Strengthening Antenatal Care through Community Interventions

An Implementation Note

2022

CONTENTS

LIST OF ABBREVIATIONS

AAA	ASHA, ANM, AWW
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AS	ASHA Sangini
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCPM	Block Community Process Manager
BMGF	The Bill and Melinda Gates Foundation
CEmONC	Comprehensive Emergency Obstetric & Newborn Care services
CHC	Community Health Centre
CRM	Community Resource Mapping
DCPM	District Community Process Manager
DH	District Hospital
FLW	Frontline Worker
FRU	First Referral Unit
GoUP	Government of Uttar Pradesh
HBNC	Home-based newborn care
HPD	High Priority District
IFA	Iron Folic Acid
LBW	Low Birth Weight
MCP	Mother and Child Protection
MIYCN	Maternal, Infant, & Young Child Nutrition
MLE	Monitoring, Learning & Evaluation
MNCH	Maternal, Neonatal & Child Health
MoHFW	Ministry of Health & Family Welfare
MOIC	Medical Officer In Charge
MoWCD	Ministry of Women & Child Development
NFHS	National Family Health Survey
NHM	National Health Mission
PNC	Postnatal Care
PW	Pregnant Women
RI	Routine Immunization
RMNCH+A	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RMNCH+N	Reproductive, Maternal, Neonatal and Child Health and Nutrition
SAPW	Severely Anaemic Pregnant Women
SDG	Sustainable Development Goal
SIFPSA	State Innovations in Family Planning Services Project Agency
SPMU	State Project Management Unit
SRS	Sample Registration System
ToT	Training of Trainers
UP	Uttar Pradesh
UP TSU	Uttar Pradesh Technical Support Unit
VHIR	Village Health Index Register
VHND	Village Health and Nutrition Day
VHSNC	Village Health , Sanitation & Nutrition committee
WHO	The World Health Organization

LIST OF FIGURES

BACKGROUND

Care during pregnancy or Antenatal care (ANC) is widely recognized as an essential element of safe motherhood. The World Health Organization (WHO) describes antenatal care as the care provided by skilled healthcare professionals to pregnant women in order to ensure the best conditions of health for both the mother and the baby during pregnancy[1]. ANC is essential to protect and promote the health of the mother and her unborn child and to detect, treat and prevent potential complications that may arise during pregnancy, child-birth or later in order to reduce maternal and newborn mortality and stillbirths. WHO emphasizes the provision and uptake of timely and sufficient antenatal care services, viz., the first visit during the first three months of pregnancy and at least four antenatal visits. Globally, during 2007–2014, only 64% of pregnant women[2] received the WHO-recommended minimum of four ANC services, suggesting that much more work needs to be done to address ANC utilization and quality. The Sustainable Development Goal (SDG) 3.1 sets a specific target for all countries to lower MMR to less than 70 by 2030. Historical trends suggest that the achievement of SDG 3.1 will require 91% coverage of at least one antenatal care visit, 78% with four antenatal care visits, 81% with in-facility delivery, and 87% with skilled birth attendance[3].

STATUS OF ANC IN INDIA & UTTAR PRADESH IN 2016

India contributes 20% of the total estimated maternal deaths (536,000) that occur globally each year as per WHO estimates. Most of these maternal deaths occur during the third trimester, child-birth and the first week after birth[4]. Among the Indian states, Uttar Pradesh (UP), being India's most populous state, accounting for approximately one-sixth of India's population, has substantially higher maternal, neonatal, infant and child mortality rates as compared to the other states. As per the SRS 2016 Census population survey, UP's contribution to maternal and neonatal deaths is 37% and 27% respectively. In terms of maternal mortality, UP ranks second with 197 deaths per 100,000 live births (SRS 2016 -18). The 2016 SRS shows that perinatal mortality is 26 while still-births is 3 and neonatal mortality is 30 per 1000 live births.

In 2016, as per the National Family Health Survey round 4 (NFHS-4 – 2014 – 15), less than half of the women (45.9%) received ANC during the first trimester of pregnancy in Uttar Pradesh. 72% of pregnant women in Uttar Pradesh received ANC for the last birth. Only 26.4% of mothers had four or more ANC visits. 51.0% of pregnant women were detected to have anaemia (<11 gm/dl) in UP and 12.9% consumed them for 100 days or more. The percentage of births in health facilities increased from 22.0% in NFHS-3 to 67.8% in NFHS-4.

STATUS OF ANC IN UTTAR PRADESH IN 2016

NFHS-4 (2014-15)

72%

of pregnant women in Uttar Pradesh received ANC for their last child delivered.

46%

of women received antenatal care during the first trimester of pregnancy

26%

of mothers had four or more antenatal care visits.

THE RESPONSE

The Institute for Global Public Health, University of Manitoba (IGPH-UoM) and India Health Action Trust (IHAT), under the aegis of a Memorandum of Cooperation between the Bill & Melinda Gates Foundation (BMGF) and the Government of Uttar Pradesh (GoUP), established the Uttar Pradesh Technical Support Unit (UP TSU). The UP TSU was first established in November 2013 to strengthen Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) outcomes in the state of Uttar Pradesh, India, through direct interventions and technical support at community and facility level in 25 high priority districts (HPDs), which were selected based on their poor RMNCH+N outcomes.

In consultation with the GoUP, 25 HPDs were selected based on their poor RMNCH+N outcomes. Among the 294 blocks in these HPDs, 100 focus blocks, covering a total population of 31 million, were selected for more intensive community and facility level direct implementation. Based on the results, the learnings and strategies would be scaled up to the remaining 194 blocks in the 25 HPDs, and across the state. In 2016, the UP TSU expanded its scope to include health system strengthening.

Immersion visits to understand RMNCH scenario in selected 25 HPDs

The UP TSU conducted a Community Resource Mapping (CRM) exercise in 25 HPDs of UP in 2014 by adopting a structured tool that captured information on the functionality of Village Health and Nutrition Days (VHNDs), Front-line worker (FLW) profiles, and the village's demographic details.

It was found that overall ANC coverage was low (about 50%), and identifying at-risk pregnancies needed improvement. Initial analysis suggested this was due to a lack of demand for ANC services. However, further analysis showed inadequate platforms for service delivery. Stakeholder consultations revealed that most women preferred to receive ANC services within their community, rather than visiting the health-care facilities.

The number of sub-centres as per population was sub-optimal and many lacked adequate infrastructure, equipment, logistics and drugs. The Village Health and Nutrition Days (VHNDs) were being widely utilized as the community level platform to deliver Routine Immunization (RI) and nutrition services for children and pregnant women. It was also observed that FLWs lacked skills in microplanning for improved availability, mobilization and coverage of ANC services.

Additionally, UP TSU noted that sub-optimal convergence and coordination among FLWs limited the uptake of ANC services. FLW skills and competencies to improve ANC coverage could be strengthened through mentoring and supportive supervision and standardized recording and reporting of services delivered at their level. Strategies would need to focus on better convergence and coordination of FLWs.

Community Outreach Intervention Strategies

In order to address the identified gaps, the UP TSU worked closely with the National Health Mission (NHM) to convene consultations with FLWs and GoUP representatives to develop a landscape of Community platforms to improve the ANC services. In response, the UP TSU adopted five strategies. A brief description of these strategies follows (Figure 1):

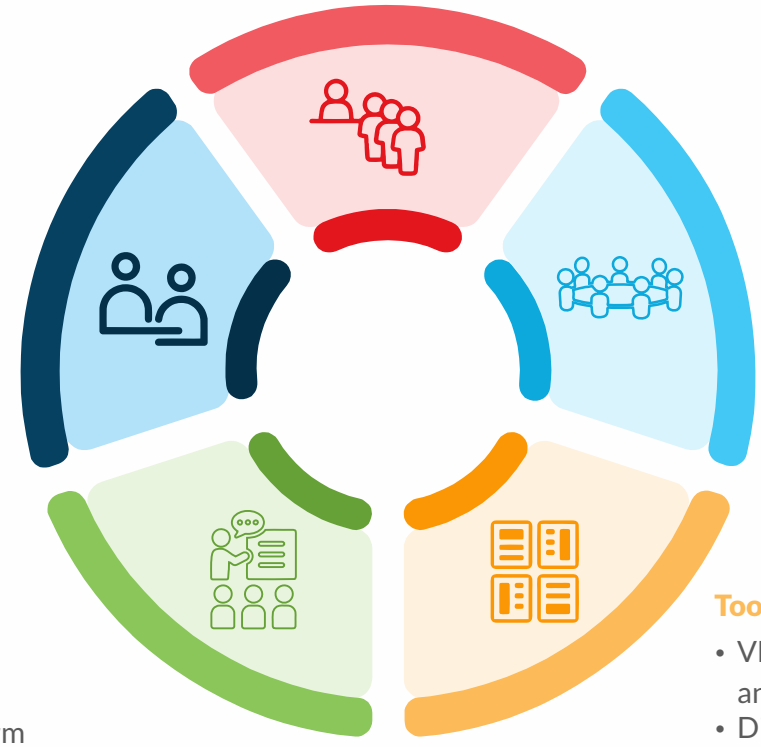
- **Establish and strengthen existing service delivery platforms**
- **Establish and strengthen coordination and convergence platforms**
- **Introduction of tools to improve the documentation and reporting skills of the FLWs**
- **Building Competencies of ASHAs**
- **Mentoring and Supportive Supervision to FLW**

Establish and strengthen existing service delivery platforms

- Government orders & guidelines
- Micro plan revised
- ASHA Payment application
- VHND observations application
- Logistics assessment
- Routine feedback to MoIC to improve availability of logistics & drugs.
- Monthly Feedback letters from NHM (Based on VHND observations data)

Mentoring

- Capacity building Platform strengthening
- Recording and reporting
- Mobilization for VHND services
- ANC & HRPs counselling
- Digital Application



Planning, Coordination Platforms

- Sub center (AAA) meetings
- Sankul meetings for coordination between ASHA and ASHA Sangini

Capacity Building

- Cluster meeting transformation as a capacity building platform
- ANM weekly meetings for follow-up
- ANM Skill Building

Tools and Job-aids

- VHIR, ASHA Sangini Diary and Tally sheet
- Digital application to capture unitized data
- Tracking tools for HRP women

Figure 1: Key Interventions to strengthen VHNDs service delivery platforms by GoUP

Establish and strengthen existing service delivery platforms

Policy Refinements to expand coverage

UP TSU supported the GoUP to revise the Government Order on VHND by including RMNCH+A in the existing Government Order. Under the new guidelines, in addition to routine immunization, VHNDs would offer family planning, ANC, newborn, child and adolescent health and nutrition services. Subsequently, GoUP state released these guidelines as a 43-page government order.

To clarify, standardize, and structure government oversight of VHNDs, the guidelines mandated VHND monitoring committees at the state, directorate, divisional, and district-level that would oversee the functioning and performance of VHNDs. The Chief Secretary and Principal Secretary, Health and Family Welfare connected with all the District Magistrates through video conferencing to orient them on the new guidelines. A series of meetings were organized at the state, district, block, and village levels for all the 75 districts. The progress was assessed and reviewed on a fortnightly basis by the District Magistrate and Chief Medical Officers in the districts. State and divisional level officials of the Health & Family Welfare Department, State Project Management Unit (NHM), and Technical Support Unit (TSU) were assigned the responsibility of providing supportive supervision support to the districts.

Landmarks/ Milestones

- VHND: Routine immunization platform transformed to deliver comprehensive services including ANC, FP and Nutrition.
- VHND GO issued by Chief Secretary.
- Standalone interdepartmental convergence GO issued by DHFW and WCD.
- Guidelines on VHIR orientation issued.
- Microplan revised.
- FLWs trained on the skills and competences required to increase ANC coverage and intake.
- Launch of 'Maatrav Saptah' campaign.

UP TSU supported the rollout of training of approximately 300,000 FLWs on the new VHND operational guidelines by adopting a cascade model. A state-level Training of Trainers (ToT) was held with the representative from Directorate, State Program Management Unit[5] (SPMU)'s of National Health Mission and State Nutrition Mission, Rural Development and Panchayati Raj Department, State Institute of Health & Family Welfare (SIHFW), UP TSU, State Innovations in Family Planning Services Project Agency (SIFPSA), and other Development Partners. The electronic and printed copies of the guidelines were shared with the districts. The FLW orientation on the revised guidelines and the technical aspects of RMNCH+N services helped to refurbish their existing knowledge and learn new skills as per the revised guidelines.

Microplans for VHNDs:

While rolling out the training, it was observed that multiple RI sessions used to take place in a village on the VHND day, and most of these sessions took place under trees or in open spaces. However, privacy for abdominal examination and toilets to enable collection of urine samples for protein testing was missing, yet was necessary to offer the complete package of ANC services. To ensure privacy for better services, UP TSU supported GoUP in initiating the microplan refinement process, developed a microplan tool, and issued a Directive for its adoption throughout the state.

UP TSU team facilitated the meetings at the district and block level and oriented the teams on developing the microplan as per the revised format. In keeping up with the revised mircoplan, FLWs were required to identify a potential place in the village that ensured easy access to everyone. A space for abdominal examination and toilets for urine collection was to be clearly demarcated. The revised block-level microplans compiled the number of ASHA areas, allocated days for VHND, the most appropriate site for VHND accessible for rural populations, and FLW details i.e. name, population and VHND etc. The refinement process addressed the gaps in accessibility, availability, and privacy.

Matra Ewam Shishu Swasthya Sanrakshan Abhiyan:
To create an enabling environment for the comprehensive RMNCH+N service delivery at the VHNDs, the GoUP drafted the guidelines with the support from UPTSU for a three-month campaign, Matra Ewam Shishu Swasthya Sanrakshan Abhiyan, aimed to improve ANC coverage, full immunization, increase institutional delivery, increase coverage and promote family planning services, and improve child nutrition. The campaign was held from 1st February to 30th April 2015.

Establish and strengthen coordination & convergence platforms

The Ministry of Women and Child Development (MoWCD) and the Ministry of Health and Family Welfare (MoHFW) recognize the ASHA, Anganwadi Worker (AWW) and the Auxiliary Nurse Midwife (ANM) as the on-ground FLW cadre to promote the health and nutrition of women, children and adolescents.

Front Line Workers (FLWs)

Anganwadi worker (AWW) under the Integrated Child Development Services (ICDS) programme: Her role is to provide pre-school education to children under six, and nutritional support and healthcare for children and pregnant or lactating mothers, to reduce mortality, morbidity, and malnutrition.

Auxiliary Nurse Midwives (ANMs) works at the health sub-centre level, which provide healthcare services at the village-level, and hence are the closest service provider to the community within the health system. ANMs have preliminary qualifications in midwifery and Maternal and Child Health, as well as in treating common illnesses. They provide a range of services, such as antenatal care, dispensing medication, immunization, family planning and assistance with deliveries.

Accredited Social Health Activist (ASHA) is a part-time, trained community health volunteer, who works as an interface between the community and the public health system. They fall within the ambit of the MoHFW, and are a key component of the National Health Mission. Their role entails tracking pregnant women and newborns, delivering key health-related information, and promoting health-seeking behaviour.

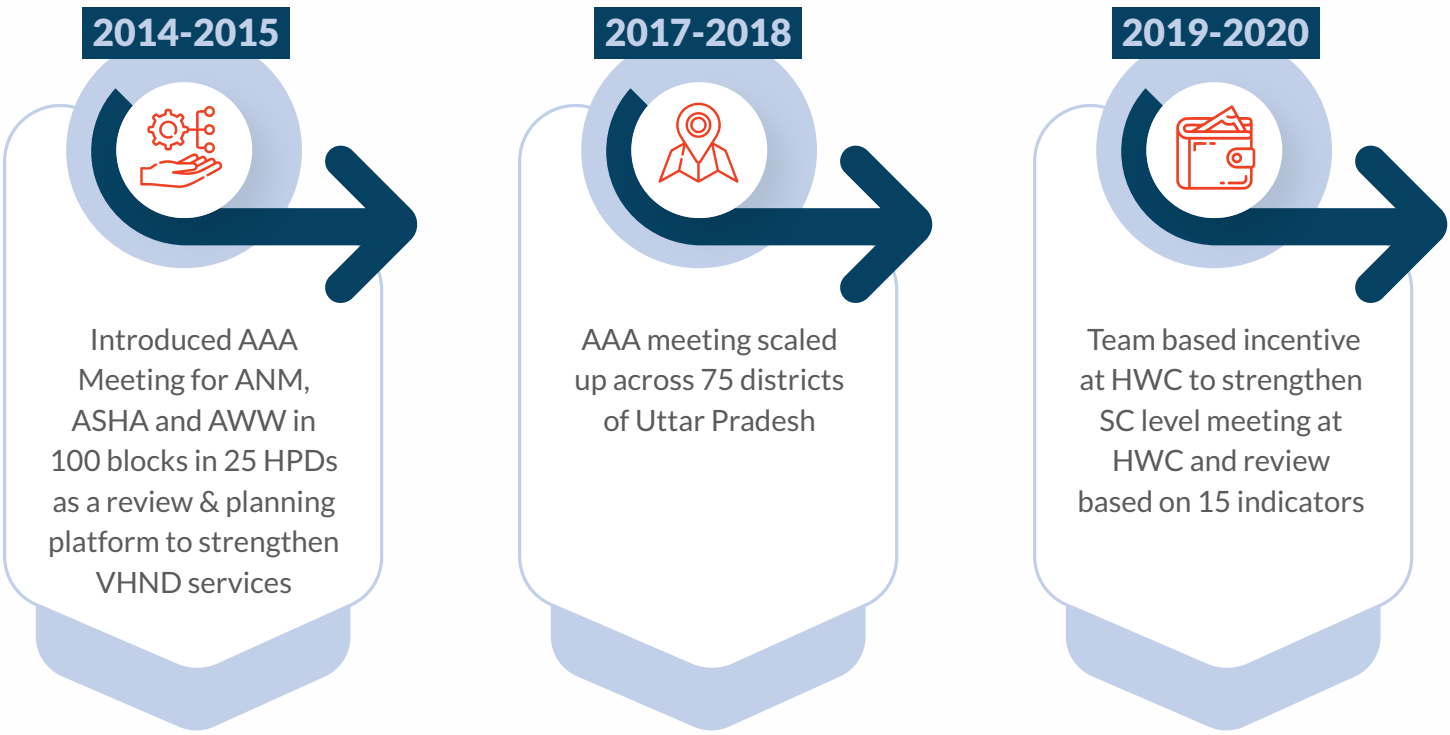
A convergence platform was perceived as vital to synchronize the functions of three FLW for better RMNCH+N outcomes. To achieve this aim, UP TSU supported the government to draft guidelines for AAA (ASHA, ANM, AWW) meetings in 100 blocks in the 25 HPDs in March 2015. These guidelines were later issued as a Government Order for roll-out across the state.

UP TSU facilitated the AAA forums at the sub-centre level to discuss the complementarity in the roles of each of the FLWs. AAA platform was therefore envisaged as a forum for discussion and coordination among the ANM, AWW, ASHA to jointly build effective coordination on the ground, creating an enabling work environment for them and preventing duplicity in their work. With proper coordination and microplanning, these efforts were channelized to implement the RMNCH+N program effectively.

> "We all are doing our task very responsibly, we are aware of our programs, and we used to communicate our concerns with each other (ANM & AWW) very casually, as we did not have any organised platform to share our problems and seek each other's support. Attending AAA meetings brought us together, improved our interpersonal communication, and gave us the opportunity to plan in coordination for better and effective service delivery at VHND".
> ASHA from Barabanki district

AAA platform was utilized to develop standard due lists (for ANC, RI, and Nutrition Services), review previous VHND services, identify and address service delivery gaps; expand the scope of roles and responsibilities of ASHA, ANM and AWW for service delivery, review and update microplans, discuss local solutions to reach out to the individuals and families who delay in accessing or refuse to receive services, and plan for outreach to unreached geographies. The Departments of Health and Family Welfare and Women and Child Development converged to conduct joint planning and review meetings at the district level to assess the functioning of VHNDs.

UP TSU successfully operationalized these meetings at a sub-district/block level and supported the district and block level functionaries to develop a microplan for AAA meetings. These meetings are scheduled cluster-wise on the third Friday of every month at a sub-centre. Based on the success with this convergence, the GoUP expanded AAA meeting platform to 75 districts of UP, covering around 160,000 ASHAs, 170,000 AWW and 35,000 ANMs, providing them with an increased incentive from Rs.50/- to Rs.75/- to promote the participation of ASHA and AWW in AAA meetings.



Emphasize & initiate SC level Meeting at HWC (2019-2020)

Figure 2: Evolution of AAA meetings over time

Introduction of tools to improve the documentation and reporting skills of the FLWs

Village Health Index Register (VHIR)- A Planning & Review Tool (Figure 3)

It was observed that ASHAs maintained 14 separate registers to record service provisions. There was no standardization in recording the details of the beneficiaries and the services, reporting and planning to map and track women in the reproductive age group, pregnant women and children. Therefore, to improve the coverage, efficiency and effectiveness of ASHA outreach, an integrated planning, recording and reporting tool was envisaged.

In the process of tool development, a consultation meeting was organized with ASHAs and GoUP/ NHM to elicit their views and suggestions on different RMNCH related components and indicators that could be integrated within one comprehensive tool. After a series of consultations and reviews of different ASHA diaries from other Indian states, a draft Village Health and Index Register (VHIR) was prepared and piloted in the districts of Barabanki, Sitapur and Hardoi to test its feasibility and adaptation. Based on the field-based pilot testing, the VHIR was further refined and shared with NHM.

UP TSU extended support to GoUP in drafting the Program Implementation Plan (PIP) proposal along with the budgets to seek funds from GoI to print the VHIR copies for the entire state. The guidelines for printing the VHIR were issued on 31st March 2014, and funds were disbursed across the state. The VHIR not only helped in the identifying critical gaps in the service delivery side and reasons for the gaps in utilization. VHIR also helped ASHAs to track their incentives received for different services by keeping a section-wise record of beneficiaries and entering the data in the payment sheet. ASHA Drug kit supply can also be tracked through the current VHIR as it has the provision of listing quarterly replenishment of drugs and supplies. UP TSU subsequently adopted a cascade approach to support NHM in rolling out orientation trainings for FLW to effectively use the VHIR.

Orientation sessions on VHIR were conducted with a total of 454 batches in 100 UP TSU blocks covering 17,800 ASHAs, 450 Sangini, 2631 ANMs, 357 Lady Health Visitors/ Health Supervisors.

Sections in VHIR

SECTION 1

Village profile, contact details of the concerned officials & service delivery platform

SECTION 2

Household Survey

SECTION 3

Details of ANC check-up, ANC services and immunization

SECTION 4

Line listing of Eligible couple, Family planning commodity distribution

SECTION 5

0-2 years infant care and immunization details

SECTION 6

2-5 years child immunization & Nutrition details

SECTION 7

0-5 years Children identified with illness & referral by ASHA

SECTION 8

Follow up with SAM children after discharged from NRC

SECTION 9

Adolescent Health

SECTION 10

Birth registration details

SECTION 11

Death registration details

SECTION 12

VHND details

SECTION 13

Details of ASHA participation in monthly meetings & other activities

SECTION 14

ASHA drug kit details

SECTION 15

Details of Non communicable & communicable disease screening & referrals

SECTION 16

ASHA Sangini supervision details

SECTION 17

Details of ASHA incentives

SECTION 18

Due list details

Figure 3: Components of VHIR

> "Earlier we used to carry so many registers for maintaining the record of the beneficiaries and service delivery, which was very cumbersome for us. VHIR is a comprehensive tool where we maintain village records, beneficiaries' details and service uptake all in one place. VHIR also helps us in planning for the next VHND, prioritize families for continuous home visits, referral and follow up."
> ASHA from the Bareilly district

VHIR facilitates documentation across a continuum of care approach. Beginning with recoding of the household survey, recording of sociodemographic information of pregnant women and newborns, preparing the due list for mobilizing individuals to access ANC and immunization services, listing of High Risk Pregnancies[6] (HRP), facilitation of birth planning, recording of delivery and postnatal care services. The due list for ANC and PNC that are part of VHIR is further validated in AAA meetings to ensure better planning for the next VHND.

High Risk Pregnancies identification, referrals and follow-up in the community (Figure 5)
While ensuring the availability of quality ANC services, special emphasis was laid on screening of HRP, particularly those with severe anaemia and hypertension in 25 HPDs. The key strategy adopted to cater to these HRP women is provided below:

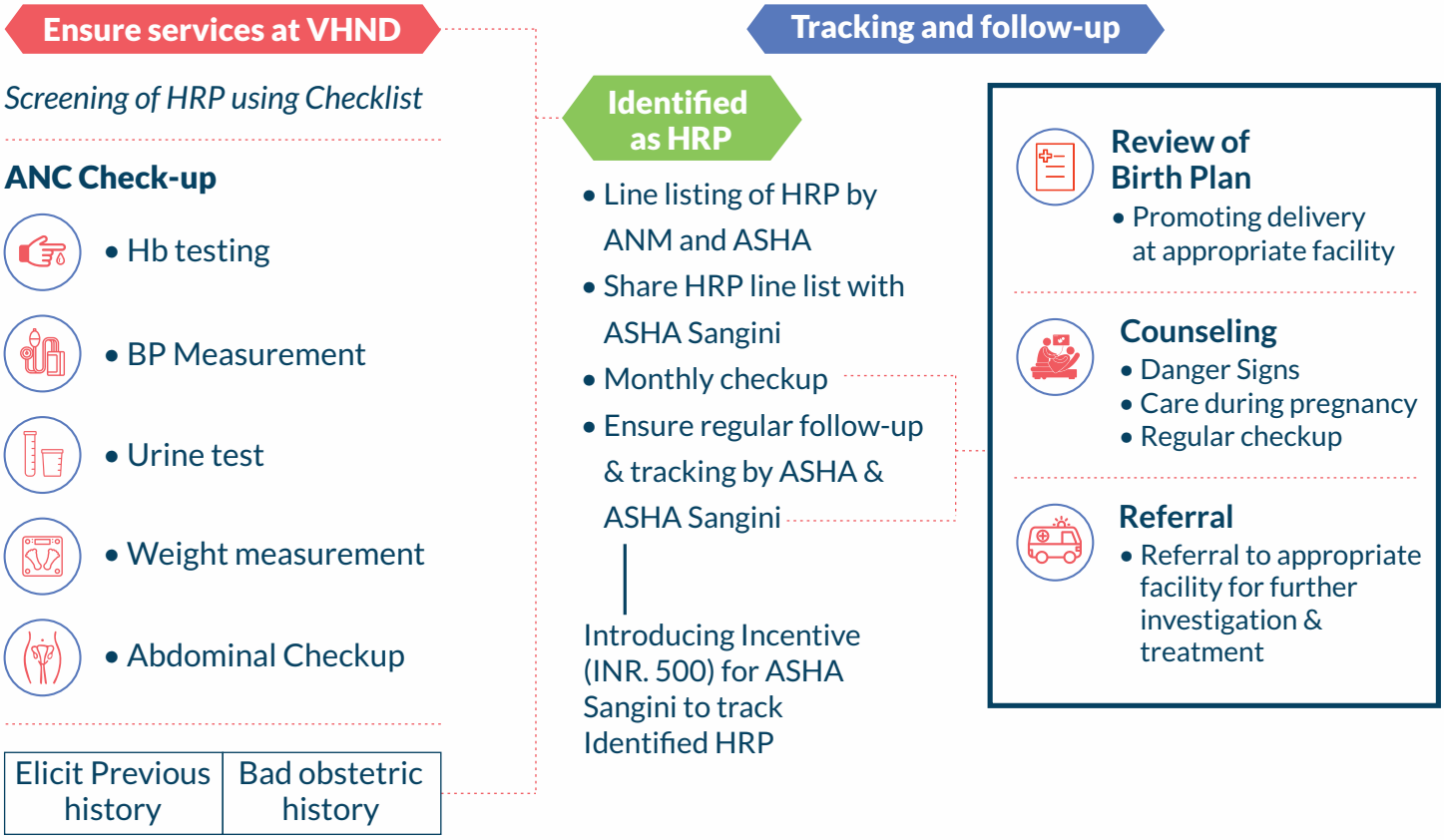


Figure 4: Strengthen HRP Identification, Referral and Follow up in Community

Improve HRP identification and management:

UP TSU focused on screening of hemoglobin (Hb) levels of pregnant women to identify anaemia, especially severely anaemic pregnant women, and to measure Blood pressure (BP) to identify hypertension. Availability of functional Hb and BP equipment at VHND sites and iron sucrose at the facility level was ensured via GoUP. To promote correct Hb screening at the service delivery platforms, Digital Hb meters were also introduced in most of the VHNDs in addition to the already available paper based Hb screening methods.

Line listing, referral and follow-up of HRP women:

HRP line-listing and tracking mechanisms for ASHA Sangini, ASHA and ANMs were introduced and integrated within the broader NHM registers. These registers record the details of HRP women, particularly severely anaemic pregnant women (SAPW). The HRP women, based on the severity are referred to the nearest Community Health Centre (CHC)/District Hospital (DH) by the ANMs for the appropriate management. A record of the availability of IFA tablets by a pregnant woman, the number of iron sucrose doses administered to them, and the number of pregnant women that underwent blood transfusion is maintained by the ASHA.

Birth planning, complication readiness and appropriate facility delivery of HRP:

UP TSU & NHM is working towards ensuring that every HRP woman is encouraged to deliver in an L3 facility where Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services are available. Special attention was given to ensure that pregnant women with severe anaemia are prepared for delivery at an L3 facility. ASHA supports in the preparation of the birth plan for identified HRP women and counsels them and their respective families on possible complications during delivery. The ANM also reviews the birth plan during the third trimester. UP TSU also facilitated the modification of GoUP HRP guidelines to include guidance for ANMs to mark the Mother and Child Protection (MCP) card with a **red** color seal and included HRP screening question in 102/108 call center algorithm. When the call for delivery is made to the Government ambulance services, they check with the pregnant woman/ASHA for the red seal on MCP card. If found, the ambulance operators are authorized to directly take the woman to a nearby functional DH, CHC-First Referral Unit (FRU) for delivery.

L1 level facilities are usually the Sub Health Centers (SHC) and Primary Health Centres (PHC) that provide delivery services.

Basic Emergency Obstetric and Newborn Care (BEmONC) facility are L2 level facilities which are provided through the PHC and Community Health Centers (CHC)

Comprehensive Emergency Obstetric and Newborn Care (CEmONC) are L3 level facilities which are usually the CHC and District Hospital (DH)/ Civil hospital.

Dr Manoj Singh, MOIC, Ahirori Hardoi commented that "ASM work in my block is commendable, I have observed a lot of improvement in the knowledge level of ASHAs and ASHA Sanginis. Today I am aware of the progress and gaps of my block due to the weekly feedback provided by ASM, which is a big contribution in making timely amendments. ASHAs are now tracking HRP, LBW and ensuring all severely anaemic PW receive iron sucrose doses. Instances of home delivery have significantly reduced in my block, and based on the feedback shared by the ASM, I have activated one additional delivery point, and I am very happy to say that there has been a significant increase in the institutional deliveries in my block".

Furthermore, block specific WhatsApp Groups were created to refer and follow up severe anaemia cases from community to facility. When a pregnant woman was diagnosed as severely anaemic by ANM at the VHND and the facility referred the patient to a higher facility for confirmation or protocol based treatment, the information was posted in WhatsApp groups for further follow up at the facility level.

According to the community process external evaluation data (2019), a comparative analysis with HRP and Non-HRP pregnant women showed that the services received by HRP pregnant women have shown improvement based on the nature of severity and priority as compared to the Non-HRP pregnant women. 52.8% of HRP women received 1st ANC in 1st trimester, 78.5% of HRP received any ANC in 2nd trimester, 84.1% of HRP women received any ANC in 3rd trimester and 88.4% of HRP delivered in a health facility[8]. (Figure 5).

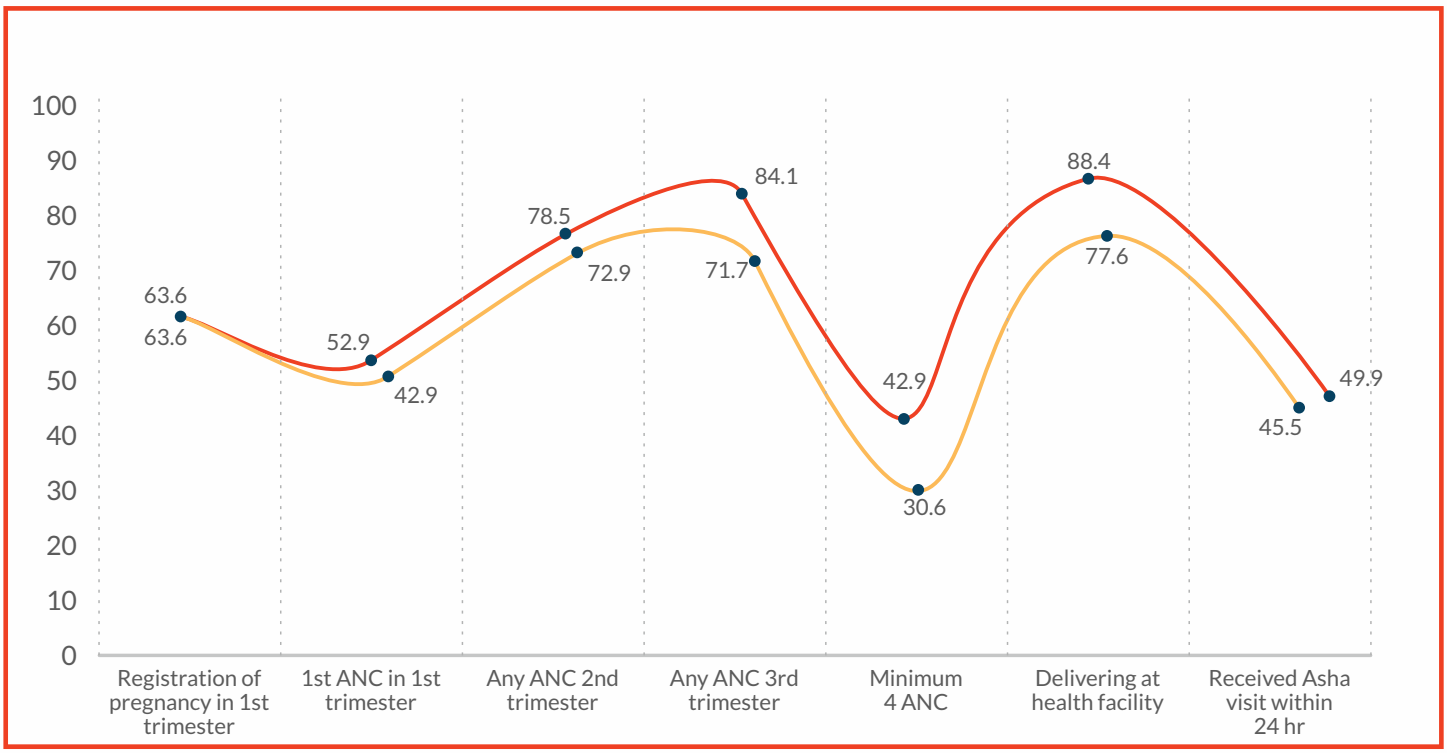


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Figure 5: Mapping outcomes across Continuum of Care (Normal vs HRP)

Radha's anaemic status improved due to ASHAs' efforts!

- Case story from Praspur Block of District Gonda, Uttar Pradesh

Radha Devi, a resident of Umrao Purva of the Gonda district, had her first delivery as a C-section, and when her child was just ten months old, she conceived again. Radha registered herself with the ASHA during her fourth month of pregnancy. Her Hb level was 9.4 grams during her first ANC check-up. The ANM prescribed IFA tablets, instructed her to take two tablets each day, and advised her to eat a nutritious diet and get ample rest, after which Radha left for her maternal home. When she returned, she was six months pregnant. After visiting VHND for her second ANC, her Hb level had dropped to 6.3 gms. She had not been taking the IFA regularly that had contributed to the drop in her Hb level. She was advised to visit the District Women's Hospital to administer iron sucrose to her.

Radha shared her concerns about her family's reservations about visiting the district hospital due to the long distance. The ASHA, alongwith ASHA Sangini and ASHA Sangini Mentor counselled her family about the need for iron sucrose doses, how critical her condition could get if her anaemia were not addressed, and the obstacles that would follow in her childbirth. Eventually, Radha's family agreed to send her to the District Women's Hospital (DWH) alongwith the ASHA.

At the hospital, a doctor examined her & prescribed five iron sucrose doses to be taken on alternate days. By the 8th month of her pregnancy, her Hb reached 12.2 grams, and subsequently regular consumption of IFA, it further increased to 13.3 grams by the 9th month of her pregnancy. Radha and her husband were blessed with a healthy child at the DWH.

**Representational image*

Building Competencies of ASHAs

Cluster meeting is a block-level forum designed as a review and planning platform convened by the Medical Officer-In-Charge (MoIC) and Block Community Process Manager (BCPM). One cluster meeting usually caters the total number of ASHA areas under two ASHA Sanginis. Each ASHA Sangini usually covers about 20 to 25 ASHAs. These monthly cluster meetings which were used as a forum for submission of payment vouchers and data collection, was transformed by NHM-GoUP to build capacities of the ASHAs. The aim was to enhance the skills, knowledge and competencies of ASHAs on RMNCH+A and Maternal, Infant and Young Child Nutrition (MIYCN) topics. A cascade model was adopted to roll out the capacity building initiative.

Three objective adopted for this purpose were:

a. Create a local-level resource pool of facilitators to provide need-based capacity building to ASHAs

b. Allow opportunities for peer learnings

c. Provide need-based mentoring and handholding support by ASHA Sanginis

Identification of capacity building concerns of ASHAs through a consultative process:

A consultation meeting was held with ASHAs and ASHA Sanginis to conduct a situational analysis of their knowledge and skills. The findings included:

- A continuous need to update knowledge on new and revised guidelines
- One-time training had limited effect on knowledge enhancement, regular onsite mentoring was important to influence practice
- Peer-experience and learnings was the best method to tackle challenges
- Critical performance indicators should be linked to the most important MNCH indicators
- There was a need to enhance the knowledge, skills and competencies of ASHA Sanginis too

> "The Cluster meetings are being held more systematically and have demonstrated quality interactions between ASHAs. Enhancing the facilitation skills of ASHA Sanginis has led to effective management of needs & issues of the ASHAs. The Common Review Mission team of Government of India appreciated this initiative during their visit to Bahraich".
> Mr. Rashid, DCPM, Bahraich

Module development on 18 thematic areas in consultation with NHM:

Key areas for the module were identified in the consultation meeting with ASHAs and ASHA Sanginis.

The module focused on using participatory approaches such as case study, group work, role plays, quiz skill demonstrations, etc., The module was field-tested with ASHAs and ASHA Sanginis and refined based on the feedback received. (Figure 6).

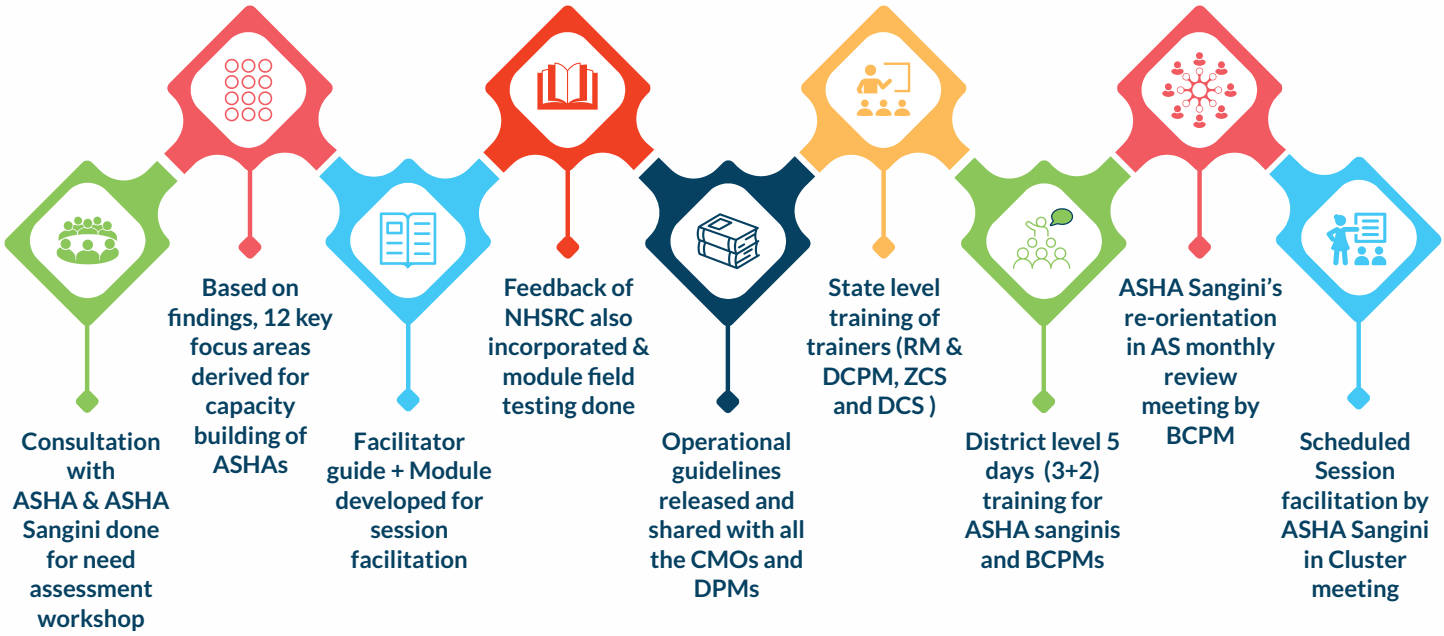


Figure 6: Intervention roll out

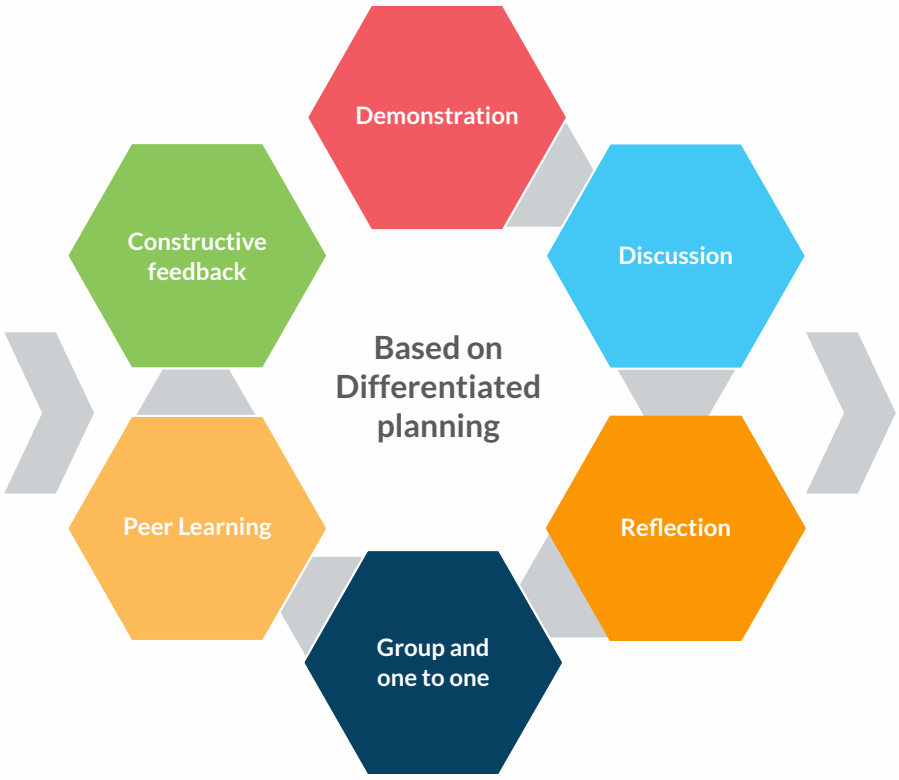
Thematic areas for Capacity building sessions	
Month	**Topics for facilitation**
April	Diarrhea
May	LBW management KMC & and EBF
Jun	VHSNC
July	Early identification and registration of PWs
August	HRP Identification & Referral
September	Birth planning, ID & Govt. Schemes
October	PPIUCD & Family Planning
November	HBNC
December	Pneumonia
Jan	Immunization and VHND
Feb	Adolescent Health
March	NCD

The Cluster module has been converted into power point presentations with embedded voiceover. These tools have been adopted by the BCPM to train ASHA Sangini as a part of ToT and for further facilitation by ASHA Sanginis in Cluster Capacity building of ASHA. A ToT was organized at the State level with the BCPMs using these voice-over embedded presentations to facilitate the sessions with ASHA Sanginis in a District level training held subsequently. Further, a three-day orientation was organized with the ASHA Sanginis using these materials; wherein potential facilitators were identified from the same pool to train the ASHAs. A standard checklist was adapted to be used by the Sanginis identified as facilitators, and they were entitled to receive an incentive of Rs.200 for facilitation while the ASHA was entitled to receive an incentive of Rs.100 for participating in these capacity building sessions. This was in addition to the regular incentive for participation in a cluster meeting.

Mentoring and Supportive Supervision to FLWs

The success of ASHA Sangini (AS) and ASHAs as effective community mobilizers was overshadowed by multifold challenges that required attention on a daily basis. With the rapid developments in the profile and responsibilities of ASHAs, there arose a clear need to enhance/upgrade their skills, capacities and identify tools that helped them deliver better services and improve Antenatal Care, Institutional Delivery utilization & Postnatal care (Figure 7).

Mentoring techniques used by ASM to Mentor AS



ASHA Sangini equips with-

- Improved Knowledge and demonstration skills on RMNCH
- Leadership in building peer learning approach among ASHA work force
- Strengthen the communication skills of ASHA for community behaviour change

Figure 7: ASHA Sangini Mentoring

ASHA Sanginis were identified as a supervisory cadre to provide supportive supervision and mentoring support to the ASHAs and build their capacities. Hence, in order to understand the skills and knowledge gaps among ASHA Sanginis as supervisors to mentor and provide supportive supervision to ASHA on RMNCH indicators, UP TSU conducted three-day workshop with select ASHAs and ASHA Sanginis in February 2017 in Lucknow. The objective of the workshop was to understand the skills and knowledge gaps among ASHA Sanginis as supervisors to mentor and provide supportive supervision to ASHA on RMNCH indicators. The major outcome from the workshop further endorsed the need for building the capacities of ASHA Sanginis so that they could effectively execute their role as Supervisors.

Furthermore, based on the consultations with ASHA Sanginis and ASHAs, the following barriers in mentoring and supportive supervision were mapped:

Barriers at ASHA Sangini level

- No system of gap analysis and planning to optimize the efforts of mobilization
- Limited skills among ASHA Sanginis (AS) to demonstrate and mentor the ASHAs
- Current curriculum for AS does not adequately build their required knowledge and skills
- Limited number of contacts between AS and ASHAs for mentoring and supervision
- Absence of tools and methods for prioritizing, planning and mentoring
- No team-based planning and problem solving process to address gaps

Barriers at System level

- Availability of facilities and commodities (ex., delivery points, VHND pregnancy kits)
- Availability of ASHA and ANMs
- Design and complexity of the ASHA incentive system and inefficiency in incentive distribution system
- Complexity of the VHIR and low use of data
- Poor coordination of demand side interventions with the supply side services

The overarching goal of the ASHA Sangini Mentor (ASM) Model was to create an evidence-based, innovative, effective and efficient intervention to ensure availability, utilization and quality of ANC and Postnatal Care (PNC) services in UP through service delivery and capacity building platforms.

Mentoring Focus Areas and Approach:

The purpose of the Mentoring was:

(a) Enhance the knowledge and competencies of ASHAs on ANC and PNC through various platforms (Cluster meeting, AAA, VHND, etc;)

(b) Build ASHAs mobilization and counselling skills through on-site mentoring and periodic supportive supervision visits;

(c) Improve the recording and reporting

ASHA Sangini Mentors (ASMs) are the block level cadre of UP TSU. ASM uses techniques like demonstration, discussion, and reflection methods to provide mentoring support to ASHA Sanginis. During on site mentoring support, ASHA Sangini is encouraged and motivated to practice their mentoring skills on the ASHAs. ASMs mentor ASHA Sanginis on their field-visit plan by using the VHIR data. The plan is customized for each ASHA depending on the gaps and needs. VHIR data directs the Sangini to decide which village and which ASHA needs more support and where she should focus her energy to achieve the desired outputs. She also assists ASHA in updating the VHIR.

Mentoring Platforms – ASM mentors ASHA Sangini at Four level: (a) VHND; (b) Home visits; (c) Cluster meeting; (d) AAA meeting (Sub Centre meeting) (Figure 8)

Figure 8: Mentoring Platforms

Mentoring coverage **-** One ASHA Sangini Mentor is assigned 3 to 5 ASHA Sanginis (AS) and one AS provides mentoring support to approx. 20 to 25 ASHAs. In 25 HPDs, approximately 240 ASMs were providing support to 889 Sangini in identifying gaps, prioritization & planning and demonstration of skills to 21869 ASHAs.

The demonstration and practice of skills to mobilize community and change behaviours by adopting a family-centred approach is focused upon during mentorship visits. IFA consumption and home-based care of the newborn were specific topics during mentoring. Another approach used by the ASM to address field-level issues was group discussion with the ASHAs at the village level in order to derive an understanding of their successes and challenges of implementing their action plan. ASM, AS, and ASHAs discuss and address some of the challenges to encourage ASHA initiated solutions. The quantity and quality of ASHA interaction with the beneficiaries were reviewed through the VHIR in the group discussions. These discussions also facilitate the development of action plans for the following month.

Mr. Anil AT, DCPM, Kannouj indicated that "Now the ASHAs are more equipped with the latest information on different guidelines," he further added that "providing training skills to ASHA Sanginis can help them in effectively addressing the needs and issues of ASHAs and enhance their skills by handholding and continuous mentoring. AS provides effective supervision to ASHAs through routine field visits; hence they are in the best position to understand the gaps and ways to address them during cluster meetings".

Mentoring to enhance ANC coverage

To identify the ASHA areas for mentoring, UP TSU introduced the ASHA progress report tool, which tracks the population of the ASHA area, registration details of pregnant women, the uptake of ANC services, the number of institutional deliveries, and the Home Based New Born Care (HBNC) status, including Low Birth Weight (LBW). ASHA Sangini collects this data on a monthly basis from each ASHA and prepares her field visit schedule based on it. The pregnancy registration coverage data of ASHA areas is segmented into three categories i.e., <40%, 40-60%, and >60%. This categorization provides a clear picture of ASHA area wise PW registration status and enables the ASHA Sangini to prioritize her field visits to ASHA areas. For mentoring purpose, ASHA Sangini plans for joint visits along with the ASM to < 40% of PW registration ASHA areas. In the 40% to 60% areas, ASHA Sangini visits along with the ASHA. Finally, in > 60% PW registration areas, ASHA discusses the process to increase the ANC coverage in cluster meetings.

Ranvijay Singh, DCPM Farrukhabad, expressed that "Although it has been almost two years since I joined here as the DCPM, I can definitely say that ASHA's cooperation has increased due to ASM and Sangini's work and the knowledge levels are higher. The registration of pregnant women and ANC status has improved; ASMs have worked hard to develop leadership qualities among ASHA Sanginis."

ASHA's Sangini's efforts pay off – ANC Registrations go up in Chidiyai village!

Case Story from Ganjdundwara Block of Kasganj District, Uttar Pradesh

ASHA Sangini realized that there were very few pregnant women (PW) in the village Chidiyai whose names were listed in ASHA's diary against the estimated PW in the area. ASHA reported the absence of beneficiaries at the VHND to receive ANC services despite her regular home visits.

ASHA Sangini, along with ASHA and ASHA Sangini Mentor, organized a village-level meeting under the leadership of the Panchayat Head. In the meeting, ASHA discussed the importance of ANC services, risks associated with high-risk pregnancies, allied complications, the need for institutional delivery, VHND services, government facilities, free ambulance services, and regular consumption of IFA tablets. The panchayat head requested the villagers to adhere to the advice of ASHA to facilitate a healthy and safe pregnancy. As the villagers followed ASHA's advice, their inhibitions gradually decreased. Over a period of time, it was observed that the PW began visiting the VHNDs, preparing their birth planning bags and eventually were in a better position to go for institutional deliveries.

**Representational image*

Table 1: To ensure early & timely registration of PW & identification, following approaches & strategies innovated by UPTSU and adopted by ASHA Sanginis in the field.

Sn	Approaches & Strategies	Adaptability	Outcomes
1	Hamlet Mapping	• In all the rural areas with scattered population & unclear demarcation of ASHA areas • Nomad population • Hard to reach areas	• Cover unreached areas • Increase in first trimester registration • Reduced gaps in service delivery
2	Last Menstrual Period (LMP) tool	• Areas with less PW registration (>40% against the estimations) • ASHA contact is less • No listing of Multipara/gravida women • Unmet needs	• Timely MTP (Medical termination of pregnancy) if there is an unmet need • First trimester registration improved • Gestational age correctly calculated (support in pre-tem identification)
3	Revalidation of Pregnant women list	• Health related community outreach services (VHND/Health camps) • Availability of community health workers (CHW)	• Same day saturation of the village for the given month • Early registration • Timely HRP identification
4	Neighbourhood alliance	• Low MNCH indicators • Low health seeking behaviour • Low literacy • TFR is more	• Message delivery to the large population • Impacting group behaviour • Improved community health seeking behaviour

Mentoring for conducting Capacity building sessions in Cluster meeting platform

Cluster meeting platform had been converted into a capacity building platform to enhance the skills, knowledge and competency of ASHAs on critical RMNCH behaviours every month and to understand and resolve the factors inhibiting their performance. ASHA Sangini is the facilitator for conducting sessions on RMNCH thematic areas in the Cluster meetings. Hence, to build the facilitation skills of ASHA Sangini, ASM mentors them in Sangini meetings on required skills to conduct sessions and prepares them to facilitate specific topics as listed on page 23 under the Thematic Areas for Capacity Building Sessions. She guides the AS on how to strengthen communication and interpersonal skills of ASHA and makes sure they understand both the content and training methodology for each topic. She also mentors them to prepare posters on relevant topics as reference material for display at their own sub-centre or health and wellness centre. AS were also trained to make sessions more participatory by conducting quiz, role plays, case studies, group discussions, etc., During the cluster meeting, ASM observes the session facilitated by AS using a standard checklist. Post-session the ASM, along with the BCPM, provides feedback to the AS on the gaps in facilitation and areas for improvement.

> "In earlier cluster meetings we would only submit vouchers and signed attendance forms, but now the cluster meetings are more effective and interactive where our ASHA Sangini didi provides us knowledge on different topics and also aids our home visits".
> Shakuntala Devi (ASHA, District - Sitapur)

Mentoring for bringing uniformity and better coordination among FLWs in AAA meeting Platform

To strengthen the community level services provided by ANM, ASHA and AWW at VHND, the AAA meeting serves as another platform for the FLW to improve ANC service uptake and beneficiary mobilization. Mentoring support is provided to the sub-centres with low ANC coverage, poor quality of due-lists, lack of coordination among FLWs, and low community mobilization. The AAA platform has been used as a mentoring platform to build the skills of FLW on the developing standard 'due-lists' (for ANC, RI, and Nutrition services), to review previous VHND outputs, to identify and address service delivery gaps, to refine specific roles of ASHA, ANM, and AWW for service delivery and to review and update microplans.

Birth preparedness for appropriate facility delivery

With an aim to prevent adverse pregnancy outcomes, UP TSU, through all of these community intervention, ensures that each pregnant woman is aware of birth preparedness, promoting timely access to skilled maternal care. ASMs, AS and ASHA ensure to review birth preparedness during home visits.

ASM mentors AS and ASHA to inform all pregnant women and their families on the birth preparedness plan from the second trimester onwards. Birth preparedness takes place at households and service delivery platform (VHND) level. During the home visit by ASHA, the beneficiary and her family are informed about the nearest facility for delivery, emergency funds for complications; supplies and materials ('prasav potli') that they need to carry with them to the facility; identification of labour and birth companion; identification of someone who can look after the home and older siblings while the woman is away for delivery; transport service facility, arrangement for transport to the facility in emergencies; and the identification of compatible blood donors in need of blood transfusion. As well as enabling beneficiaries to detect complications earlier, it further reduces the duration between deciding to seek care and reaching the designated facility where skilled care from qualified providers is available. The ANM reviews the birth plan in early third trimester during VHND sessions and counsels the pregnant woman about the social entitlements, transportation facility, the importance of facility-stay and food availability during their stay in the facility after delivery.

Jhoola (Prasav Potli) (a term used for a cloth bag in the local UP dialect) comprises of essential items required during delivery such as Aadhar card, MCP card, bank passbook, clothes, and money.

IMPACT

The National Family Health Survey 2020-21 (NFHS-5) factsheet for Uttar Pradesh was released on 24 November 2021. Following are some important points from the comparative analysis between NFHS-4 (2015-16) and NFHS-5 (2020-21) pertaining to selected indicators of MNCH+N.

Neonatal mortality rate (NMR) has declined to 35.7% (NFHS 5) from 45.1% (NFHS 4). 15.9% increase in pregnant women registration. Improvement in antenatal care is indicated by 16.6% increase in women getting an antenatal check-up in the first trimester and 16.0% increase in women receiving 4 ANC check-ups (Figures 9 to 11).

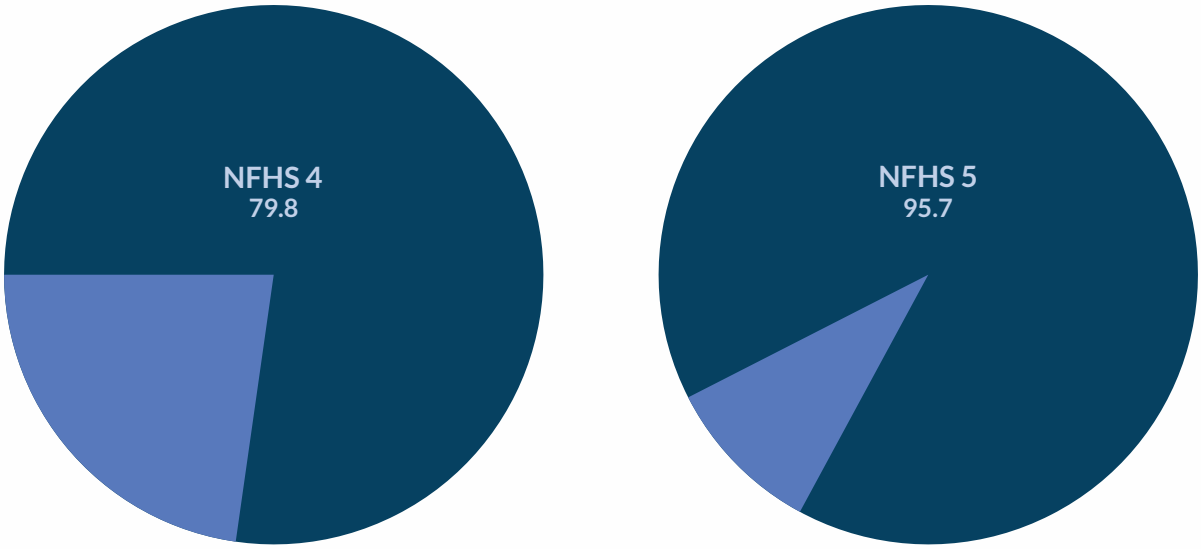


Figure 9: ANC Coverage (% received MCP card)

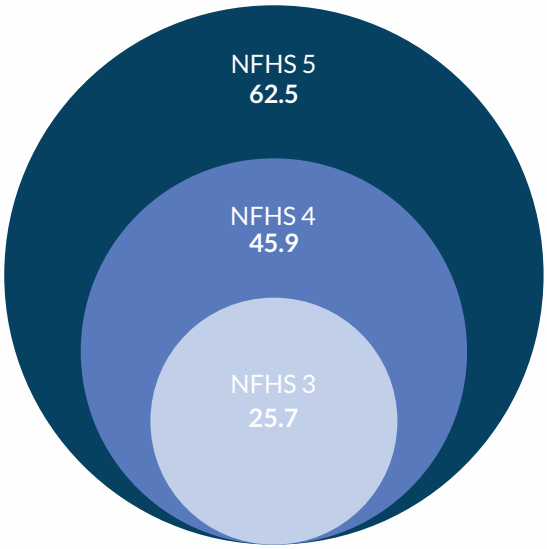


Figure 10: ANC in first trimester (%)

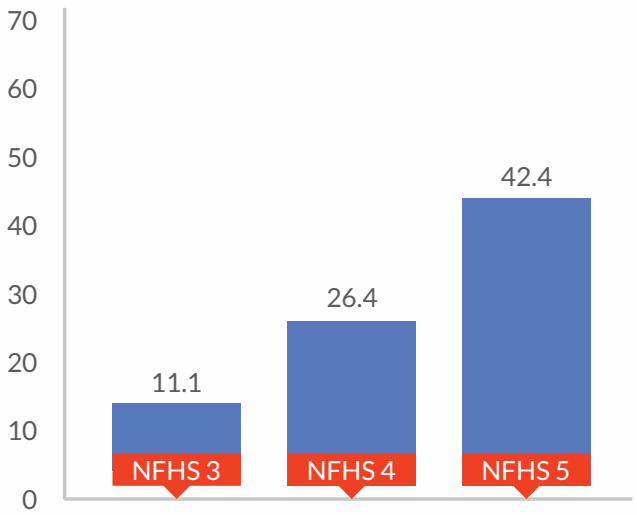


Figure 11: Percentage of PW received at least 4 ANC

A very encouraging increase is seen in institutional births with more than 4 out of 5 women now delivering in health facilities (an increase of 15.6%). An increase of 5.8% is observed in mothers who consumed iron-folic acid for 180 days or more when they were pregnant. Anaemia rates in pregnant women reduced from 51.0 to 45.9%.

The impact evaluation conducted externally by the external Monitoring, Learning and Evaluation (xMLE) of the UP TSU showed encouraging results in improving ANC coverage and quality in the 25 HPDs of UP. VHND was acknowledged as an important platform for providing primary ANC services at the village level to the marginalized and vulnerable rural populations of UP. Around 38% of PW reported using VHND for their first ANC service.

The proportion of PW who registered in the first trimester improved from 47.0% in 2016 to 65.4% in 2019, and the proportion of PW who received ANC services in their first trimester increased from 32.5% in 2016 to 50.8% in 2019 in the 25 HPDs (Figure 12).

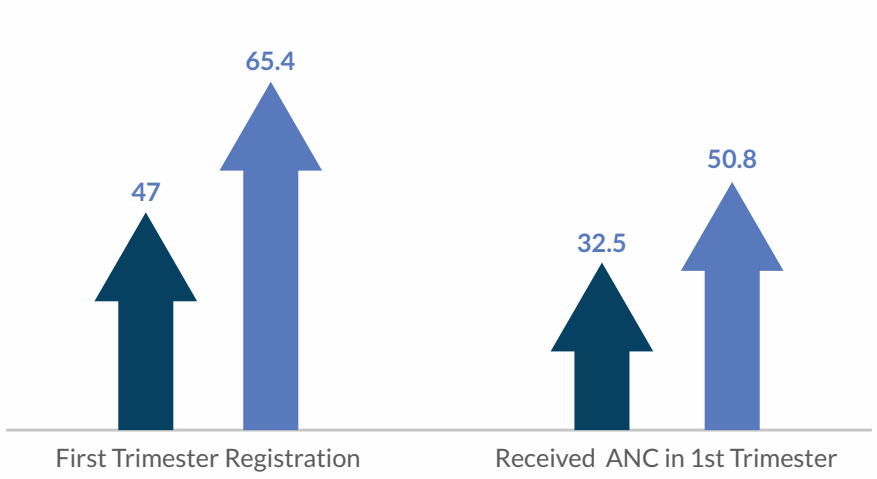


Figure 12: Early Registration of PW and ANC Service in 1st Trimester

Simultaneously, a significant improvement was recorded in the proportion of pregnant women receiving any ANC services from 49.4% in 2014 to 89.7% in HPDs. (Figure 2). A noteworthy proportion of 31.8% of pregnant women receiving 4+ ANC services was also observed in intervention districts. This was 8% in 2014 (Figures 13a and 13b).

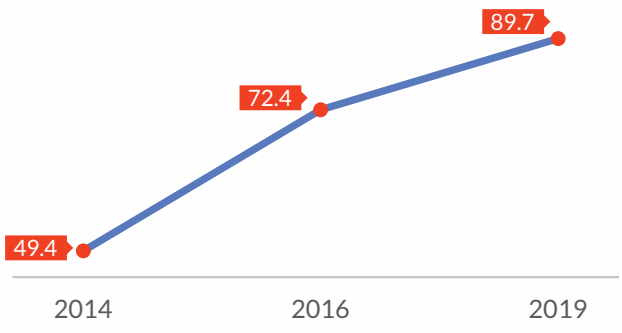


Figure 13a: Trends in any ANC received by pregnant women

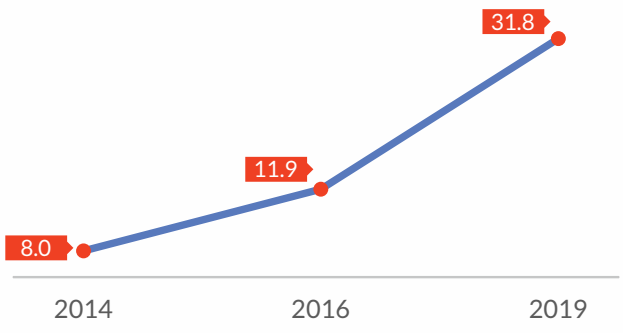


Figure 13bTrends in at least 4 ANCreceived by pregnant women

Through the interventions at VHND, UP TSU has been focusing on improving the quality of ANC services by screening of all PW for Hb, BP, Weight, Urine and Abdominal check-up by the ANM. The project ensured the availability of logistics and drugs at all VHND sites through regular supportive supervision and advocacy at the block, district and state levels. Hence, as a result of these activities, there has been an improvement in the measurement of Hb for PW from 58.9% in 2016 to 79.2% in 2019. A similar trend can also be observed in BP measurement for PW, which increased from 55% in 2016 to 77% in 2019 and weighing of PW, which increased from 57% to 78%. Urine testing and abdominal check-up of PW also increased (Figure 14). However, there is scope for further improvements.

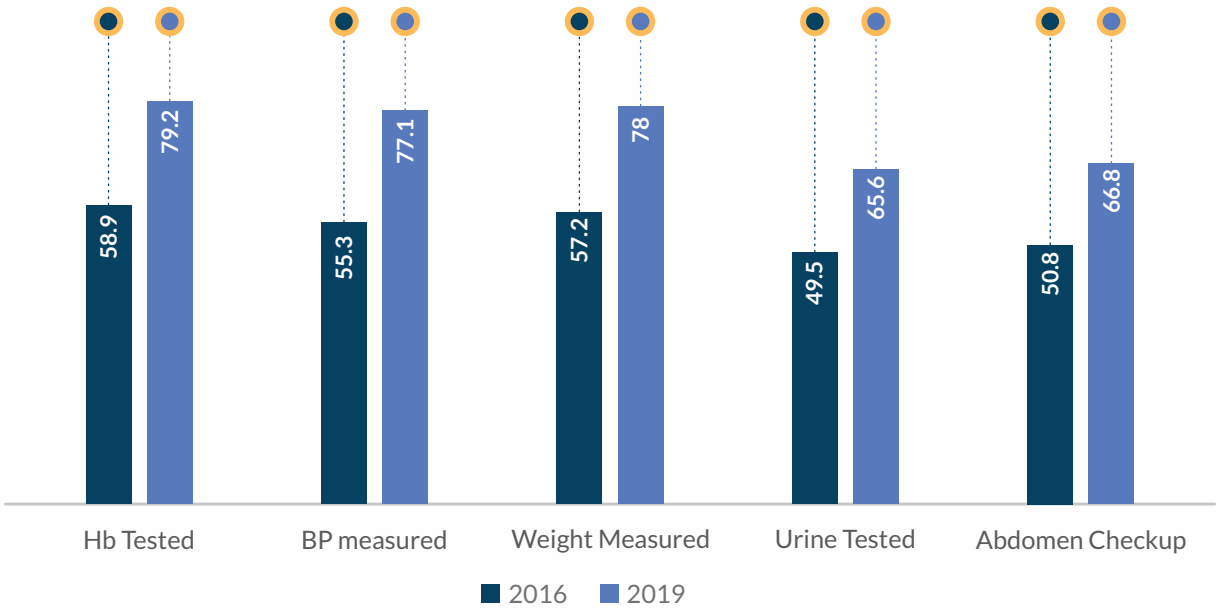


Figure 14: Quality of ANC received by pregnant women during pregnancy

WAY FORWARD

The interventions and activities implemented thus far has substantially improved the overall coverage of ANC (Any ANC = 95.7% as per NFHS-5). However, gaps exist in the delivery of comprehensive and quality services during pregnancy. In order to improve the coverage of quality ANC (early ANC, 4+ ANC, minimum standard of services received, etc.,), in the next phase of the project, the UPTSU envisages building an integrated community platform to provide comprehensive RMNCH and Nutrition services. UPTSU will continue strengthening key community-based platforms and improving FLW capacities for improved availability, utilization, and quality of services as part of improving program understanding and bridging coverage and quality gaps, and improving effective coverage. Cluster meetings will be scaled up across the state as capacity building platforms for improving ASHA capacities. Interventions pertaining to maternal nutrition, maternal weight gain, Infant and Young Child Nutrition (IYCN) and improving identification for better management of anaemia among pregnant women will be given high priority in community interventions.

Group interventions have been shown to be effective in influencing behaviour change including enhanced health-seeking behaviour and adherence to standard treatment and follow-up services[9,10,11,12,13]. Group ANC (g-ANC) formative research is proposed in Fatehpur district to assess the adaptability and challenges of a group approach in community settings. Based on the learnings, g-ANC would be scaled up in the rest of the geography by integrating the usual individual pregnancy health assessment with tailored group educational activities and peer support, with the aim of influencing positive behaviour change among pregnant women, improving pregnancy outcomes, and increasing women's satisfaction with services. The intervention typically involves self-assessment activities (e.g. blood pressure measurement), group education with facilitated discussion, and time to socialize. This intervention is proposed as implementation research and will therefore be initially executed in select VHNDs.

Integration of relevant RMNCH and nutrition services at the VHND as a 'one-stop' service delivery point is another intervention conceptualized as the 'Integrated Village Health and Nutrition Day' (iVHND). iVHND is a convergent approach to delivering a systematic, bespoke, and beneficiary-focused package of defined RMNCH+N services, with improved quality and effectiveness for women and children. This would ensure improved delivery and utilization of customized and defined service packages for the client/beneficiary. iVHND will be implemented across Uttar Pradesh by facilitating the process of refining the present guideline on iVHND.


DATE-
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समीक्षा
जन्म की तैयारी के मुख्य घटक
SANGINI-NEETA TIWARI
MASAUDHA

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[6]The term high risk pregnancy is used by health care providers to demarcate a pregnancy in which a mother, her foetus or both are at higher risk of developing complications during pregnancy or child birth than in a normal pregnancy. (https://www.nhp.gov.in/disease/gynaecology-and-obstetrics/high-risk-pregnancy)

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