QI4SBC

Incorporating Quality into Social and Behaviour Change Interventions for Newborn Child Survival

Process Documentation of QI4SBC Proof-of-Concept Initiative (April - December 2022)

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Disclaimer: Results achieved are specific to limited geographical settings and should not be generalised.

QI4SBC project has covered all the eligible rights-holders in the time duration of 1st June to 15th Dec 2022 - Lakhana (ANC):175; Baneli (FP):1081; Gurhi (HBNC): 51; Mohani (Institutional deliveries): 72; Malharia (EBF): 74; Bareta (EBF):100; Kulla Khash (Anemia): 57; Ghordaur (Anaemia):73

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List of Abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CBOs	Community-Based Organisations
CDPO	Child Development Project Officers
CHC	Community Health Centre
CHO	Community Health Officers
CM	Community Mobiliser
CNRP	Community Nutrition Resource Person
FLW	Frontline Worker
Hb	Haemoglobin
HBNC	Home Based Newborn Care
HBYC	Home-Based Care for Young Child Programme
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IFA	Iron & Folic Acid
ILA	Incremental Learning Approach
IPC	Interpersonal Communication
MCP	Mother and Child Protection
MMR	Maternal Mortality Ratio
MOIC	Medical Officer In-charge
NFHS	National Family Health Survey
NMR	Neonatal Mortality Rate
PDSA	Plan, Do, Study, Act
PIP	Performance Improvement Plans
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PRI	Panchayati Raj Institution
QI	Quality Improvement
QI4SBC	Quality Improvement for Social and Behaviour Change
RI	Routine Immunisation
RMPs	Registered Medical Practitioners
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SHG	Self Help Group
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
SNCUs	Special Newborn Care Units
THR	Take Home Ration
TOT	Training of Trainers
VHSNC	Village Health, Sanitation and Nutrition Committee
VHSND	Village Health Sanitation and Nutrition Day

1 Background and Rationale

1.1. Understanding the Context

There is a firm acceptance in health programming that along with improving the quality or coverage of health products and services, health-seeking behaviours of individuals and communities, and norms that underpin these behaviours have a bearing on health outcomes. Therefore, social and behaviour change (SBC) interventions that seek to change behaviours by addressing the knowledge, attitudes, and norms of healthcare service seekers as well as providers, complement the role played by various players to ensure access to services and products.

Changing behaviours and social norms is a complex process requiring a scientific enquiry and evidence-based planning and implementation.

Government of India acknowledges the importance of a well-rounded SBC approach in improving health and nutrition outcomes and has consistently expressed the intent to invest in comprehensive social and behaviour change communication (SBCC). National Family Health Survey (NFHS), one of the largest national and state-level surveys, ascribes crucial importance to the knowledge, beliefs, attitudes and practices of populations at the individual, community, household or facility level to demonstrate healthcare-seeking behaviours.

Several government programmes are focused on taking maternal, reproductive, neonatal, infant, and child nutrition healthcare, and family planning to the doorsteps of rights holders in communities. They come under the purview of departments such as Health, Women and Child Development and Social Welfare, and are implemented by their established frontline cadres at the community level. The mandate clearly focuses on making healthcare accessible to the communities and the frontline workers (FLWs) are the conduit between these communities and health facilities.

Newborn child survival is largely linked to community perceptions and beliefs leading to attitudes and practices which can act as barriers to conducive practices or service seeking. FLWs play a decisive role in breaking these barriers and inculcating positive perceptions, attitudes and beliefs, which support healthy behaviours that support a child's survival.

Government of Bihar has shown its commitment towards institutionalising SBC through its efforts to incorporate it into the existing health system structures to enhance health outcomes. However, key maternal and child health indicators in the state point to an urgent need for improvement in the quality of SBC, to increase the uptake of maternal care services and prevent uninformed newborn care practices (Table 1).

Table 1: Maternal and newborn health indicators in Bihar

Maternal Mortality Ratio (MMR) per 100,000 live births*	118
Neonatal Mortality Rate (NMR) per 1,000 live births*	21
Mothers who had at least 4 antenatal care (ANC) visits (%)	25.5%
Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	18%
Institutional births in public facility (%)	56.9%
Children under age 6 months exclusively breastfed (%)	58.9%
Pregnant women aged 15-49 years who are anaemic	63.1%

Source: NFHS-5 *SRS 2020

1.2. A Focused SBC Strategy for Newborn Child Survival

Recognising the need to address the poor health-seeking behaviour of women and undesirable health outcomes of newborns, in 2018, UNICEF commissioned Praxis – Institute of Participatory Practices to formulate a SBC strategy for enhancing newborn survival in Bihar. A participatory approach was used to involve all the key stakeholders – community members, key health functionaries, FLWs, as well as some select duty-bearers. Community-level consultations were conducted at three sample locations – Gere village (Gere panchayat in Manour block of Gaya district), Parsurampur village (Parsurampur panchayat in Parsauni block of Sitamarhi district) and Taria village (Damalbari panchayat in Pothia block of Kishanganj district) to understand the knowledge, attitude, practices, and perceptions with regard to maternal and newborn healthcare and experiences of availing health services. This strategy looked at both the demand and supply side factors for commodities and other factors affecting health-seeking behaviours among women and undesirable health outcomes of newborns. .

The consultations pointed to some key determinants of health-seeking behaviours among mothers. These were:

- Knowledge, attitudes, perspectives and beliefs
- Gender and social norms
- Affordability of services
- An enabling environment to access services
- Behaviour of service providers
- Vested interests at facility level
- Availability of resources and services
- Capacity needs
- Coverage of schemes, facilities, etc.

In view of the identified bottlenecks at various levels, the following focus areas for action were proposed in the strategy:

- Promoting recommended reproductive, maternal and newborn care practices
- Linking with relevant entitlements towards improving overall quality of life
- Promoting women's agency to empower them to negotiate conditions affecting their sexual and reproductive health rights
- Creating a favourable social environment by engaging with local Community-Based Organisations (CBOs)/leaders
- Developing a mechanism of community-level monitoring of services and compliance to the desired behaviour
- Ensuring availability of proactive, timely, corruption-free delivery of services and incentives

- Strengthening outreach and tracking exclusions
- Strengthening accountability mechanisms
- Integration of different interventions and channels of communication
- Strengthening capacities
- Ensuring effective implementation of schemes and programmes
- Enhancing budget allocation for maternal and child healthcare services
- Filling up vacant positions
- Ensuring accountability and monitoring mechanisms
- Introducing new or redesigning existing schemes/programmes/communication strategy for better results.

The community-specific recommendations of the strategy pointed to increased capacities among FLWs to promote healthy reproductive, maternal and newborn care practices and to monitor community behaviours.

1.3. A SBC Training Module for FLWs

In April 2022, UNICEF Bihar, in partnership with Civil Surgeon, Purnea, and Envisions Institute of Development, and in coordination with Alive & Thrive initiated an effort to put the community-specific recommendations of the newborn child survival strategy into practice. As a first step towards this effort, the TARANG[1] SBC training module was adapted to develop a SBC cum Quality Improvement (QI) module for newborn child survival incorporating the concepts of QI.

What is QI4SBC?

An innovative methodology was introduced that has hitherto been followed in controlled settings like health facilities. This methodology is called QI[2]. The key objective of this methodology is to arrive at the core issue or problem statement and then identify solution levers through a series of steps. This innovative approach was married with the principles of SBC and implemented in uncontrolled community settings. This experiment was called Quality Improvement for SBC (QI4SBC).

Eight projects were identified by community members to implement this innovation. Four were from health and four from nutrition. The health projects were co-led by the UNICEF health team while UNICEF entered into a non-financial partnership with Alive & Thrive that supported the implementation of QI4SBC for the nutrition projects along with the nutrition team.

[1] The TARANG Social and Behaviour Change Communication training package has been designed to develop an understanding of and capacities in integrating SBC communication as a key component in public health programming. It has been developed to help SBCC practitioners to understand various forms of social exclusion and its role in behaviour and social change communication process.

[2] QI is a management concept that seeks to standardise processes and structures to reduce variation, achieve predictable results, and improve outcomes for consumers, facilities, services, and organisations. QI framework, when used in health settings, aims to be used to systematically improve healthcare.

The SBC module for newborn child survival was focused on building the capacities of FLWs to:

- Understand the various socio-cultural and other challenges that impact newborn child survival in the state
- Develop an understanding of SBC and its use in changing behaviours in the community
- Undertake effective interpersonal communication (IPC) and group counselling sessions, and mobilise communities for newborn child survival
- Develop and implement effective communication plans for newborn child survival.

Kasba block in Purnea district was identified for implementation of QI4SBC. Purnea is a priority district and a learning lab for UNICEF in Bihar. Kasba block's proximity to the district headquarters and also the Community Health Centre (CHC) Kasba being a state certified LaQshya facility, allowed for strengthening the linkage between communities and facility with improved services at both levels.

Incorporating Community Inputs into the SBC Strategy

Before initiating on-ground implementation, a consultation was held with key implementers in the block. It included the Auxiliary Nurse Midwives (ANMs), Accredited Social Health Activists (ASHAs), Anganwadi Sevikas, JEEViKA workers, Block Community Mobiliser, Medical Officer In-charge (MOIC) and the UNICEF team. Some representatives from the community were also invited for this consultation. They included community elders, Panchayati Raj Institution (PRI) members, and pregnant and lactating women. This consultation helped understand the bottlenecks and challenges in service provision at the community level, be it in terms of community practices, inability of FLWs to effectively counsel the pregnant and lactating women, and their families, or attitudinal problems of the staff at the health facilities.

The in-depth discussions at this consultation threw light on issues critical for newborn child survival. These included:

Key reasons for death of newborns (in order of priority as suggested by the community)

- Pre-term births including low birth weight
- Issues related to breathing (difficulty in breathing or rapid breathing)
- Hypothermia
- Infections such as pneumonia and diarrhoea
- Fever

Reasons for pre-term births

- Low uptake of iron and calcium
- Iron deficiency in pregnant women
- Side effects related to consumption of iron tablets
- Inadequate diet
- Negligence towards one's health

- Death of an unborn child since no check-ups were done
- Early marriage and a lack of understanding about motherhood, with most girls becoming mothers at the young age of 17 or 18
- Difficulty during labour, breach delivery, weak and underweight babies

Aspects to keep in mind for safe delivery

- Birth preparedness
- Blood donation arrangement
- Identification of a facility of delivery

Myths in community

- TT vaccinations lead to abortion
- Albendazole leads to miscarriage

General observations

- Men do not play a key role during pregnancy, labour or delivery
- PRI and ward members are not much involved
- No knowledge of Mother and Child Protection (MCP) card among Anganwadi Workers (AWWs). They fill the dates in POSHAN tracker
- Bad behaviour of health facility staff deters women from marginalised communities to go for institutional deliveries
- Home delivery is done by Registered Medical Practitioners (RMPs) or *dais* in hard-to-reach areas
- Maulana advises against family planning, routine immunisation or any vaccinations

Challenges communicated/observations made by JEEViKA workers

- Low coordination with ASHAs
- They advise lactating mothers on breastfeeding, complementary feeding and nutrition
- Self Help Group (SHG) members deposit INR 10 per week towards health insurance in the village organisations. This money can be taken by women as and when they need. JEEViKA workers lend up to INR 15,000 to pregnant women.

Key gaps and key asks

- Comprehensive training of newly recruited ASHAs and refresher trainings of ASHAs
- Vacant ASHA positions to be filled
- The supply and demand gap for paracetamol tablets should be bridged
- Men in general and influential men in the community should be made aware of and involved in newborn child survival
- Behaviour of health facility staff should be more friendly

» These observations also corroborated closely with the earlier consultations that are part of the Newborn Survival SBC strategy.

1.4. Piloting a New Initiative – QI4SBC

QI4SB was a one-of-a-kind Proof-of-Concept initiative focused on building capacities for improved SBC through team building, problem identification, and a solution-orientated approach to address the different behaviour-related issues for newborn child survival.

The QI4SBC pilot was undertaken to gauge its replicability on a wider scale. It attempted to make SBC at the village level Specific, Measurable, Achievable, Relevant and Time-bound (SMART) with QI. It was expected that with continuous and sustained efforts over a period of 3 to 4 months, this combination would positively impact the behavioural indicators.

The duration of the programme was nine months – April to December, 2022. In keeping with the short duration of the pilot, a decision was taken to implement the pilot in eight[3] out of 13 gram panchayats of Kasba block. The criteria for selection of these gram panchayats was the best combination of motivated members of four cadres of FLWs – ASHAs, ANMs, AWWs and JEEViKA staff (Community Nutrition Resource Persons [CNRPs] and Community Mobilisers [CMs]) – with a drive to work. These FLWs were nominated by their respective departments.

Objectives of QI4SBC pilot

- To increase **demand** for, and **equitable access** to, **maternal care services** for pregnant women including reproductive care services.
- To increase demand for, and equitable access to, **newborn care services** for newborns with special focus on **girl child**.
- To increase access to, and demand for, **quality counselling services at community level**.
- To increase adoption and practice of **preventive and protective behaviours** such as breastfeeding, maternal nutrition, regular ANC, family planning and instituional delivery.
- To increase male involvement in the arena of maternal health and nutrition.
- To bridge the divide between FLWs and community members.

[3] Gurhi, Lakhana, Mohani, Malharia, Bareta, Kulla Khash, Ghordaur and Banaili.

1.5. Strategic Approach of QI4SBC

QI4SBC adopted a life stage approach targeting specific interventions towards specific audience at appropriate times. The life stages, covered under the pilot were from conception to 28 days after the birth of a child – a period covering approximately 306 days i.e. the first, second and third trimester, leading up to delivery, and neonatal care covering 28 days. Each of these stages requires a certain set of specific interventions for the mother as well as the child.

The strategy worked towards addressing both demand as well as supply aspects of the issues. It aimed to build the understanding and capacities of FLWs in QI to understand and analyse the problems of their areas, and identify context-specific solutions within their means.

2 What is QI Approach in Healthcare

QI projects are driven by an implementing team working within the existing framework of service delivery in alignment with their job responsibilities, without the team getting overburdened. They emphasise sustainability and showcase results in a short period of time.

2.1 Focus of QI

- Identification of gap (problem identification): Problem or opportunity for improvement (current status and desired state)
  - **Resources:** People, infrastructure, materials (i.e. vaccines, drugs etc.), information technology
  - **Activities (processes):** What is done? How it is done?
  - **Results (outputs or outcomes):** Improved health status; patient satisfaction

2.2 The Model of Improvement

- **Aim:** What are we trying to accomplish?
- **Measurement:** How will we know that a change is an improvement?
- **Change:** What change can be made that will result in improvement?
- **Cycle of learning and improvement:** Plan, Do, Study, Act (PDSA)

2.3 Steps for Improvement

- **Step 1:** Identify the problem
  - Achieve consensus on the problem as a team. Choose a problem that:
    - Is simple, easy to fix and amenable to change
    - Has value for patient/rights-holders (impact)
    - Does not need too many resources
    - Motivates the team
    - Gives results in short term

Quality health services should be:

- **Effective:** Delivering evidence-based care that results in improved outcomes and is based on need.
- **Efficient:** Delivering care which maximises resource use and avoids waste.
- **Accessible:** Delivering care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need.
- **Acceptable/patient-centered:** Delivering care which takes into account the preferences and aspirations of patients and the cultures of their communities.
- **Equitable:** Delivering care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socio-economic status.
- **Safe:** Delivering care which minimises risks and harm to patients.

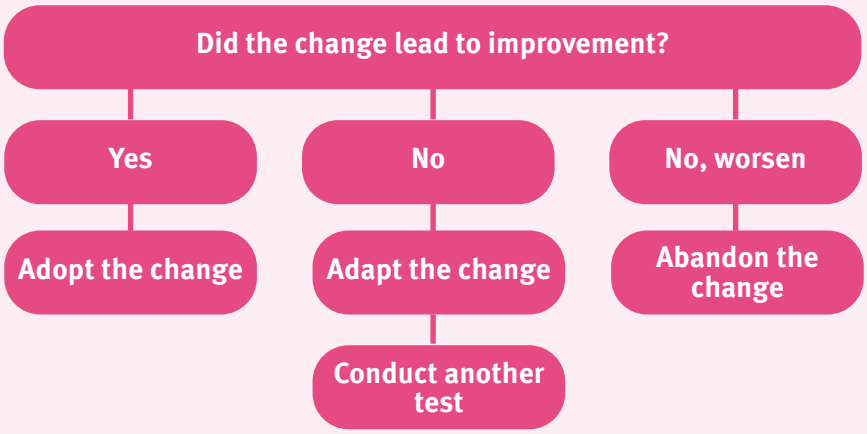
The 4 steps for improvement

- Build a team for change
  - Decide who should be on team that will solve the problem
  - Encourage team to identify problems and generate ideas to resolve them
  - Ensure participation of team members to increase buy-in and reduce resistance to change
  - Encourage accomplishment of things together to build confidence of team members and empower the system
- Determine the process(es)/system for improvement
- Build a SMART aim
  - Clear and specific aim linked to specific rights-holders/patient population
  - Should include a goal
  - Neither too difficult nor too long to achieve

» **Step 2:** Analyse the problem using any of the following tools
- Fishbone
- Pareto
- Root cause problem analysis: 5 Whys
- Process mapping

» **Step 3:** Develop changes
- Determine possible changes (interventions) that may lead to improvement
- Organise changes according to importance and practicality
- Test one change at a time

» **Step 4:** Test and implement
- **Plan:** Plan the change
- **Do:** Test the change
- **Study:** Collect the data
- **Act:** Test and implement changes (Adopt, Adapt, Abandon)[4]



2.4 Implementing Changes and Sustenance

» Making successful ideas embed into system requires concrete actions e.g. framing guidelines, standard operating procedures or job responsibilities

» Continuous process with eye on improvement

[4] No QI project will reach its aim with only one PDSA. Multiple PDSA's are needed depending on the analysis and identified causes and change ideas. One change idea should be tested at a time.

3 Ownership of QI4SBC and Capacity Building

As part of implementation of QI4SBC certain key steps were taken at the district and block levels before initiating the activities on ground.

QI4SBC strategies

- A pool of master trainers created for QI
- Capacities of health staff and community networks developed in QI
- Team of FLWs created for project implementation
- Problem area identified by project team for QI intervention
- Strategic use of data during project implementation
- Data collection, reporting and monitoring systems developed
- Periodic review meetings held
- Mentorship and handholding
- System and infrastructure strengthening
- Local solutions found

3.1 Building Ownership

A one-day district-level sensitisation workshop was organised under the leadership of the Department of Health to ensure buy-in and support of the district administration. District nodal officers from various departments including Integrated Child Development Services (ICDS), Bihar Rural Livelihoods Project (JEEViKA), Panchayati Raj, Education, Food and Consumer Protection (PDS), among others attended this orientation focused on the health situation in the district and importance of SBC in improving health indicators. The concept of QI was introduced to the stakeholders in this sensitisation session, which built their ownership and ensured their buy-in into QI4SBC.

3.2 Capacity Building Plan

Creation of a Pool of Master Trainers

Subsequently, a training of trainers (TOT) was organised for block-level duty-bearers. This TOT included MOICs, Child Development Project Officers (CDPOs), Lady Supervisors, ANMs, Block Health Managers and Block Community Mobilisers, among others, from Kasba and other blocks of Purnea. These duty-bearers were introduced to the QI4SBC pilot and oriented on the key concepts of QI, and IPC and community dialogue tools to engage with the community and generate demand for health services.

This TOT built a pool of around 50 master trainers who have the potential to scale up the concept in other blocks of Purnea and in other districts of Bihar.

Orientation of FLWs

The QI4SBC capacity building package based on the SBC strategy for newborn survival, explicitly focuses on improving the capacities of ANMs, ASHAs, and Anganwadi Workers (AAA team) and JEEViKA workers to deliver behaviour change communication and actions in the community with the express aim of changing individual behaviours and norms related to maternal and child health, and nutrition.

Once the pool of master trainers was created, the next step was a two-day training in Purnea for FLWs from Health, ICDS and JEEViKA on QI4SBC. They included ASHAs, ANMs, ASHA Facilitators, Staff Nurses, Anganwadi Sevikas and JEEViKA's CNRPs and CMs. Block-level duty-bearers too attended these trainings. These trainings focused on developing a comprehensive understanding of SBC and QI among FLWs. Each SBC component which was explained included a checklist to help the FLWs review their work. The trainings helped to make the concepts of SBC clear to FLWs. Alongside, the key steps of QI – understanding the problem, setting a SMART aim, analysing the problem and understanding the reasons behind it, creating change ideas, implementing changes and recording progress, and sustaining improvements – also became clear. Subsequently, these FLWs implemented QI projects in their respective gram panchayats.

3.3 Mentoring and Handholding Teams

Two mentoring and handholding teams were created with members from UNICEF and Alive & Thrive[5] and block-level duty-bearers. There were eight projects – four on health and four on nutrition behaviours.

These teams provided supportive supervision during the implementation of the projects, through observation visits and handholding support, as and when needed. They also supported with block-level advocacy for smooth supplies.

A block-level coordinator was also appointed by the Civil Surgeon to monitor day-to-day activities of the project.[6]

[5] The team from Alive & Thrive provided mentoring and handholding support in four (two each on Maternal anemia and two on EBF) nutrition-related projects (exclusive breastfeeding and anaemia)

[6] Mandated to make visits to all project areas at least three times in a month to see the QI cycles happening as per plan. Monthly reports were submitted to the Civil Surgeon as well as the MOIC Kasba block.

4 On Ground Implementation

4.1 Gram Panchayat Level Workshops for Problem Identification and Goal Setting

Field level QI projects were formulated in each of the eight panchayats. The teams of trained FLWs were guided by the UNICEF and Alive & Thrive team to translate their newly acquired knowledge and skills on QI4SBC into ground-level reality, for their gram panchayat.

The FLWs worked together and followed the key steps of QI process, as presented below.

TOTAL NO. OF TEAM MEMBERS PER GRAM PANCHAYAT

Malharia	11
Lakhana (two groups)	8 & 12
Bareta	6
Kulla Khash	11
Ghordaur	12
Gurhi	12
Mohani	14
Banaili	17

Step 1: Identification of Problem[7] to be Addressed

Key criteria for identification of problem: Vital for newborn survival; implementation within timeframe and with existing resources; easy to measure variables; team's control over the factors.

Team for change: Since the teams had already been formed and trained, a team leader was chosen by the team members in each team. The team leader oversaw and coordinated on-ground activities, held regular meetings (at an interval mutually decided by the team members) and consolidated data to keep track of the progress.

Building a SMART aim: Clear and specific aim linked to a specific right holder population, with a goal that is neither too difficult nor takes too long to achieve.

Step 2: Analysis of the Problem

Fishbone analysis[8] and 5 Whys method[9] used for problem analysis.

Step 3: Developing Changes

Determine possible changes (interventions) that may lead to improvement; organise changes according to importance and practicality; and test one change at a time.

Step 4: Test and Implement – PDSA

Plan the change; Do (test the change); Study (collect the data); and Act (test and implement changes – Adopt, Adapt, Abandon)

The following matrices showcase the problems identified in the selected gram panchayats, the SMART aims developed, analysis of the problems and the change ideas[10] suggested.

[7] The problem identification process involved grading the earmarked challenges against the key criteria for identification, each assigned five points. The problem with the maximum score against 20 (sum total of all four parameters) got earmarked as the problem area for further intervention.

[8] A cause analysis tool that helps identify many possible causes for an effect or problem. For QI4SBC the participants divided the causes into four categories – people, processes, policy and location.

[9] A tool to understand the underlying causes behind a problem.

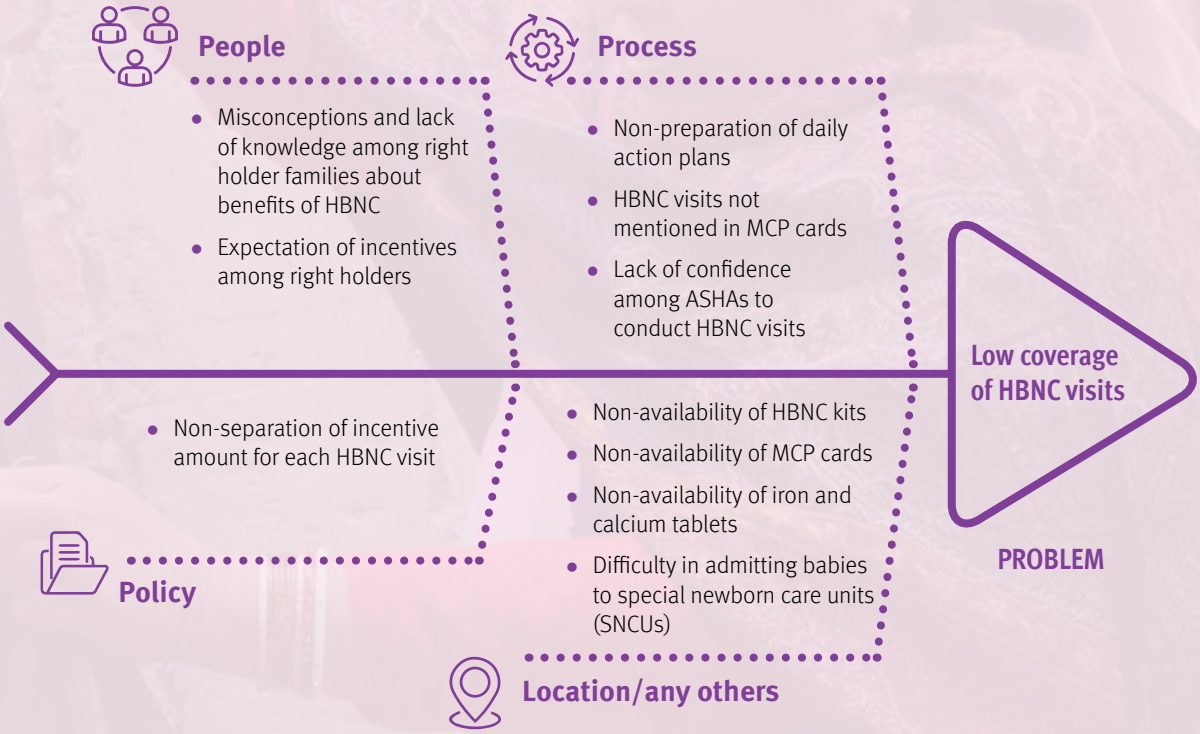
[10] Change ideas are developed basis what may lead to improvement, why this change will result in an improvement and how it will work?

Gurhi Gram Panchayat

Problem identified: Low percentage of Home Based Newborn Care (HBNC) visits by FLWs

SMART aim: To increase the percentage of HBNC visits from 70 percent to 90 percent, by ensuring a minimum of six home visits per newborn in ward numbers 3, 4, 6 and 13 of Gurhi Panchayat between June 3, 2022 and September 5, 2022.

Analysis of problem areas leading to low coverage of HBNC visits



Scale to measure progress

Process measure

- Percentage of ASHA workers that made a daily plan for at least 25 days in a month
- Number of right holders informed about the benefits of HBNC

Outcome measure

- Increase in the percentage of HBNC visits

Corresponding change ideas and their implementation

Ideas planned and implemented

- Orientation of all ASHA and Anganwadi Sevikas on MCP cards
- Entry of HBNC visits in MCP cards
- ASHAs developing and maintaining daily action plans
- Conducting HBNC visits based on the standard process flow chart
- During HBNC visits, counselling of family members on danger signs in newborns, benefits of breastfeeding, maintaining hygiene and warmth etc.
- To motivate ASHAs, monitoring of at least one HBNC visit by ANM per month and at least two HBNC visits by ASHA Facilitator per month
- Conducting mothers' meetings to inform mothers about the importance of HBNC visits

Implementation observed

- HBNC coverage data collected for each scheduled visit till 42 days
- Review carried out to see the effectiveness of change ideas
- Regular counselling by ASHAs observed
- Supply of HBNC kits and MCP cards streamlined
- Midcourse correction done with replenishment of HBNC kits using Village Health, Sanitation and Nutrition Committee (VHSNC) funds

Actions retained

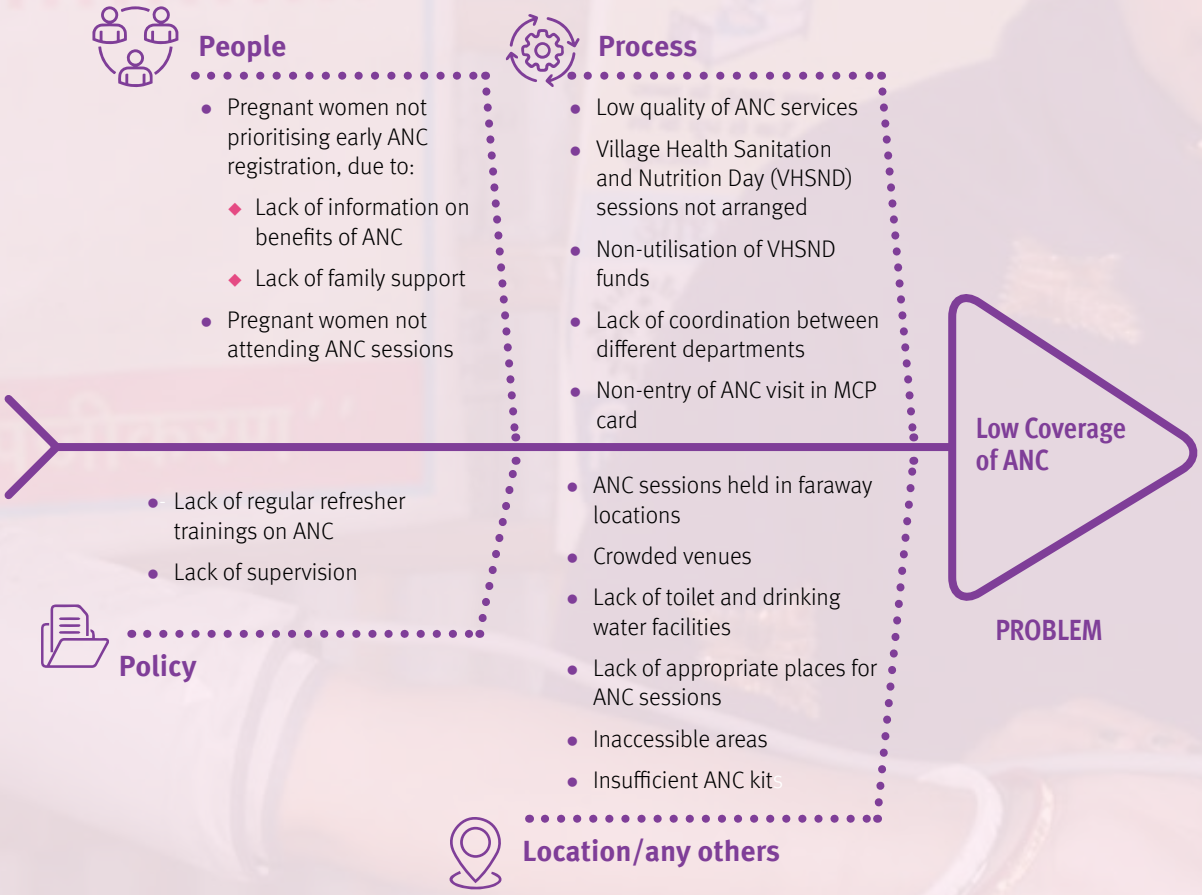
- Timely and quality-focused HBNC visits
- Guidelines followed during HBNC visits
- Emphasis on HBNC visits post day 14
- Counselling of right holders by FLWs during home visits and at mothers' meetings
- Handholding support for ASHAs by the ANMs and ASHA Facilitators

Lakhana Gram Panchayat

Problem identified: Low registration for ANC

SMART aim: To increase the percentage of ANC from 50 percent to 90 percent in ward numbers 3, 4, 7 and 8 of Lakhana gram panchayat, within the next three months (June 1, 2022 to August 31, 2022).

Analysis of problem areas leading to low coverage of ANC



Scale to measure progress

Process measure

- Total number of pregnant women
- Identification of newly pregnant women
- No. of pregnant women counselled about the benefits of ANC during home visits
- No. of pregnant women informed of the ANC session a day in advance
- No. of mothers' meetings held in one month

Outcome measure

- Percentage of ANC visits: 1st, 2nd, 3rd and 4th ANCs

Corresponding change ideas and their implementation

Ideas planned and implemented

- Preparation of daily action plans by ASHAs
- IPC and counselling by FLWs on the importance and benefits of four ANC check-ups at prescribed intervals during pregnancy. Counselling sessions undertaken with the pregnant woman and other caretakers supporting the woman during pregnancy, especially husbands and mothers-in-law
- Pregnant women informed in advance about the VHSND session where ANC check-ups are conducted
- Crowd control during the VHSND to ensure quality ANC for pregnant women
- FLWs kept track of the number of times a pregnant women came for the ANC during VHSND
- Reasons for unwillingness of pregnant women to go for ANC understood. One of the reasons for hesitation among women to go for ANC check-ups was lack of infrastructure and privacy during check-ups
- Equipment such as weighing machines and blood pressure apparatus acquired with the support of UNICEF

Implementation observed

- Pregnant women divided in four categories based on the ANC visit they needed to make
- Data of women requiring ANC recorded by ASHAs
- Observation of ANC check-up rates for first, second, third and fourth ANC visits
- Mother's meetings utilised to counsel women on the benefits of ANC
- Local solutions implemented:
  - A basic ANC facility created at the local Anganwadi Centre (AWC), with community's support
  - ANC kits procured by the team leader at her personal expense, to ensure continuity in project

Changes made/actions retained

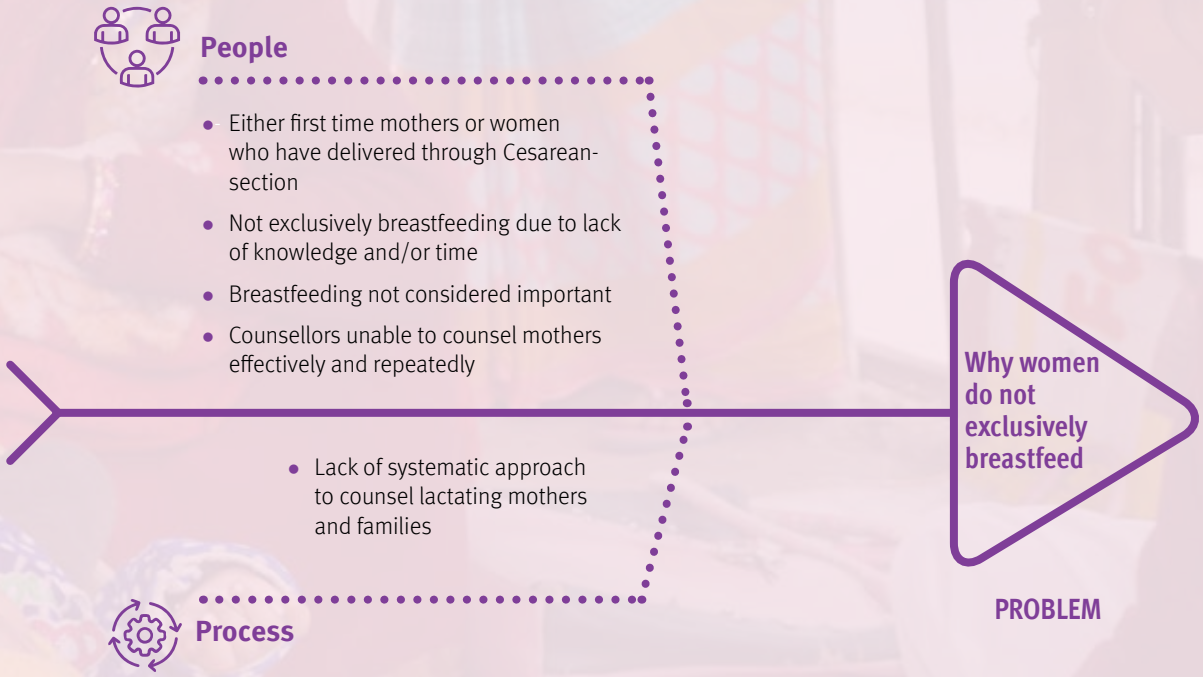
- After observing the positive results, all the steps were replicated in all the villages

Malharia and Bareta Gram Panchayats

Problem identified: High percentage of women in the community not exclusively breastfeeding their babies on the first three days after delivery. Alongside, bottle feeding the newborn was a prevalent practice.

SMART aim: To increase the percentage of lactating mothers who exclusively breastfeed their newborns (between 0-28 days) from 0 percent to 60 percent in wards 6, 7, 8, and 9 of Malharia gram panchayat and wards 5 and 6 of Bareta gram panchayat between May 21, 2022 and July 20, 2022.

Analysis of why women do not exclusively breastfeed



Scale to measure progress

Process measure (weekly)

- No. of home visits made by FLWs
- Frequency of urination by the newborn in the last 24 hours
- Difficulty felt by the mother in breastfeeding

Outcome Measure (monthly)

- Weight gained by the child

Change ideas – PDSA

Plan (change ideas planned)

- Counselling of mothers on scheduled HBNC days, with additional counselling in selected facilities till the child reached six months.
- During the visits, FLWs to use the 24-hour recall method and check the number of times a child has been fed and has urinated in the last 24 hours.

Do (change ideas implemented)

- FLWs counselled the mother and other caretakers who supported her in breastfeeding on exclusive breastfeeding. Counselling included proper attachment and positioning, and addressing difficulties in breastfeeding.
- FLWs recorded the frequency of feeding and urinating in the last 24 hours to ensure that the newborn was fed properly. This would have a bearing on the weight of the child.

Study (implementation observed)

- Mothers were found to be comfortable in adhering to the norm of 'no water and only mother's milk'.
- Though initially the rights-holders found it difficult to recall the number of times the child was fed and passed urine, gradually they could do so.

Act (changes made or actions retained)

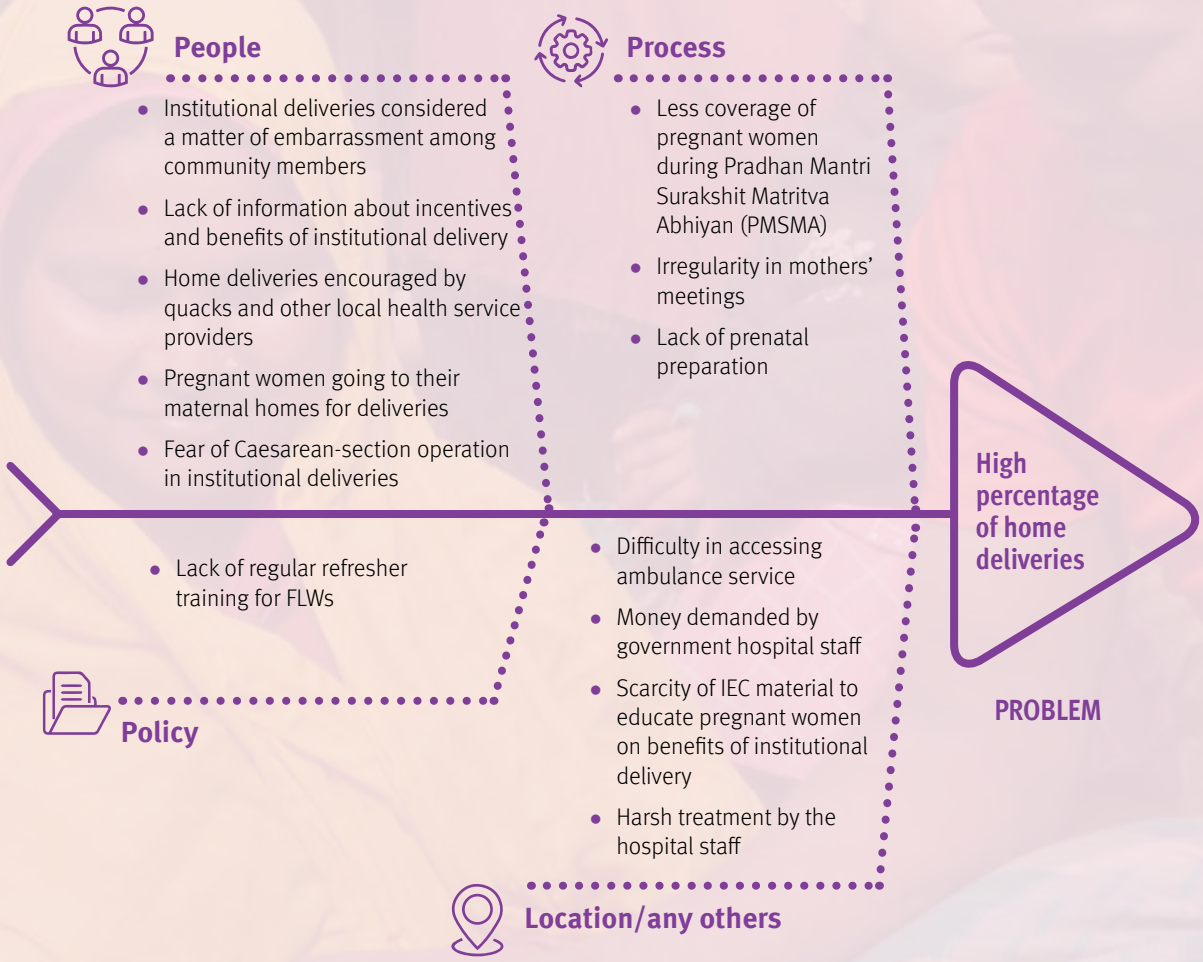
- As per discussions and initial observations, the QI team decided to counsel the mother and other caretakers regularly on their day of visit and also started checking the frequency of the baby being fed and passing urine. Weight growth was taken as proxy indicator of exclusive breastfeeding.

Mohani Gram Panchayat

Problem identified: High percentage of home deliveries

SMART aim: To reduce the rate of home deliveries from 80 percent to 20 percent in ward numbers 4, 8, 9 and 10 of Mirchaibari village of Mohani panchayat, between June 1, 2022 and August 31, 2022.

Analysis of problem areas contributing to high percentage of home deliveries



Scale to measure progress

Process measure

- No. of mothers' meetings organised
- No. of pregnant women counselled individually about institutional delivery and its benefits

Outcome measure

- Percentage of home deliveries

Change ideas and their implementation

Ideas planned and implemented

- Counselling of pregnant women at mothers' meetings (mata baithak)
- Counselling of pregnant women at home in the presence of their husbands and other family members explaining the importance and benefits of institutional delivery and entitlements related to institutional delivery in public facilities
- Use of MCP card to counsel pregnant women
- Taking second and fourth trimester pregnant women to PMSMA
- Providing exposure visits for the pregnant women to the labour room at the health facility
- At meetings informing people about the telephone number to call the ambulance
- Telephone number for ambulance written on walls and public places in the village for easy recall
- Coordination for ambulance service
- Implementing the change ideas based on the sequence planned during the project inception

Implementation observed

- Fortnightly trend of institutional delivery studied in the project area
- No. of counselling sessions organised in the project area studied

Changes made/actions retained

- Based on improvement shown after every change made, change ideas accepted as part of routine working of ASHAs
- Additional activities conducted by FLWs such as updating the due list of pregnant women, earmarking pregnant women in separate groups as per the trimester for need-based counselling and utilising mother's meetings to counsel women on the benefits of institutional delivery.

Kulla Khash and Ghordaur Gram Panchayats

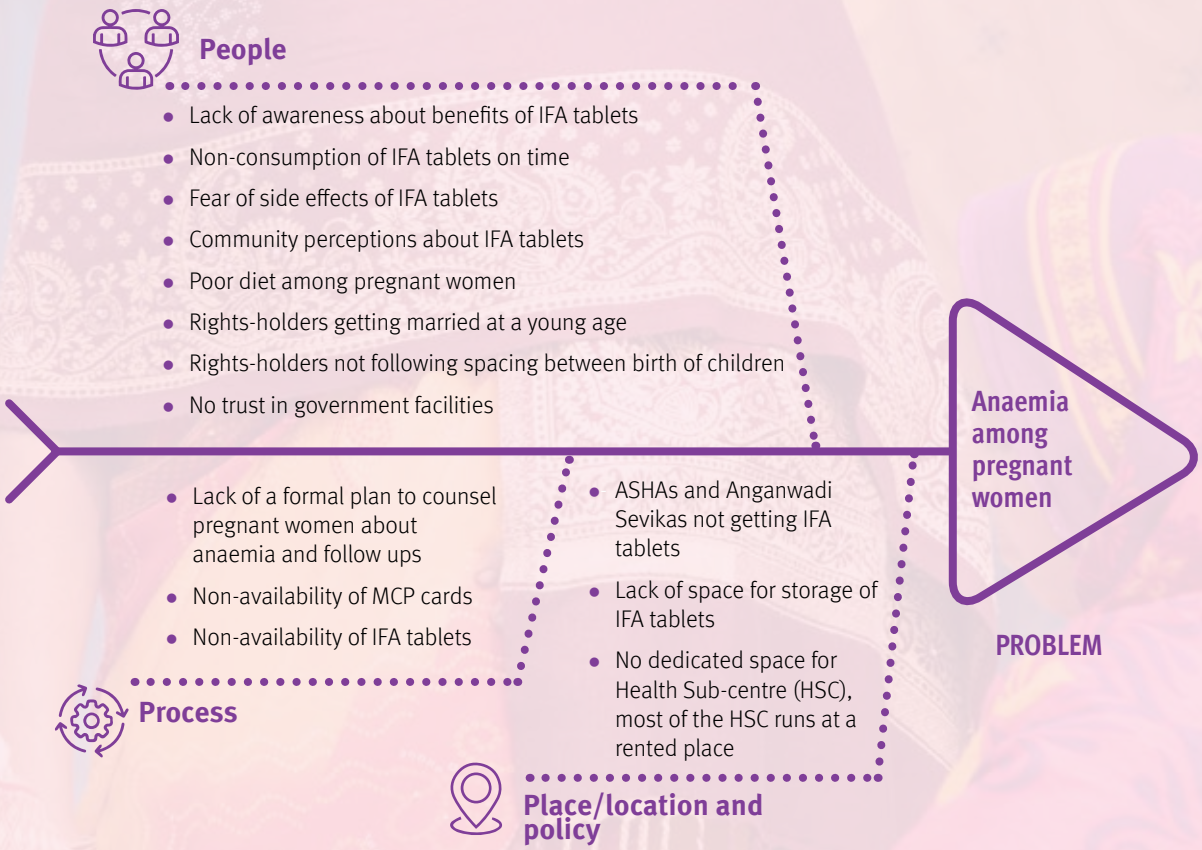
Problem statement: High percentage of anaemia among pregnant women

SMART aims:

Kulla Khash panchayat: To reduce the rate of anaemia among pregnant women from 97 percent to 60 percent in ward numbers 9, 10, 11 of Basantpur village of Kulla Khash gram panchayat between May 17, 2022 and August 17, 2022.

Ghordaur panchayat: To reduce the anaemia rate from 80 percent to 50 percent among all pregnant women of ward numbers 4, 5, 6, 8 and 10 of Ghordaur gram panchayat between May 18, 2022 and August 17, 2022.

Analysis of problem areas leading to anaemia among pregnant women



Scale to measure progress

Process measure (weekly)

- No. of home visits
- No. of pregnant women and family members counselled
- No. of pregnant women who consumed IFA tablets
- No. of pregnant women who attended meetings (such as mata baithaks)
- No. of pregnant women who consumed Albendazole

Outcome measure (monthly)

- Monthly count of every pregnant woman's Haemoglobin (Hb) level

Change ideas – PDSA

Plan (change ideas planned)

- Nutritional counselling for pregnant women, husbands and mothers-in-law in the evenings by FLWs. Issues taken up one at a time: for example, IFA consumption, then having more green leafy vegetables, then consuming sour foods with IFA and even in the meal, and so on.
- Monthly Hb test for pregnant women and IFA dosage as per Hb levels (for normal levels 1 IFA tablet per day, for mild and moderate levels 2 IFA tablets per day and for severe cases IV Sucrose). Monitoring of IFA consumption by FLWs during home visits.

Do (change ideas implemented)

- Counselling in the evenings to ensure husband's participation and/or male participation.
- Consumption of greens ensured in meals through home visits. FLWs asked pregnant women to show their food plate during home visits.
- During counselling sessions benefits of IFA linked with improved IQ, and better physical and cognitive development of the child.
- Supply of IFA ensured by the district health personnel to address shortage.

Study (implementation observed)

- Review of steps to see if change ideas were working. Counselling was undertaken by the FLWs regularly, as per a planned schedule, along with food demonstrations in food plates.
- Gradually adding one message after the other was found to be a good strategy.
- Non-availability of trained ANMs was observed, which created challenges in Hb testing.

Act (changes made or actions retained)

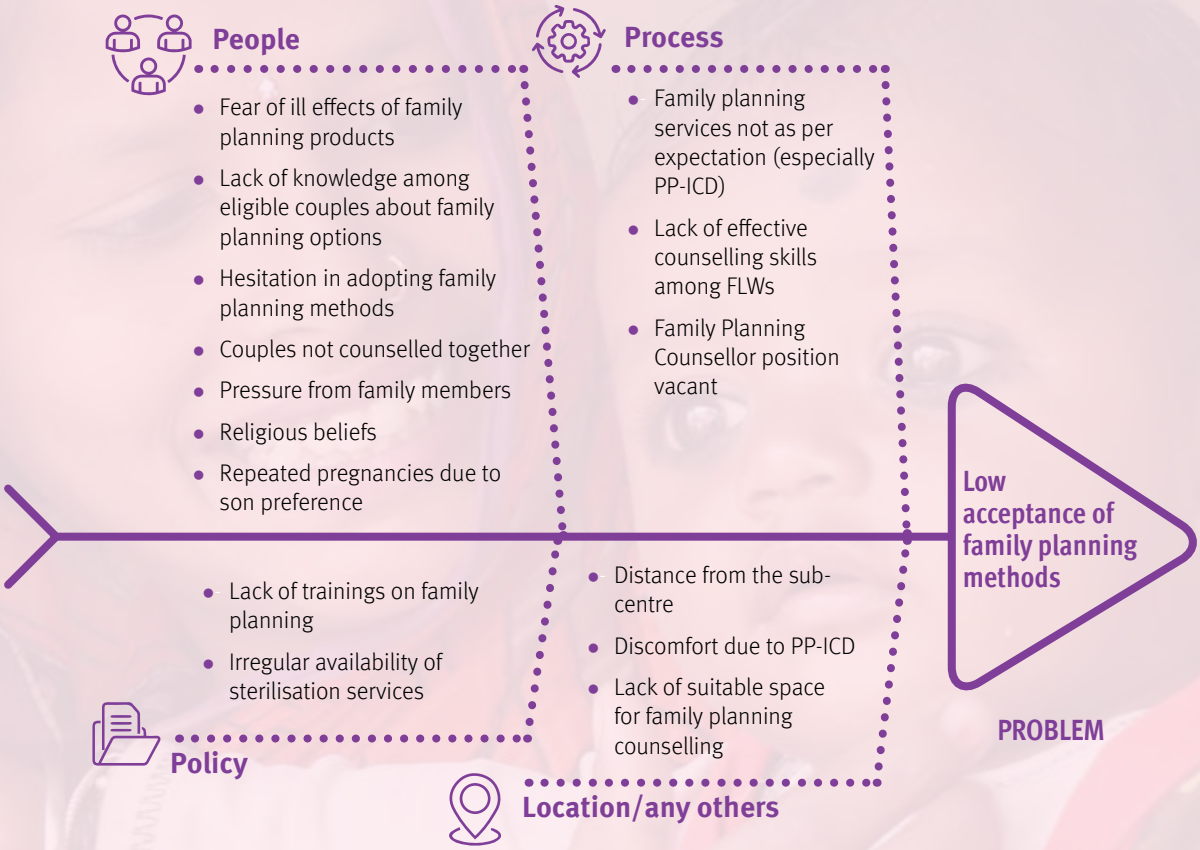
- Counselling and monitoring of IFA consumption were found to be easy and of high value, to address anaemia among pregnant women.
- Pregnant women and other family members were found to be supportive once they got to know about the benefits of IFA. Thus, both these interventions were continued.
- Challenges related to monthly Hb testing for pregnant women were faced, since regular Hb testing is not adopted in the system as yet but is a non-negotiable for the anaemia project. Tremendous advocacy efforts were required at the block and district levels to ensure these tests.

Banaili Gram Panchayat

Problem statement: Low acceptance of family planning

SMART aim: To take the present rate of family planning from 27 percent to 50 percent between June 1, 2022 and August 31, 2022 in ward numbers 2, 5, 7, 9, 10, 11 and 12 of Banaili gram panchayat.

Analysis of problem areas leading to low acceptance of family planning methods



Scale to measure progress

Progress measure

» Number of counselling sessions held with eligible couples

Outcome measure

» Number of eligible couples that adopted any family planning method

Change ideas and their implementation

Ideas planned and implemented

- Development of daily activity plan for ASHAs
- Orientation of ASHAs, ANMs and Anganwadi Sevikas on family planning to provide in-depth knowledge on family planning – modern contraceptive methods, benefits, side effects etc.
- IPC and counselling sessions with eligible couples and mothers-in-law on the importance and benefits of spacing child birth by at least three years. Couples also informed about where to access the products and services
- Development of IEC material on family planning and usage of material during counselling
- Mothers' meetings organised every month with a focus on family planning
- Support taken from influential members of the community by involving them in counselling of eligible couples on family planning options
- Regular family planning commodity supplies ensured

Implementation observed

- Simultaneous tracking of adoption of family planning methods by eligible couples to document the number of eligible couples who adopted any modern temporary or permanent family planning methods
- Observation of IPC and counselling sessions
- The participation of JEEViKA workers was not as expected

Changes made/actions retained

- FLWs were able to organise better IPC and counselling sessions. Thus, these sessions were continued
- Support from influential community members proved effective

5. Challenges Faced and Lessons Learned

5.1 Convergence among FLWs

While visualising QI4SBC, a convergent approach was anticipated with the FLWs from Health, ICDS and JEEViKA working closely. Experience of QI4SBC showed that in each project the FLWs evolved their own system organically, with all the three coming together and working synergistically in some projects (for example, Exclusive Breastfeeding and Anaemia projects). In most of the projects it was the ASHA who played a key role and the participation from Anganwadi Sevikas and JEEViKA workers was lesser.

Lower level of enthusiasm and participation among Anganwadi Sevikas in projects such as HBNC, family planning, institutional deliveries and ANC projects was also linked to ASHAs being incentivised for these services, leading to an expectation of incentives among Anganwadi Sevikas.

5.2 One Size Doesn't Fit All

QI4SBC showed that a single approach does not work in all the locations and for all the projects. In some projects, FLWs came together to hone their skills and win over the confidence of the community (HBNC project), whereas in others creating schedule-facilitated systematic individual visits worked. In such cases every FLW chipped in by making scheduled visits, which led to frequent meetings and regular counselling of the right holders and their families, and thus better recall of messages (such as in exclusive breastfeeding project). This is a valuable lesson and moving forward, adaptability as per the need of the community and the problem being addressed should be kept in mind as a good practice.

5.3 Supply-related Issues

The anaemia and HBNC programmes faced initial supply-related challenges with a shortage of IFA tablets, HBNC kits and MCP cards. Regular Hb tests were imperative to monitor progress in the anaemia and ANC projects, though these are not adopted in the system as yet. Constant advocacy at the district and block levels ensured these tests and helped alleviate other supply-related issues. This also points to the fact that any QI project would need to be mindful of such supply chain and logistics-related issues and the challenges where such shortages can lead to obstacles in achieving the SMART aim.

Another issue with respect to measuring the Hb count is the use of WHO colour scale for estimation, which mostly shows the Hb levels between 8 and 10. This makes it difficult to identify high risk anaemia cases. Hence, acquiring Digital Haemoglobinometers would be better to monitor Hb levels for the QI4SBC projects. The FLWs being able to do Hb testing with prowess would be a crucial prerequisite for monitoring Hb levels.

5.4 Handholding and Mentoring Support

The handholding and mentoring support provided by the UNICEF and Alive & Thrive team helped the project teams navigate through challenges related to supplies, refresher trainings and any difficulties that they faced during home visits. This highlights the importance of handholding and mentoring in QI projects through formation of mentoring teams. It is necessary to have a regular field plan and stocktaking, once the project is scaled up.

5.5 Tracking Rights Holders to Measure Project Results

A specific challenge faced in the ANC project was pregnant women going to their maternal homes for delivering the baby. In such cases and also in case of pre-term babies, the fourth ANC visit was not getting recorded. Many pregnant women, though registered with government hospitals were visiting private hospitals for their ANC, and thus it was a challenge for the FLWs to track their data and maintain their records.

5.6 Refresher Trainings

FLWs needed refresher trainings to brush up their knowledge for effective counselling. HBNC also required initial support to help ASHAs gain confidence in weighing the newborns. As part of the pilot, these refresher trainings were provided based on the need of the projects. They point to the need for regular refresher trainings for FLWs for QI4SBC to show results at scale.

5.7 Data Recording, Monitoring and Analysis

QI4SBC pilot hinged upon stringent data recording, monitoring and analysis. It is essential for any QI project to move ahead, since analysis of successes and failures will help create long lasting implementable models.

5.8 SBC and Self-efficacy Trainings

The QI4SBC trainings for FLWs strengthened their counselling skills. They were able to counsel the pregnant/lactating women and their families more effectively. During the observation visits made by the mentoring and handholding teams, FLWs were found to listen and respond as per the query of the rights-holder and communicate more clearly and precisely. The FLWs suggested that this was a change they had observed in themselves. They were able to adopt and adapt to the concept of QI with ease, which shows that QI4SBC as a concept has the promise to be incorporated in trainings of FLWs.

"Many rights-holders were initially uncomfortable opening up to the FLWs. In our training we were taught to first befriend the rights-holders and gradually start the counselling process. I developed an in-depth understanding on anaemia and the importance of iron and calcium tablets. Alongside, more importantly, I learned about behaviour change. One crucial learning for us was the importance of involving the family of the rights-holder as well as the community. We involved husbands and the mothers-in-law particularly. Now in my area, most women are defeating anaemia and moving towards healthy motherhood. They themselves ask for the iron and calcium tablets."

Pallavi Kumari
Anganwadi Sevika, Anaemia project
Ghordaur gram panchayat

"Earlier, we ourselves did not know the importance of ANC visits for the mother and child. We would register pregnant women for ANC visits but would not bother to follow up with them. After the training, our team worked in a focused manner, particularly the ASHAs, ANMs and Sevikas, and now the rights-holders in our area know the importance of ANC visits."

Bibi Sagra Khatoon, ASHA
ward number 4, ANC project
Lakhana gram panchayat

"Mothers have slowly started to understand that HBNC visits are for the benefit of their babies. But more importantly, when we started working with QI in mind, our own way of interaction with the community has also changed."

Lakho Devi, ASHA
HBNC project, Gurhi gram panchayat

6. Results Achieved

6.1 Increase in Quality and Quantity of Counselling

All the projects of QI4SBC showed extremely encouraging results, despite below par participation from ICDS and JEEViKA workers in some projects. The quality of IPC sessions, mothers' meetings and other counselling sessions improved. The FLWs have become comfortable talking to family members and elders during counselling sessions, a change from the past. Visits of ANMs have improved. The FLWs have now started developing systematic daily plans and maintaining their diaries. The WhatsApp groups formed by FLWs to share progress of their projects have remained active with everyone sharing results and encouraging developments.

As a spillover effect, the FLWs claim that they used and are still using the project as an opportunity to counsel and help the rights-holders get other services that they are entitled to. Birth registration increased, uptake of other services increased, and now the community seeks out FLWs for advice, etc..

This enthusiasm among the FLWs augurs well and showcases the ease with which they have acclimatised to the concept of quality in counselling and incorporated it in their work.

"In the past 15 years of my work tenure, I have undergone many trainings. But this QI4SBC training has given us in-depth knowledge on newborn and maternal care, which we did not have earlier. Building our skills in counselling hasn't been a part of our earlier trainings. Having honed our SBC and technical skills through these trainings, we can counsel the mother and her family about the benefits of colostrum and the need to exclusively breastfeed the baby for the first six months."

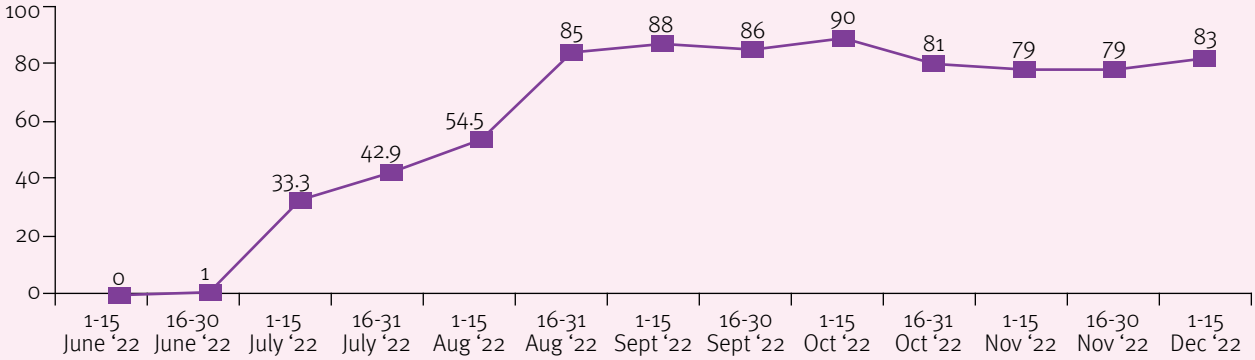
Mamta Kumari
Anganwadi Sevika, Bareta gram panchayat

"Collective monitoring and supportive supervision is crucial for us to record QI as well as behaviour change in the community. Such training programmes should continue in future too, and also the cooperation we have received from the Health Department through smooth supplies of equipment and kits. This way we will be able to service the community better."

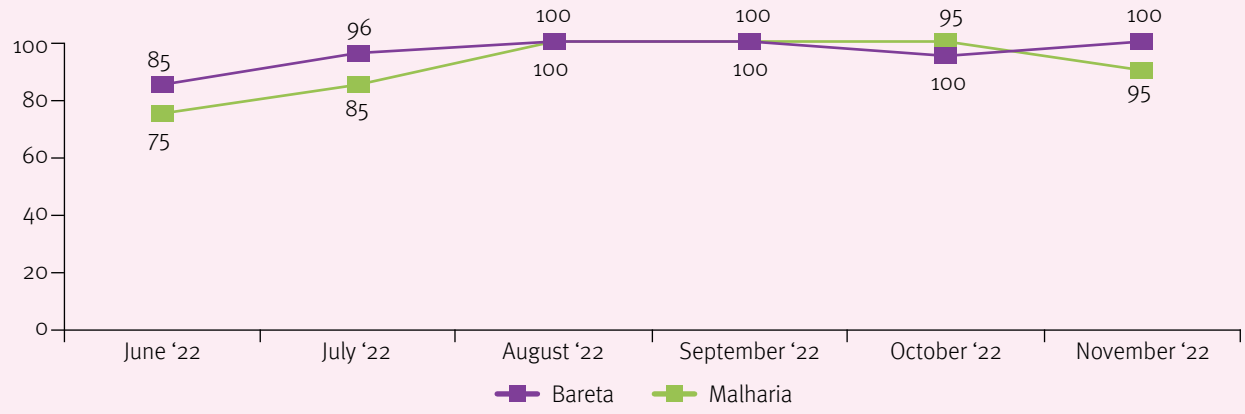
Yasmin, ASHA
Gurhi gram panchayat

FLWs have gained the capacity to identify challenges and build solutions, which is an achievement. QI4SBC programme attempted to create human capital and a resource pool which can take the learnings forward. The trained and experienced FLWs are now capable of training other FLWs on this methodology.

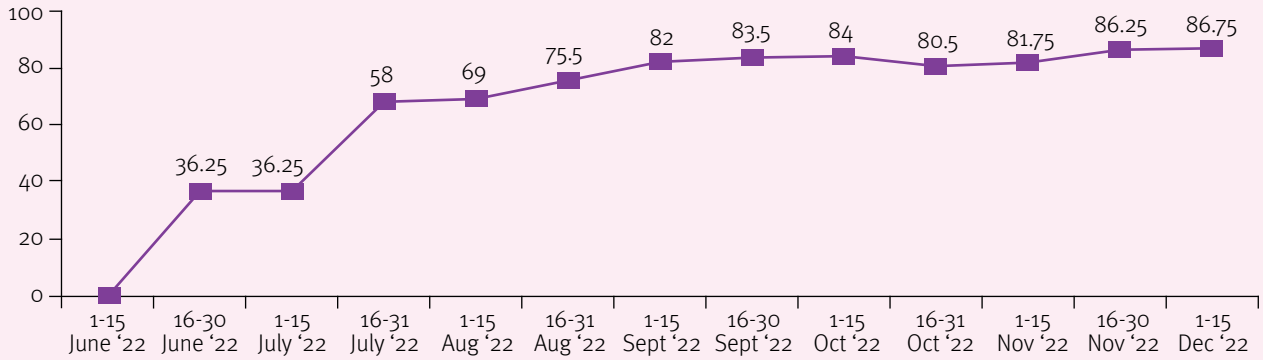
Percentage increase in newborns who received all home visits (HBNC project)



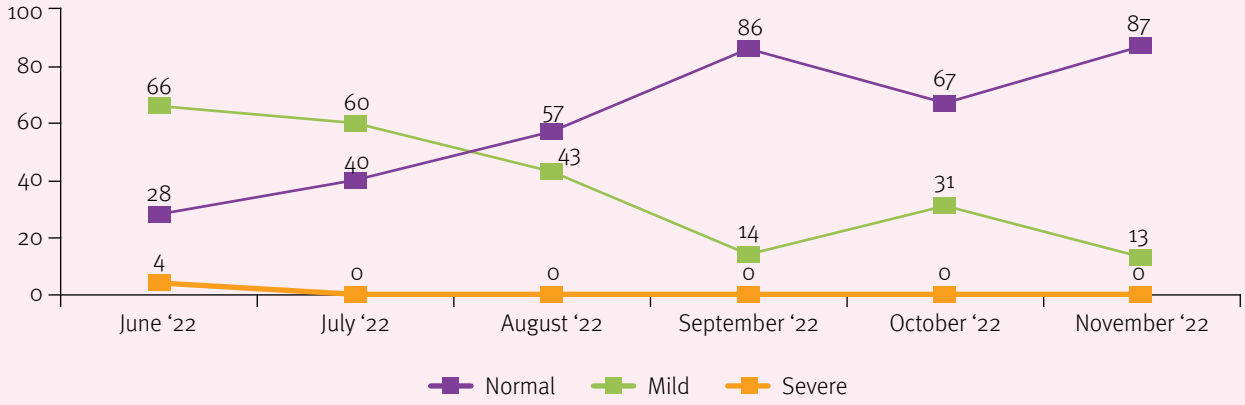
Percentage nutrition counselling (seven or more times in a month) (EBF project)



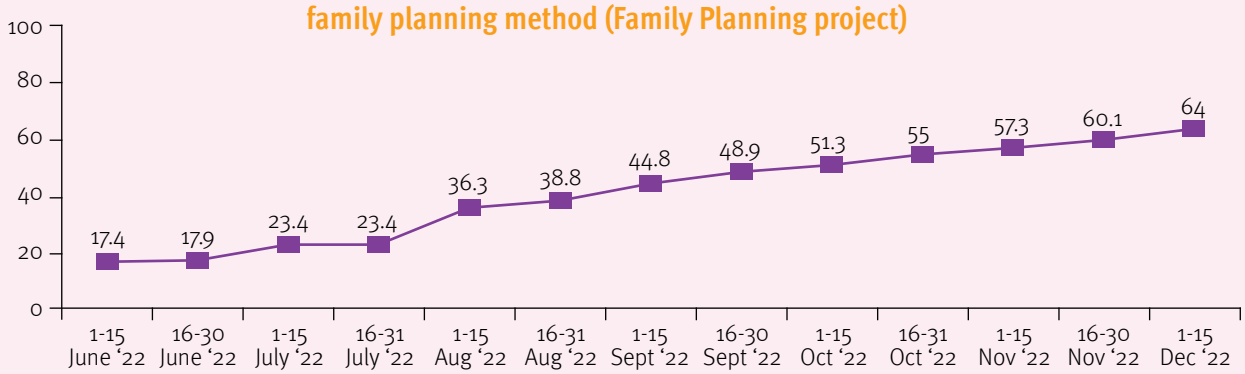
Increase in percentage of women who received counselling after any ANC (ANC project)

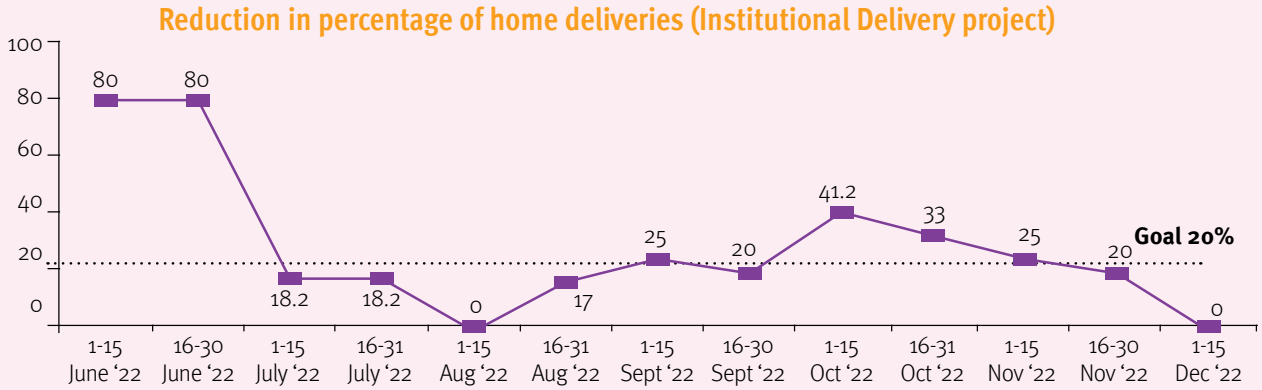


Percentage increase in Hb among pregnant women (Anaemia projects)



Percentage increase in eligible couples who opted for a temporary family planning method (Family Planning project)





The experience of projects such as the ANC project showed that alongside the percentage of pregnant women getting regular ANC check-ups going up, the elders in the community too have started visiting health camps for check-ups. Anecdotal evidence from the ANC project has shown that with regular ANC there has been an increase in the birth weight of babies, with the newborns weighing around three kilograms.

Elders in the community, like the Mukhiyas joined the efforts of the FLWs. In some places husbands of FLWs helped reach out to the community, demonstrating that communication did not just reach the right holders and their immediate families, but permeated through the other tiers of the community.

6.2 Need-based Solutions Found

QI4SBC pilot took an organic approach and molded itself within the existing framework of healthcare. While analysing the problem and articulating change ideas, the FLWs formulated action points based on their understanding of what would work in the context of their gram panchayat. The PDSA cycle helped revisit ideas that were not working, to rework and test them or adopt new action points. Some local systems were also set up.

While drawing up change ideas for each project, some turned out to be common across all the projects, whereas others were specific to a particular project or location. Need-based solutions found for each project and those running across all the projects are listed below.

Need-based solutions

HBNC project

- Handholding support for ASHAs by the ANM for one HBNC visit and by ASHA Facilitator for two HBNC visits
- Joint HBNC visits with the team leader taking lead in weighing the baby and others learning from her
- Counselling sessions during mothers' meetings explaining the benefits of HBNC
- Supply of HBNC kits ensured by mentoring team through advocacy with block duty-bearers
- FLWs accessed VHSNC funds to replenish HBNC kits

Exclusive Breastfeeding project

- Visit schedule and reporting formats for ASHAs, Anganwadi Sevikas and JEEViKA workers for first 28 days
- During home visits, asking mothers to demonstrate breastfeeding and asking specific questions on how many times the baby was fed and how many times the baby urinated
- Slogans to help community understand the message (vajan badh raha hai toh vikaas ho raha hai)
- Explaining the benefits of exclusive breastfeeding during mothers' meetings
- A detailed template of technical messages to be conveyed during counselling sessions with mothers and families

Need-based solutions

ANC project

- Making ASHAs play a more proactive role than just being mobilisers for ANC
- Quality counselling of pregnant/lactating women and families by ASHAs about benefits of ANC registration
- Reminder to pregnant women about ANC visit a day before ANC session
- Mothers' meetings used as forums to stress the importance of ANC

Anaemia project

- Refresher training of FLWs on IFA supplementation
- Adoption of 5-6 pregnant women by each FLW for weekly counselling during home visits
- Counselling of families along with pregnant women
- Promoting local foods for prevention of anaemia
- Checking thali and IFA strip during home visits to observe the food consumed and whether the tablets are being consumed or not
- Using forums such as Godbharai, Take Home Ration (THR) and PMSMA for counselling on anaemia and importance of IFA supplementation

Family Planning project

- Regular and systematic counselling sessions with couples and in-laws, where possible
- Engaging local community leaders to advocate for family planning
- **Role model:** Despite the other CNRPs and CMs not taking interest, CNRP Khusboo Kumari went out of her way to not just counsel women and their families on family planning but also became a role model by adopting family planning methods.

Institutional Deliveries project

- Pregnant women and their families counselled on the benefits of institutional deliveries
- Organising mothers' meetings to discuss the benefits of institutional deliveries
- Telephone number to call ambulance repeatedly shared in all meetings
- Number of ambulance written on walls for easy recall
- Block-level sensitisation of quacks who encouraged home deliveries in the gram panchayat

All projects

- Line listing of rights holders
- Refresher trainings on thematic areas for all the projects
- Including family members in counselling sessions
- Formats developed to record data
- Preparation of daily plans by ASHAs
- Clear role division between ASHAs and Anganwadi Sevikas during joint visits
- Regular team meetings to discuss progress and collate data
- WhatsApp groups for information and progress sharing
- Reviving use of existing counselling tools that had not been used for long.

"I had attended a training session by UNICEF and Alive & Thrive team in one of the gram panchayats where all the FLWs from the three departments were present. After the training, their knowledge is refreshed and their capacities have increased. They feel more motivated to work in the field."

Meera Kumari
CDPO, Kasba block, Purnea district

"FLWs have been the pivot of this programme. Their capacities have increased with the implementation of QI4SBC. I feel that the training of FLWs from all departments was the key component, and it should continue every three or six months to retain these newly built capacities in the FLWs."

Dr. Ashok Kumar Singh
ICMO/MOIC, Kasba Primary Health Centre
Purnea district

In January 2023, QI4SBC was awarded the first prize at the state level Quality Conclave as an innovative approach to QI. Results from the HBNC, ANC, family planning and institutional deliveries projects were showcased to highlight how QI approach has led to improvements in counselling and subsequently service uptake.

7. Way Forward

7.1 Potential for Scale-up

The QI4SBC pilot was designed to encourage deliberations among the team to come up with change ideas based on an understanding of the community's context and adapted to the need of the hour. No prescriptive solutions were proposed and no set ideas were imposed on how things should be taken forward. The pilot proved effective and all the eight gram panchayats were able to achieve the SMART aims that they had set for themselves. It demonstrated how FLWs can take initiatives to fit in their mandated work into systems, in coordination with other FLWs, and sync in with the systematic framework of QI to enhance efficiency and impact.

The trainings built the capacities of FLWs from Health, ICDS and JEEViKA on SBC as well as QI. Those who actively participated, ably demonstrated improved counselling skills, enhanced self-efficacy and an ability to put QI to practice, with minimal handholding support. The pilot showcases their capacity to absorb and comprehend the concepts of SBC and QI and, subsequently, utilise them for improvement of health and nutrition indicators in community settings. Integrating the concept of quality with counselling in community settings helped measure the improvement in newborn and maternal health indicators and demonstrated the significance of systematic and repeated counselling and self-efficacy among FLWs.

The pilot underscores the need to build self-efficacy and counselling skills into trainings as is evident from the results of all the projects.

Bihar has an expansive and well-established network of FLWs with around 90,000 ASHAs, 4,300 ASHA Facilitators and 25,000 ANMs working with the Department of Health[11] and around one lakh Anganwadi Sevikas from ICDS[12] programme. They have an unprecedented reach and acceptance in the community. Being a part of the existing framework of service delivery that focuses on maternal and child nutrition and health, they provide the potential to scale up the pilot to the whole state. Their contribution is immense in changing norms and perceptions through counselling, driven by the tenets of QI, and ensuring continuity through follow ups to help communities adopt healthcare and nutrition practices that support maternal and newborn health and wellbeing.

Since the pilot was implemented through the existing government system, it enhances the feasibility of a scale up. A well-trained resource pool of around 50 master trainers is available in Purnea district, who can facilitate the scale up in other blocks of Purnea, and subsequently other districts. For ensuring scale up, Incremental Learning Approach (ILA) can also be used with the creation of capsules of learning, which can be rolled out in block-level meetings of different functionaries.

Though the pilot worked on six thematic areas, the simple and easy to replicate steps of QI have the potential to be utilised in other areas critical for child survival, growth and development.

[11] https://ashwin.bih.nic.in/Ashwin/PublicReports/ConsolidateRpt.aspx

[12] https://covidwarriors.gov.in/covid_statewise.aspx?orgid=31

Since the project was designed by the FLWs themselves, level of ownership was high, the individual projects are still going on even when external support from UNICEF and Alive & Thrive has stopped. Adaptability to local context was a key success factor.

Scope for mid-term course correction makes it feasible for scale up, while testing different change ideas makes it challenging and non-monotonous. Seeing quick results keeps up motivation levels, and building new relationships with community where FLWs are regarded with respect adds to the motivation.

7.2 Recommendations for Scale-up of QI4SBC

QI4SBC has the scope to take a continuum of life and continuum of services approach. Going forward, QI4SBC can be scaled up in a phased manner at the district level for the six thematic areas undertaken during the pilot, and other themes can be added subsequently. The key recommendations to ensure this scale up have been listed below.

Convergence of Health, ICDS and JEEViKA at District Level

QI4SBC should be institutionalised as a district-level mechanism under the aegis of the District Health Society. This would ensure the buy-in and agreement of the concerned departments, mainly Health, ICDS and JEEViKA. This would also support facilitation of mechanisms to be created for joint planning and implementation of QI4SBC, to ensure programmatic convergence and participation of FLWs from these departments.

An enabling environment would need to be created at the district and block level to ensure convergence among FLWs from Health, ICDS and JEEViKA at the community level. This can be done through:

- Inclusion of QI in the agenda of District Health Society review meetings
- Planning joint monthly review and planning meetings of the departments at the district, block and sector levels, ensuring QI as one of the agenda points

This district-level buy-in needs to be followed up with departmental agreement for inclusion of QI4SBC in FLW trainings during sector meetings and their subsequent involvement in the QI exercise at the community level. This plan would need to be chalked out in detail, by Health, ICDS and JEEViKA. UNICEF can provide support in creating these detailed plans of action.

Creating a Pool of District-level Master Trainers and Monitors

The existing pool of master trainers from Purnea district can be utilised to take the trainings forward in other blocks of Purnea. Alongside, UNICEF will be able to provide support to create a pool of district-level master trainers in other districts for scale up of trainings in other districts.

Though QI works within the existing resources, training and creating a pool of master trainers and monitors who are well-versed in QI4SBC would require a separate budget in the Performance Improvement Plans (PIPs) to support the training of trainers, since current budgetary allocations would not be able to absorb this expense. This would be an essential investment to scale up QI4SBC across the state. These trainings can be absorbed in as part of the IEC budgetary allocations.

Monitoring and Handholding of FLWs

Once the implementation of QI4SBC is initiated in other blocks of Purnea and subsequently other districts, the FLWs should be provided handholding and supportive supervision by monitors to ensure that they are able to continue their work without any glitches. This would help the FLWs on ground

do effective counselling to increase the uptake of family planning commodities, ANC check-ups, institutional deliveries, build acceptance for HBNC visits by families of newborns and other practices to improve newborn child survival. The experience of the HBNC project has shown that handholding support provided to the FLWs by ANMs with one joint visit helped immensely in improving the quality of HBNC visits. These supportive supervision visits by ANMs should be continued to support ASHAs during HBNC visits. Adequate monitoring by the monitors would also ensure a better work division among ASHAs, Anganwadi Sevikas and JEEViKA workers during home visits.

For this it is imperative that a well-coordinated schedule of supportive supervision field visits by monitors is created for them to visit all project sites. Also, monitors would need to support the FLWs create systematic home visit schedules, formats for recording information and hold regular stocktaking meetings.

Regular visits by FLWs would need to be ensured as it was seen that regular follow-up visits ensured better adherence to new behaviours. This way caregivers feel there is someone to support, monitor and handhold when required.

Institutionalising QI4SBC Curriculum

The QI4SBC curriculum should be built into the existing training curricula of ANMs, ASHAs, Anganwadi Sevikas and JEEViKA workers. It should be developed as a standard module covering QI cycles, counselling and self-efficacy, with successful change ideas.

This training can be delivered during the monthly sector meetings by the master trainers. The training module developed for the pilot can be adapted to the ILA delivery system and the three-day training can be divided into sessions over a period of three months. The concept of QI4SBC can then be implemented on ground from the fourth month onwards. Sharing of successful experiences by FLWs should be encouraged at forums such as sector meetings for exchange of ideas and to build acceptance for QI as a practical and implementable approach.

Alongside, refresher trainings of FLWs on technical aspects of their work would help QI work effectively. Training platforms can once again be used for refresher trainings. UNICEF can provide technical support in developing this module.

Encouraging Local Solutions

The QI4SBC initiative showed that FLWs can be enterprising and find solutions on their own, suitable for their context. In the Institutional Deliveries project they wrote the ambulance telephone number at strategic places in the villages and supported the community in accessing ambulance service. In the Exclusive Breastfeeding project the FLWs used simple and effective slogans to emphasise its benefits. Such slogans had a high recall value and helped women imbibe the message faster. In most projects, mothers' meetings were used as forums for group counselling. FLWs ensured utilisation of VHSNC funds to refill HBNC kits, and used their enterprise to create spaces for ANC check-ups. Such successful practices and local solutions adopted by FLWs on a smaller scale can be incorporated into larger implementation framework.

Streamlining Logistics and Supply-related Issues

One of the key factors that would ensure the success of QI4SBC after scale up is streamlining commodity supplies. This was absolutely essential for most of the QI4SBC projects that were taken up in the pilot phase. Even after scale up, supplies would play a key role in the success of any of the newborn survival-related projects.

Timely and uninterrupted supply of commodities related to family planning, IFA, HBNC, and ANC, among others is paramount. MCP cards are a must and used by FLWs in most of their counselling sessions. Alongside, uninterrupted supply of HBNC and Home-Based Care for Young Child Programme (HBYC) forms will have a bearing on the performance of projects. Streamlining these logistics is crucial.

Since Hb testing came up as a challenge, with paper strips not being as effective and Haemoglobinometers not vastly available, other feasible solutions can be tested. Special ANC camps can be organised to test Hb levels. Another option is provision of supportive supervision by the Community Health Officers (CHOs) at VHSND sites, so that their Hb testing kits can be used during VHSND. Right holders can also be linked to the nearest health and wellness centres.

Involvement of Communities and Health Facilities

Health facility staff can play a big role by helping the FLWs reach and convince communities in the most hard-to-convince areas, in projects such as the family planning project. Alongside, FLWs should be encouraged to garner support from key influencers such as community elders and religious leaders. For this, orienting these influencers on the specific focus areas of the projects and their inclusion during the QI planning phase, with a clarity of their role during the implementation phase, would be a strategic approach post scale up. Male involvement by engaging male influencers such as ASHA ***patis,*** ***Mukhiyas*** and ***Panchayat Sachivs*** should also be ensured. Garnering community's support would also be beneficial in acquiring support for issues such as smooth implementation of activities like ANC check-ups.

Registered medical practitioners (RMPs) and quacks need to be brought into the fold and sensitised about the specific issues taken up by the projects, as was the case in the Institutional Deliveries project. In most communities quacks are trusted and respected by the community members and their sensitisation would be critical for the success of QI4SBC projects in future.

Streamlining THR distribution is another community-level activity which will have significant ramifications on the uptake of services such as ANC and Routine Immunisation (RI). Systematic and streamlined distribution of THR will build the faith of the rights holders on provision of health and nutrition-related services and encourage them to seek services beneficial to mothers and newborns. Thus, measures should be taken to ensure the same.

Broadening the Scope of HMIS

Health Management Information System (HMIS) data involving private providers can be tracked to ensure that pregnant women seeking ANC services in private hospitals do not get missed and comprehensive data can be captured and analysed.

7.3 UNICEF's Support in Scale-up

UNICEF will provide technical support in scaling up QI4SBC in Purnea district. The first step would be creation of a pool of district-level master trainers who can subsequently train duty-bearers in other blocks of Purnea as well as other districts. The training of master trainers can be taken up either at the state level or the district level. Apart from this UNICEF will develop the following to ensure that the scale up of QI4SBC is smooth.

- Module on SBC and self-efficacy to be included in the training of all ASHAs, Anganwadi Sevikas and JEEViKA workers

- A complete and comprehensive training module on QI4SBC covering the QI cycles, including:
  - Compendium of successful change ideas that can be referred to by the implementing team of FLWs, while building their change ideas at the community level
  - A template of suggestions that can be used by gram panchayats while implementing QI4SBC
- Guidelines and Standard Operating Procedures for implementation of QI4SBC at scale including:
  - Guidelines for implementation at panchayat level – setting up meetings, deciding project aim, developing change ideas and implementing change ideas
  - Guidelines for implementation at block level – consolidating all panchayat level plans, creating and supporting monitoring schedules, facilitating planning at the gram panchayat level and compiling results
- IEC material and tools to support the FLWs for projects.

7.4 Amplifying the Project

Social media should be utilised to amplify the project and build connections with the community. It provides a medium for news and information to reach thousands of people at the same time, which generates more curiosity, along with informing the community about the efforts being made.

Throughout the period of the pilot, the FLWs were connected with the block-level team and the mentors from UNICEF and Alive & Thrive through WhatsApp groups. These groups helped share information and news with a large number of people at the same time and supported sharing, discussions and collective problem solving. Some Anganwadi Sevikas are posting pictures from the project in their official WhatsApp groups, which has led to an interest among other Anganwadi Sevikas and enquiries from them about the project.

Similarly, social media (including WhatsApp, Facebook, Twitter and Instagram) can be used to amplify QI4SBC project at scale and build a connection with the community by sharing the intent and the positive developments as part of the project.