Policy Brief

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Social and Behaviour Change Interventions for Promoting Antenatal Care and Institutional Delivery

Statement of Issue

India has a high maternal mortality ratio of 167 per 100,000 live births (Census of India, MMR Bulletin 2011-13). About half of the maternal deaths occur due to haemorrhage and sepsis, so timely detection of obstetric emergencies, promoting full antenatal care, 24-hour services and skilled attendance at birth are required to prevent maternal deaths.The Government of India promotes these activities under the National Health Mission (NHM) which has accelerated the adoption of antenatal care and institutional delivery through an incentive based scheme called Janani Suraksha Yojana (JSY). As a result, in India, 78.7 per cent (RSOC 2013-14) of women have institutional delivery, however, there is great disparity across different states of the country. Same data source shows that only 19.7 per cent of women in India receive full antenatal care (ANC) comprising receipt of 3+ANC, at least one dose of TT and consumption of 100 IFA tablets/syrup.

Antenatal care is essential for improving maternal and child survival rates because it acts as gateway behaviour to improving a cluster of other healthy behaviours (Varma et al. in Khan et al., 2012).These cluster behaviours include institutional delivery, postnatal care (PNC) and newborn care behaviours (early breastfeeding, delayed bathing, skin-to-skin care, cord care, exclusive breastfeeding), which lead to enhanced child survival. Evidence shows that at least four ANC examinations and institutional delivery, including access to emergency obstetric care (EmOC), are important supply and demand side interventions that could significantly reduce maternal mortality and enhance child survival (Maine, 1996).

Methodology

Under Call to Action, Population Council in partnership with UNICEF and USAID conducted an evidence review to identify key social and behaviour change (SBC) strategies and health outcomes supporting child survival in the South Asia region, especially in India. More than 7605 articles on Maternal and Child Health published during the last 13 years (2002-2015) were scanned after database searching, and of these, 149 intervention studies wereselected for analysis. On Antenatal care behaviour, a total of 1232 articles were identified and screened, 159 abstracts were read, 52 articles were downloaded and reviewed and 22 were selected for final review. The outcome of the review was a Report, “Evidence Review on Population Level Social and Behaviour Change in South Asia for Enhancing Child Survival and Development” on which this policy brief is based. In addition, a technical group in UNICEF India has enhanced the findings and recommendations with new literature and relevant evidence.

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There is evidence to show that the demand side barriers to access services such as tradition, lack of knowledge, and financial constraints may be as important as supply factors in deterring health users from utilising services (Griffiths and Stephenson, 2001; Ensor and Cooper, 2004). A study conducted by Population Council in 2011 in Bihar and Uttar Pradesh suggests that behavioural barriers to institutional delivery include:(1) perception that the delivery is normal, (2) cost and transportation issues, (3) lack of knowledge of availability and benefits of Skilled Birth Attendant, (4) lack of knowledge of danger signs during pregnancy and delivery, (5) lack of delivery preparedness and lack of perceived need for emergency preparedness (6) stigma in accepting JSY incentive money. System level barriers have been identified as: (1) lack of comprehensive counselling (2) poor coverage of remote villages by community health workers, (3) lack of EmOC services, infrastructure and human resource capacity at health centres, and (4) poor quality of care and lack of privacy.

Literature Review: Key Findings

1. **Behavioural economics schemes have been widely successful** in India, Afghanistan, Pakistan and Bangladesh. This demand side financing (DSF) reduces financial barriers (cost of transport and delivery) to the beneficiary to avail under-used good quality services. It also acts as an incentive to motivate the healthcare provider and community health worker to perform better. Evidence from the literature review shows 18–35 per cent increase in institutional delivery in interventions that used behavioural economics in combination with communication interventions such as inter-personal communication (IPC), mass media etc. For JSY, the findings of this evaluation 2-3 years into the implementation of the programme are encouraging. JSY has greatly increased the proportion of pregnant women delivering in a health facility. Furthermore, the findings suggest that the programme is reducing perinatal and neonatal mortality; however, its effect on maternal mortality remains unknown.The different types of DSF include (1) conditional cash transfers (CCT) for clients to avail specific services, (2) pay for performance (P4P) to motivate health functionaries, (3) health insurance schemes and (4) voucher schemes for clients to avail services.

   (Chiranjeevi Yojana evaluated by Bhat et al., 2009 and Mavalankar et al., 2009; Janani Suraksha Yojana evaluated by CORT, 2008 and UNFPA &GfK MODE, 2009; REACH Program in Afghanistan evaluated by Hadi et al., 2007; voucher booklets in Pakistan evaluated by Agha, 2011; vouchers evaluated by Schmidt et al., 2010; an impact evaluation of JSY by S Lim et al, 2010)

2. **Men's involvement has led to adoption of healthy behaviours.** Men's participation in reproductive, maternal and family health is essential because in the South Asian context women depend heavily on men for access to healthcare. This has been studied by several programmes and a review of evaluations shows successful models where husbands accompany women for counselling meetings, antenatal care and postnatal care visits, which argues towards a strong commitment for men's involvement in an effective scale up of SBC interventions. For example, complete ANC in the Sure Start project increased from 13 to 25 per cent in Uttar Pradesh and from 70 to 83 per cent in Maharashtra, after giving the husband of a pregnant woman a letter, *Chiththi Mere Papa Ke Naam* (“A Letter to My Father”), describing his potential role in his wife's and unborn baby's good health.

   (First-time Parents Project, Santhya et al., 2008 and MiM, Varkey et al., 2004 from India; Mullany et al., 2007 andManadhar et al., 2004 from Nepal, Sure Start Project, PATH, 2012)

3. **Integration of different channels and interventions at all levels – individual, community and health system – leads to successful SBC outcomes.** The key weaknesses identified from review of literature include lack of knowledge and low perception of risk. Studies show that using a single channel such as mass media can improve knowledge to some extent but cannot bring about behaviour change. So, a synchronized effort using different channels is needed to reach the beneficiary, such as counselling and services by frontline workers, activities at health centre, community mobilisation and mass media. The Janani Suraksha Yojana in India (UNFPA, 2009) through integration with other programmes showed a 35 per cent increase in institutional delivery and the Sambhav voucher scheme showed an 18 per cent increase. Hadi et al. (2007) showed a significant increase in ANC from 14.9 per cent to 67.6 per cent, and in institutional delivery from 31.3 per cent to 55.2 per cent. Eleven studies in this review covered all three levels of integration resulting in positive impact. Moreover, to affect social norms on gender and stigma, any intervention needs to operate at all three levels. For example, in Santhya et al. (2008) first time ANC improved from 33 per cent to 55 per cent in Diamond Harbour, West Bengal and from 66 per cent to 75 per cent in Vadodara, Gujarat. The mean number of ANC received was also significantly higher (3.2 to 4.4 in Diamond Harbour, 4.3 to 5.0 in Vadodara). Institutional deliveries increased from 40 per cent to 51 per cent in Diamond Harbour but remained almost unchanged, from 71 per cent to 70 per cent in Vadodara. A significant increase in delivery preparedness, PNC, breastfeeding, spousal communication and contraceptive use was also achieved. Institutional delivery increased from 40 per cent to 51 per cent in the experimental group but remained unchanged in the control group. Dixit, P. et al (2013) found that women who made 1 - 2 ANC visits had 6.6 percent higher chance to deliver in an institution compared to women who made no visit. And if a woman visited health centre three or more than three times, her chances of delivering in an institution were 31 per cent higher.

   (PATH's Sure Start project; BBC Trust's 360 degree approach in Bihar; Santhya et al., 2008; Hadi et al., 2007; Mullany et al., 2007; Dixit, P. et al., 2013)

4. **Strengthening of the existing health system**. Several studies reviewed interventions which operated on or supported strengthening of the existing health infrastructure and recommended improving quality of existing health systems (both public and private) to achieve desired delivery of health services. Study by Thomas, D. et al (2015) provided evidence of how health systems can be strengthened to improve health equity in Odisha. The institutional delivery rate rose from 11.7 per cent (2005-06) to 67.3 per cent (2011) for Scheduled Tribes and the social gradient also closed for antenatal and postnatal care and immunisation. Private sector partnerships with the Government health system (as in Chiranjeevi Yojana, Comprehensive Rural Health Project and Sure Start Project) also effectively complemented this effort. Although it is difficult to assess the effect of health system intervention in isolation, 21 of the 22 successful interventions reviewed included a key health system component.

   (Baqui et al., 2008; Barua et al., 2003; Ekman et al., 2008; Koblinsky et al., 2006; Jeffery et al., 2007; Stephenson & Sui, 2002; Nair et al., 2010 ; Thomas, D. et al., 2015)

Policy Recommendations

1. **Behavioural economics interventions need to be supported by improvements in infrastructure and interpersonal communication.** Activities such as community promotion and house visits to bring about successful behaviour change are needed to support cash incentive and voucher schemes. Government should rethink the cash incentive system to reduce maternal mortality and reconsider maternal health care as a continuum of care. In addition, it is important to improve focus on socially and economically marginalised women and pay attention to quality of obstetric care in health facilities.

2. **Interventions need to be conducted at all three levels – individual/family, community and health system.** Strategies need to operate at multiple levels. At the individual level, counselling should involve not just the woman but the family as well, including husband, mother-in-law and any other decision maker or caregiver; at the community level, conduct mid-media activities such as cultural programmes (i.e. folk dance and health fairs or melas) and involvement of community based organisations such as Self-Help Groups (SHGs); and at the health system level, capacity and skill building of health professionals and Community Health Workers. Political will, committed policy makers and fiscal space together energise the health system to promote equity. Further, to address social norms on gender and stigma, the interventions need to operate at all three levels with the health system as the backbone. At the health system level, availability of trained staff, supplies and equipment, and provision of good quality EmOC must be addressed for behaviour change interventions to be successful.

3. **Involving men is critical in ensuring maternal and child health outcomes.** Inter-spousal communication and involvement of men in availing health services such as making all ANC visits have been vastly successful in increasing communication between couples/family members, increasing use of health services including chances of institutional delivery, uptake of healthy behaviours (especially family planning and child care), self-efficacy and autonomy of the woman and reducing issues rooted in gender differences.

4. **Integrating various mutually reinforcing communication components is essential to successful SBC.** The health messages imparted through different channels must be based on the same strategy. They should be aligned in terms of timing and content and complementary to each other. There are many ways to reach the beneficiary with health messages. These include information communication technology (ICT) (i.e. voice messages on mobile phone and advertisements on TV, radio), newspapers, wall paintings, IPC by CHW, posters at health centre and messages discussed during women's group meetings or by religious/panchayat leaders.

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