable
- Skilled in enabling people to cooperate for getting things done

#### Leadership Style

People adopt different leadership styles. The two common styles are **Authoritarian and Participatory:**

- **Authoritarian leaders** do not welcome cooperation or collaboration from others. They expect people to do what they are told without question or debate. They are usually intolerant of what they do not agree with. It is difficult for team members to contribute their views or empower themselves under this kind of leadership.
- **A participatory leader** creates a positive environment in which all members can reach their highest potential. They encourage the community to effectively reach the set goals and simultaneously strengthen the bonds among various members. This leads to a more productive team. ***As an ANM, it is most appropriate to adopt a participatory leadership style.***

For participatory leadership, the ANM needs to:

- **Establish goals and set the direction:** First articulate an achievable goal for your area. Involve your community through local institutions especially the Mahila Aarogya Samiti on how, where and when

it would be completed. For example, all children of your area should be immunised in the next six months.

- **Set high standards and high expectations:** Be firm about ensuring high quality health care services from Outreach session/spl outreach session and the U-PHC for your community. E.g. Make sure that the ASHA/AWW reaches the area on the designated UHND, requisite equipment and drugs (weighing scales, BP apparatus, disposable syringes for immunisation, ice box for vaccines) and provides the package of services for mothers and children. If the health service provider treats a community member with disrespect or does not provide the services or does not pay attention to quality, you should feel able to ask her to change behaviour or practice.
- **Be accountable and responsible:** to the community and the health care provider by **being an effective link and sharing information.** However, being constantly critical of the situation will have no positive outcome. Address the issue by sharing your grievances with authorities who can take action. For example, if the ASHA is not coming to your area regularly or she is not visiting the houses of socially backward families, **have the courage** to tell her that you have noted her absence and you will take the necessary steps if this continues. Enlist the help of MAS, Medical Officer or Ward Members.
- **Involve others in decision-making:** Do not make any decisions alone. A decision affecting the community, needs to be taken along with the community members, with their complete ownership. For example, better results are attained if priorities and decisions regarding community health needs are taken as part of collectives such as the MAS.
- **Motivate others:** By involving the ULBs, SHG members and MAS through regular contact, sharing necessary information, giving them responsibility and acknowledging their support and efforts in public. Invite the community to join you in availing of their right to quality healthcare. Involve community members in the process when availing for them their entitlements from the public health system or by giving them some responsibility to improve the health status of the community.
- **Achieve unity:** As a leader you need to promote unity among your community members and between the community members and health care providers. Unity comes when community members feel the ownership for their health and see that they also have a role in achieving the goal.
- **Serve as a role model:** Always set an example that can be followed. For example, you are assigned the role of accompanying a pregnant woman for a referral. If you performed this role and saved the life of woman in your area, you have set an example. Next time, when the need arises, other community members will come forward to accompany a pregnant woman during an emergency. They may also arrange for money and transport, if required.

### What is Communication?

Communication is the exchange or flow of information and ideas between two or more persons. Your communication skills will enable you to counsel women and families on health promotion, adopting healthier practices and mobilizing them to avail services at health institutions. They also help you establish rapport with the stakeholders and other health functionaries. **People who do not communicate well, create confusion, frustration and problems.** There are three different forms of communication - verbal; non-verbal and written, described below. Each of these is useful for you.

**Verbal communication:** This is the most common way of communicating, but should be done in a way that the person or persons to whom you are communicating the message has understood it. So you must deliver it in a way that the person understands what you are saying. To know if your message was received properly, get feedback from the person whether she or he understood the message.

**Non-Verbal Communication:** We all know that communication is not only about words and languages. Silence also communicates, and there are gestures that people make with their hands, body and eyes. These forms of communication are referred to as non-verbal communication. Here are some non-verbal forms of communication:

- **Eye contact:** with the person to whom you are talking will indicate your sincerity and confidence
- **Body posture:** Facing the person, standing or sitting appropriately close and holding your head erect gives value or weight to your messages.
- **Facial expressions:** Effective communication requires supporting facial expressions therefore express appropriate feelings on your face.
- **Gestures:** Use of hand gestures to describe and emphasise adds value but it should not be overdone in excitement or anxiety.

**Points to take care of while communicating face to face:**

- When you visit families, greet the individuals and explain the reason of your visit
- Maintain eye contact with the person to whom you are talking, act with confidence but speak in a gentle tone which is loud enough to be heard and always be respectful
- Stick to the point so that you do not end up using too much time and use simple words in local language. Do not use technical words or jargon. Your pronunciation should be clear.
- Be specific, sincere, honest and direct while communicating
- Be empathetic and try to share the feelings of individuals
- Be open-minded. This will help you understand the other person's point of view. In case of talking to your beneficiary check if she has any question and answer in simple language.
- Acknowledge the efforts made by the beneficiaries and never forget to compliment/appreciate them

**Written Communication:** As an ANM you will need to write applications and letters to the authorities to improve access to health care services. You also need to document the processes and decisions taken during meetings such as monthly MAS meetings, community meetings etc. You will thus have to learn to write simply and effectively. Use as few words as possible to make your point, and always chose the simplest words.

**What is Decision Making?**

As an ANM you will be often required to take decisions, that will affect the community at large. Hence, you should learn the skill of participatory decision-making by involving the community at all levels. Some basic steps of decision-making are:

**Define the problem:** Examine the situation carefully and analyze it from all perspectives to find out the actual problem.

**Gathering Information and share with the community:** As a next step collect all the necessary information, seek advice from the appropriate authority and involve the community. Take information on what exists, what does not exist and what needs to be there. At this stage of decision-making you need to arrange a community meeting and discuss the situation to help them become part of the solution.

**Think of possible solutions:** You should work with the MAS and Urban Local Body (municipal bodies through ward councillors) if needed on identifying solutions. At this stage many solutions will be offered. It shows that people accept and understand the problem, and are interested in identifying solutions.

**Choose one solution by consensus:** Part of effective decision-making is the ability to select one alternative from the various options available. This can be done through consensus of the community and approval of the authorities. To gain consensus and approval you need to discuss this in the MAS meetings and the Urban Local Body. Before selecting the right alternative, assess all available options.

**Put the decision to work:** An effective decision is one which can be put into action. Thus, implementation is very important. During this process, keep checking if it is moving towards the expected solution, and if there is something else which needs to be addressed. An effective decision should not leave any unhappy feeling among group members after the meeting has been adjourned. It does not set up conflict of a debilitating nature among persons or groups.

*Decision-making skills are sharpened through experience and practice. But one needs to be confident and prepared to take responsibility if the decision fails.*

### What are Negotiation & Co-ordination Skills?

Negotiating is the process by which two or more people/parties with different needs and goals work to find a mutually acceptable solution to an issue. As an ANM you will have to deal with differences. It is important to realize that it is quite a challenge to negotiate with people in authority but with enough preparation and practice you can deal effectively with any kind of situation which requires negotiation.

### The Steps of Successful Negotiation

- **Ask for the other person's perspective:** In a negotiating situation use questions to find out what the other person's concerns and needs might be. Some examples of likely questions are: What do you need from me on this? What are your concerns about what I am suggesting/asking?
- **State Your needs:** In the process of negotiation the other person requires to know your needs. It is very important to state not only what you need but also why you need it.
- **Prepare options beforehand:** Before entering into a negotiation, prepare some options that you can suggest if your preferred solution is not acceptable. Anticipate why the other person may resist your suggestion and be prepared to counter the same with an alternative.
- **Do not argue:** Negotiating is about arriving at solutions. Arguing is about trying to prove the other person wrong. We know that during negotiation when each party tries to prove the other one wrong, no progress is made. If you disagree with something state your disagreement in a gentle, but assertive, way. Do not demean the other person or get into a power struggle.
- **Consider timing:** There are good times to negotiate and bad times. Bad times include those situations where there is a high degree of anger on either side, a preoccupation with something else, a high level of stress or tiredness on one side or the other.

### How to use your negotiation skills effectively

In your community you may come across several issues that require to be addressed. For example, UHND does not take place, the Anganwadi is not functioning well; children and women are not receiving their entitlement of supplementary food; the midday meal provided is not adequate or cooked properly; pension for widows is not being received despite completion of formalities etc.

- To change such situations first try to find out if things can be changed by drawing the attention of people like ward members, the MAS members, the schoolteacher, AWW through direct dialogue.

- If the situation still does not improve, try to organise people and facilitate group discussions over the issue. The MAS meeting is a good forum to address such issues.
- If this also does not work, try to identify organisations working on the same issue and seek their support. If you decide to initiate a movement along with the people to change a situation, organising people who are affected with the same issues is important and is essential for activism to be effective.
- Activism/protest may not always be the best method of changing the situation but it can be quite useful under the right circumstances. It gives voice to a cause.

### Co-ordination Skills

As an ANM you are a link between health care services and the community and expected to regularly coordinate with various stakeholders and the community. The MAS is the key body which can take the collective action on issues related to health, nutrition, water, sanitation and all other social determinants at community level. Therefore, you can work with MAS members to perform the above mentioned functions effectively.

To achieve the goal of healthy community, you need to work in coordination with different departments and stakeholders. Coordinated action between different departments is called as “Convergence”. These departments include:

- Health Department
- Education Department
- Urban Local Bodies
- Women and Child Development
- Local NGOs

You should work in coordination with the field level functionaries of these departments:

- Monitor the situation of water, sanitation, nutrition, housing, education services in your area
- Arrange a monthly and quarterly meeting with all relevant stakeholders to discuss community issues and devise a plan to address those issues.
- Coordinate with your ANM and supervisor to arrange a meeting with the above mentioned stakeholders.
- Advocate with the local authorities for taking necessary actions to address the identified issues. For e.g. construction or repair of community toilets, water drains, improving sewerage, drainage and disposal system etc.



## SECTION

## 5

PERFORMANCE ASSESSMENT OF  
ANMs UNDER NUHM

Reviewing the performance of ANMs will be helpful to assess their level of service delivery and guide her in improving her performance wherever there is scope for improvement. Specific indicators for this performance appraisal will consist of two components:

1. Self-appraisal
2. Appraisal from supervisor

Self appraisal shall be done by the ANM herself for her performance while Appraisal from supervisor shall be done by her reporting officer, usually the Medical Officer. If there are differences in the indicator scores filled by the ANM (as self-appraisal) and the score given by the assessor (supervisor), these should be discussed between them to understand areas of improvement for the ANM.

Three categories of indicators can be used for the assessments :

- i. General Conduct and Engagement
- ii. Community Activities
- iii. Administrative Work
- iv. Technical Performance

	Score by ANM	Score by Assessor
<b>I. General Conduct and Engagement</b>	Score 1 to 5	
1. Inter-personal relationship ( <i>Attitude towards seniors, colleagues and beneficiaries</i> )		
<b>II. Community Activities</b>		
1. Number of Routine outreach session (UHND) & special outreach conducted (Monthly/Quarterly)		
2. Average number of houses visited per field visit (list of household, Area/ GIS map)		
3. Availability of line listing for beneficiaries for all categories of health events (Pregnant women, children to be immunized, high risk cases, malnourished individuals, eligible couples (protected and unprotected), Patients on DOTs (TB / Leprosy), Visually impaired patients requiring cataract surgery / spectacles, any terminally ill patient etc. must be available and forming)		
4. Mapping of vulnerable population (Description of her vulnerable areas – location with population of the slums / JJ Cluster / resettlement block/ cluster of homeless, nomads / vulnerable families or individuals)		
<b>III Administrative Work</b>		
5. Timely completion and submission of monthly reports to State/City/District level (according to State protocol)		

6. Total number of monthly meetings - organized against planned at UPHCs (separately for ASHA & MAS)		
7. Maintenance of various registers (according to State protocol)		
8. Utilization of UHND funds (* Utilization i.e. submission/settlement of Bills for expenditure incurred)		
Total score	x	y

Score parameters for (I) general and (II) administrative skills:

1. 1: Poor
2. 2: Fair
3. 3: Good
4. 4: Very good
5. 5: Excellent

Add the scores given by ANM and assessor and use this cumulative score as final score 'X'

**Total score (X) = x + y (Maximum score = 40, minimum score = 8)**

#### IV. Technical performance indicators (Formula for calculation is provided later in the section)

	100-80% (10 points)	79-60% (8 points)	59-50% (6 points)	49-40% (4 points)	<40% (2 points)
1. Rate of UHNDs organized					
2. Rate of high risk pregnancies					
3. Rate of high risk pregnancies detected and followed up					
4. Rate of full immunization coverage in infants					
5. Rate of severely Anaemic (< 7 gm) pregnant women line listed					
6. Rate of IFA consumption / distribution among pregnant women					
7. Rate of IFA consumption /distribution among women in reproductive age group of 15-49 years					
8. Rate of Albendazole consumption among adolescents					
9. Rate of protected eligible couples registered					
10. Screening for Ca Breast / Cx					
11. Rate of high blood pressure patients identified in the registered population					
12. Rate of high blood glucose patients identified in the registered population					
13. Counseling and followup of diagnosed cases.					
<b>Total score 'Y' (aggregate)</b>					

**Score Y = \_\_\_\_\_ (Maximum score = 60, Minimum score = 12)**

**Grand Total score: X+Y = \_\_\_\_\_ %**

This grand total score can be used to link performance to individual incentives and employment management as shown below:

S.No	Overall appraisal score (X+Y)	Performance grade	Incentive	Remarks
	90-100	Grade A	10% of their total remuneration	Renewal of contract
	70-89	Grade B	8% of their total remuneration	
	50-69	Grade C	5% of their total remuneration	
	40-49	Grade D	No incentive	Renewal with warning
	Less than 40	Grade E	Not applicable	Extension of 6 months followed by review

### Calculation formulae for performance appraisal indicators

S.No	Indicator	Calculation Formula	Data Source
1.	Rate of UHNDs organized	$\frac{\text{Number of UHNDs conducted in her catchment area}}{\text{Number of UHNDs planned in her catchment area}} \times 100$	Register or HMIS reports
2.	Rate of high risk pregnancies	$\frac{\text{Number of high risk pregnancies identified}}{\text{Estimated pregnancies}} \times 100$	
3.	Rate of high risk pregnancies detected and followed up	(Number of high risk pregnancies identified during ANC or number of high risk pregnancies followed up till 42 days post-delivery (data from own register, facility based register & PNC register & private facilities)/ Estimated high risk pregnancies x 100  (* All the high risk women identified should receive time appropriate services.	
4.	Rate of full immunization coverage	$\frac{\text{Total number of children below 1 year who have been fully immunized}}{\text{Estimated children below 1 year}} \times 100$	
5.	Rate of Albendazole consumption among adolescents	No of adolescents consumed Albendazole tablets/ Total number of adolescents x 100  (* Adolescents (Boys & Girls- going to school and distribution through outreach service)	
6.	(a) Rate of severe Anemic (< 7 gm) pregnant women line listed	(a) $\frac{\text{Number of severe anemia (<7gm) pregnant women line listed}}{\text{Total number of ANC registrations}} \times 100$	
	(b) Rate of IFA consumption /distribution among pregnant women	(b) No of pregnant women provided with 100 IFA tablets/ No pregnant women registered x 100	
	(c) Rate of IFA consumption /distribution among women in reproductive age group of 15-49 years	(c) No of women distributed with IFA tablets/Total women population in reproductive age group of 15-49 years x 100	
7.	Rate of protected eligible couples	Total number of protected eligible couples / Estimated eligible couples x 100	

S.No	Indicator	Calculation Formula	Data Source
8.	Screening for Ca Breast / Cx	% of women of the identified age group screened for Ca Breast & Cervix / Estimated women population 30 years and above 30 years(*) (*) As per census 2011	NCD Register/ ANM Diary &
9.	Rate of high blood pressure patients in the registered population	$\frac{\text{Number of patients identified with high blood pressure}}{\text{Registered population(*)}} \times 100$ (*) 30 years and above 30 years As per census 2011	As per NCD guidelines
10.	Rate of high blood glucose patients in registered population	$\frac{\text{Number of patients identified with high blood glucose level}}{\text{Registered population (*)}} \times 100$ (*) 30 years and above 30 years As per census 2011	
11.	Counseling and followup of diagnosed cases	% of diagnosed patients of High BP / Diabetes counselled and are being followed up.	

# DANGER SIGNS DURING PREGNANCY AND IN NEWBORNS

The following checklists can be utilized by ANMs to carry out their RCH related activities:

## CHECKLIST 1: Danger Signs During the Course of a Pregnancy

### Ante-Natal Period

- Anaemia: Palpitations, easy fatigability, breathlessness at rest
- Excessive nausea and vomiting
- High fever
- Headache / Blurring of Vision / Dizziness
- Convulsion / Fits
- Swelling all over the body
- Pain / Burning while urinating
- Increased frequency of urination
- Foul smelling discharge with or without fever
- High blood pressure
- Leaking for more than 24 hours without labour pain
- Bleeding from vagina or abnormal discharge
- Loss of Foetal Movements

### Intra-Natal Period

- Bursting of water bag without labour pains
- Bleeding from vagina
- Convulsions / Fits
- Labour pain for more than 12 hours
- Retained Placenta

### Post-Natal Period

- Excessive bleeding i.e. soaking more than 2–3 pads in 20–30 minutes after delivery
- Convulsions with or without swelling of face and hands, severe headache and blurring of vision
- Fever
- Severe abdominal pain
- Difficulty in breathing and breastfeeding

- Foul-smelling lochia
- Breast engorgement, cracked nipple
- Perineal swelling and infection
- Inability to pass urine or burning while urination
- Post-partum mood changes

### CHECKLIST 2: Danger Signs in a Newborn

- Weak sucking or refusal to breastfeed
- Lethargic or unconscious
- Baby unable to cry/difficult breathing
- Convulsions
- Fever or cold to touch
- Yellow palms and soles
- Bloody stools

ANNEXURE  
 II

## LIST OF DIAGNOSTIC SERVICES AT THE UPHC

	Diagnostic Tests
<b>Clinical Pathology</b>	<ul style="list-style-type: none"> <li>• Haemoglobin Estimation (Hb)</li> <li>• Total Leukocyte Count (TLC)</li> <li>• Differential Leukocyte Count (DLC)</li> <li>• Platelet count</li> <li>• MP (Slide Method)</li> <li>• ESR</li> <li>• Clotting Time (CT)</li> <li>• Blood Group (ABO-RH typing)</li> </ul>
<b>Biochemistry</b>	<ul style="list-style-type: none"> <li>• Blood sugar</li> <li>• Serum Bilirubin</li> <li>• Lipid Profile (Blood Cholesterol)</li> </ul>
<b>Sero Microbiology</b>	<ul style="list-style-type: none"> <li>• Rapid Plasma Reagin (RPR) Kit Test</li> <li>• HIV Test</li> <li>• Sputum for AFB</li> <li>• Dengue (Rapid test)</li> <li>• Malaria (Rapid test)</li> <li>• Typhoid (Widal Test/Typhi Dot test)</li> <li>• Hepatitis (HBsAg Test)</li> </ul>
<b>Urine Analysis</b>	<ul style="list-style-type: none"> <li>• Urine Sugar / Albumin/Leucoyte Esterase#</li> <li>• Urine Pregnancy test (UPT)</li> </ul>
<b>Stool Analysis</b>	<ul style="list-style-type: none"> <li>• Stool for OVA and cyst</li> </ul>
<b>Water Quality</b>	<ul style="list-style-type: none"> <li>• Water Quality Testing-H2S Strip test for Faecal Contamination</li> <li>• Estimation of chlorine level of water using ortho-toluidine reagent</li> </ul>





## HISTORY TAKING/RISK ASSESSMENT FORM FOR NON- COMMUNICABLE DISEASES (TO BE FILLED BY URBAN ASHA)

General Information				
Name of ASHA	Ward/Zone			
Name of ANM	Slum/Area			
UPHC	Date			
Personal Details				
Name	Any Identifier (Aadhar Card, UID, Voter ID)			
Age	RSBY beneficiary: (Y/ N) _____			
Sex	Telephone No.			
Address				
Part A: Risk Assessment				
Question	Range		Circle any	Write score
<b>1. What is your age? (in complete years)</b>	30-39 years		0	
	40-49 years		1	
	≥ 50 years		2	
<b>2. Do you smoke or consume smokeless products such as Gutka or Khaini?</b>	Never		0	
	Used to consume in the past / Sometimes now		1	
	Daily		2	
<b>3. Do you consume Alcohol daily?</b>	No		0	
	Yes		1	
<b>4. Measurement of waist (in cm)</b>	<b>Female</b>	<b>Male</b>		
	<80 cm	<90 cm	0	
	80-90 cm	90-100 cm	1	
	>90 cm	>100 cm	2	
<b>5. Do you undertake any physical activities for minimum of 150 minutes in a week?</b>	Less than 150 minutes in a week		0	
	At least 150 minutes in a week		1	
<b>6. Do you have a family history (any one of your parents or siblings) of high blood pressure, diabetes and heart disease?</b>	No		0	
	Yes		2	
Total Score				
A score above 4 indicates that the person may be at risk for these NCDs and needs to be prioritized for attending the weekly NCD day				

**Part B: Early Detection: Ask if patient has any of these symptoms**

B1: Women and Men	Yes/No	B2: Women only	Yes/No
Shortness of breath		Lump in the breast	
Coughing more than 2 weeks		Blood stained discharge from nipple	
Blood in sputum		Change in shape and size of breast	
History of fits		Bleeding between periods	
Difficulty in opening mouth		Bleeding after menopause	
Ulcers /patch /growth in the mouth that has not healed in two weeks		Bleeding after intercourse	
Any change in the tone of your voice		Foul smelling vaginal discharge	

In case the individual answers Yes to any one of the above mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available.





Ministry of Health and Family Welfare  
Government of India