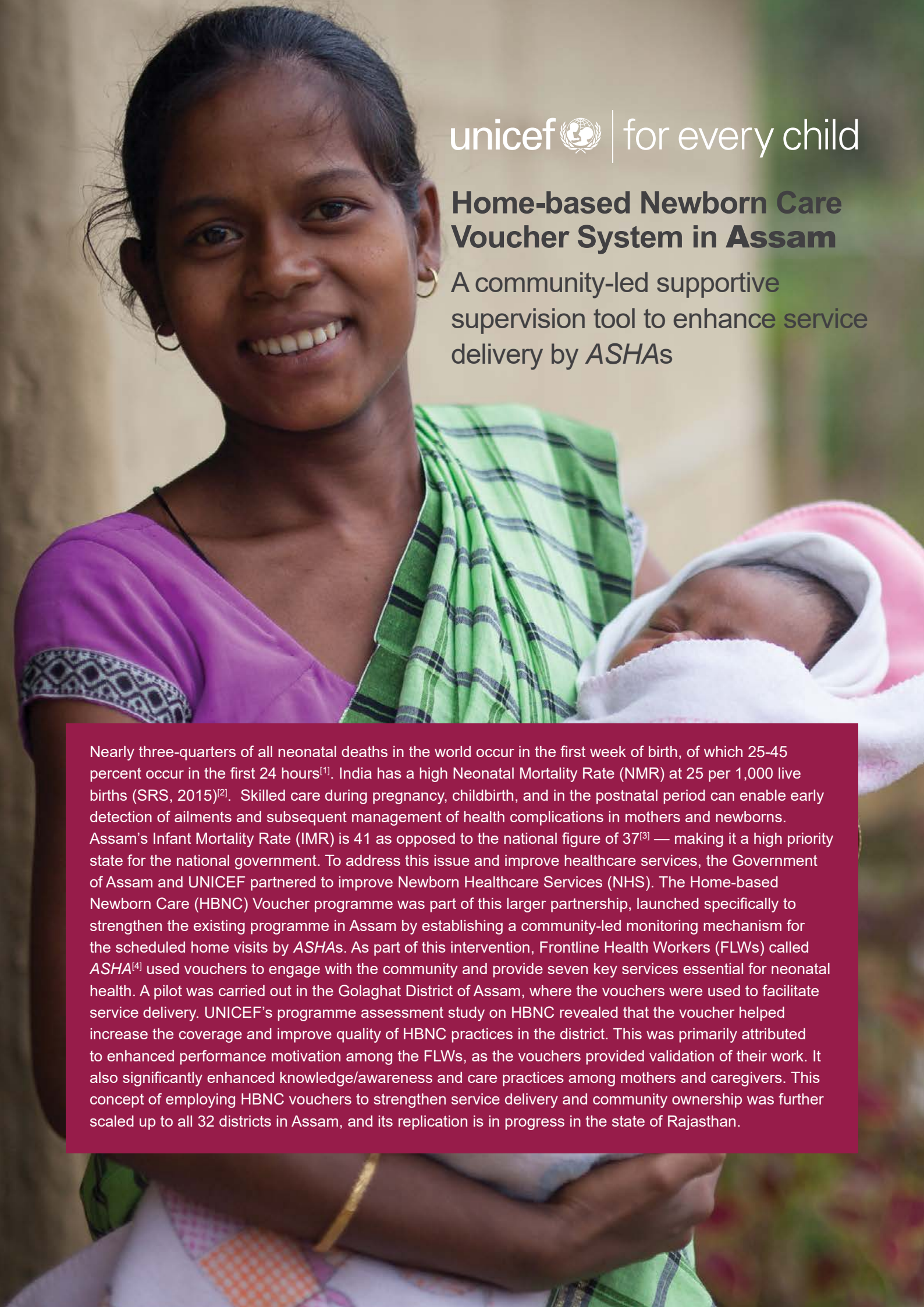

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Home-based Newborn Care Voucher System in Assam

A community-led supportive supervision tool to enhance service delivery by *ASHA*s

Nearly three-quarters of all neonatal deaths in the world occur in the first week of birth, of which 25-45 percent occur in the first 24 hours[1]. India has a high Neonatal Mortality Rate (NMR) at 25 per 1,000 live births (SRS, 2015)[2]. Skilled care during pregnancy, childbirth, and in the postnatal period can enable early detection of ailments and subsequent management of health complications in mothers and newborns. Assam's Infant Mortality Rate (IMR) is 41 as opposed to the national figure of 37[3] — making it a high priority state for the national government. To address this issue and improve healthcare services, the Government of Assam and UNICEF partnered to improve Newborn Healthcare Services (NHS). The Home-based Newborn Care (HBNC) Voucher programme was part of this larger partnership, launched specifically to strengthen the existing programme in Assam by establishing a community-led monitoring mechanism for the scheduled home visits by *ASHA*s. As part of this intervention, Frontline Health Workers (FLWs) called *ASHA*[4] used vouchers to engage with the community and provide seven key services essential for neonatal health. A pilot was carried out in the Golaghat District of Assam, where the vouchers were used to facilitate service delivery. UNICEF's programme assessment study on HBNC revealed that the voucher helped increase the coverage and improve quality of HBNC practices in the district. This was primarily attributed to enhanced performance motivation among the FLWs, as the vouchers provided validation of their work. It also significantly enhanced knowledge/awareness and care practices among mothers and caregivers. This concept of employing HBNC vouchers to strengthen service delivery and community ownership was further scaled up to all 32 districts in Assam, and its replication is in progress in the state of Rajasthan.

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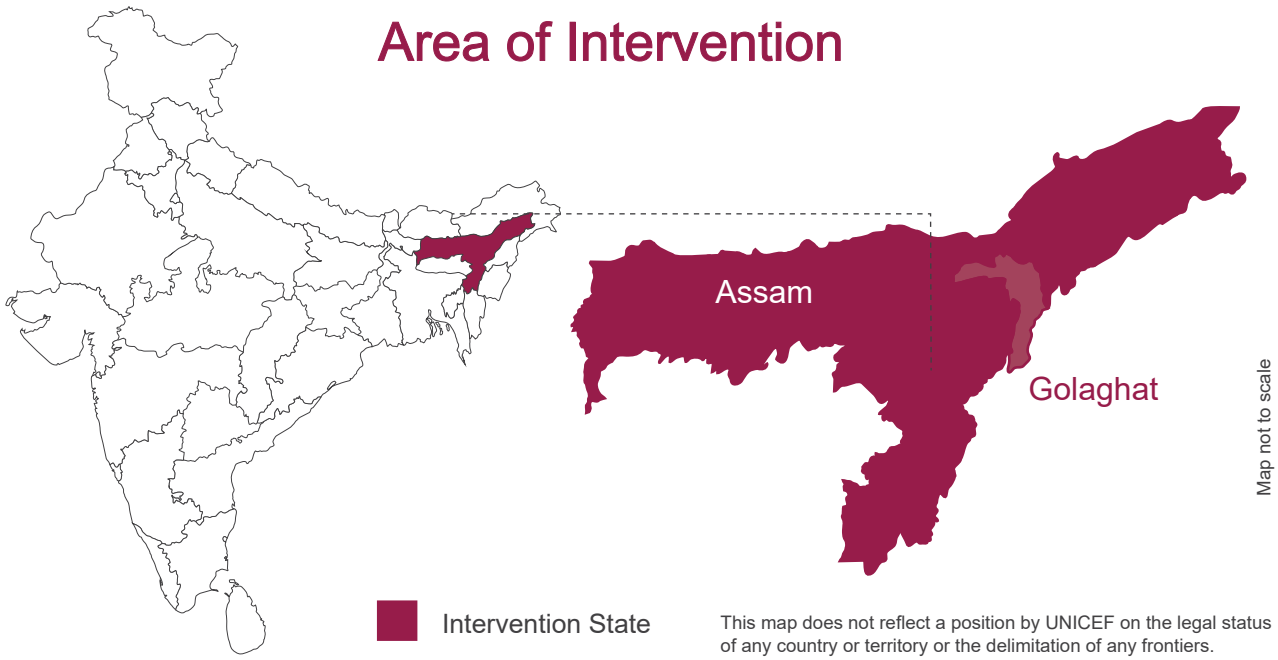
Area of Intervention



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Source: http://d-maps.com/carte.php?num_car=4183&lang=en

Situation

In India, and around the world, the Infant Mortality Rates have decreased over the last two decades. Between **1990 and 2015**, IMR in India had reduced from **87 to 37**. However, in the same period, the share of neonatal deaths were high and had, in fact, increased from **46 percent to 58%**[5] for deaths under the 5-year category. Three major causes of neonatal death are infections, asphyxia, and preterm birth – accounting for nearly **80** percent of all neonatal deaths[1]. Apart from disparity in available healthcare facilities, poor health-seeking behaviours and unscientific practices followed by the community due to prevalent maleficent social norms and customs create further challenges. Their demand for health services is limited or absent, making the situation more complex for interventions targeting healthcare improvement.

Assam has a high IMR at **48 per 1000 live births**[6]. According to the National Family Health Survey (NFHS), Assam's health indicators have improved between NFHS-3 and NFHS-4. However, there is substantial scope to prevent infant deaths through a targeted focus on neonatal health. One of the gaps identified by various expert reviews and anecdotal evidence was the inadequacy in quality supportive supervision of *ASHA*s. They are trained on maternal and infant care, but their capacity to effectively communicate, engage, and involve the communities warranted continued strengthening. Further, an output-driven supervision system often undermined the quality of work presented on field. On the demand side, correct and consistent infant healthcare practices in the community were noted to be inadequate (NFHS-4). Based on opinions from health system experts, challenges in the existing neonatal care service delivery model in Assam were as below:

1. Irregular HBNC home visits and inconsistent newborn care advice by *ASHA* pointed towards the paucity of quality monitoring and supportive supervision mechanism.
2. Missed opportunities of Interpersonal Communication (IPC) on newborn care create a void in the sphere of health communication and promotion activities.
3. Limited demand from community for essential HBNC for their infants.

The HBNC voucher initiative provides a window of opportunity for quality counseling during HBNC home visits. It is a Communication for Development (C4D) approach strategically aimed at harnessing behaviour change; both at the service delivery as well as community levels.

Theory of Change

Desired Long-term Change

Improved Neonatal Health

Improved service delivery by *ASHA*s & empowered communities for newborn care

Precondition 2

Improved social accountibility among *ASHA*s with regard to neonatal care

Improved awareness and practice in community with respect to neonatal care

Precondition 1

Effective monitoring of HBNC visits by *ASHA*

Timely disbursement of incentives to *ASHA*s for HBNC visits made

Enhanced demand for quality HBNC services from community

Enhanced access of community to primary health care functionaries

Activities

Voucher designed with multiple pages and key messages

Capacity building of ANMs/*ASHA*s on HBNC

Print communication campaign for community awareness

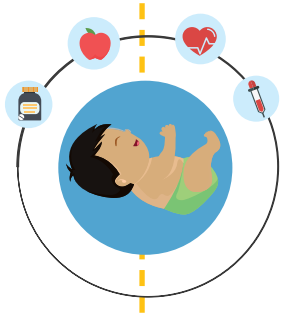
Logical Framework

PLANNING DOWNWARDS

GOAL-SETTING UPWARDS

IMPACT

Improved neonatal health and better service delivery by FLWs



RISKS: Confounding factors for IMR

ASSUMPTIONS: Improved HBNC = Reduction in NMR

OUTCOME

Improved social accountibility among *ASHA*s and better awareness and practice in community

RISKS: Social distance between community and FLW

ASSUMPTIONS: Desired reach = Desired impact

OUTPUTS

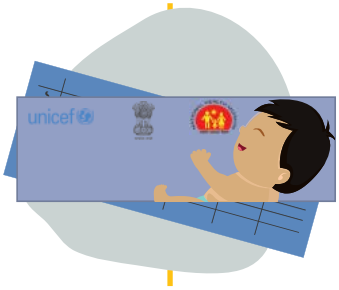
Vouchers distributed across SCs, 8,000 FLWs trained, and print campaign rolled out across Golaghat

RISKS: Disparity in distribution

ASSUMPTIONS: Smooth implementation

ACTIVITIES

Voucher designing, Capacity building of FLWs, and print campaign for community awareness



RISKS: Initiative dislike by FLWs

ASSUMPTIONS: Desired reach

INPUTS

Concept building, advocacy with government, HR, consensus building among stakeholders

Method

In 2013-2014, the Government of Assam (GoA) in partnership with UNICEF launched the HBNC voucher as a pilot initiative through the National Health Mission[7] (NHM). Within UNICEF, health units and C4D converged their efforts for this intervention which was rolled out in 88 health centres in the Golaghat district. The Community Medicine department from Assam Medical College Hospital (AMCH), Dibrugarh was brought on board for its technical expertise and assistance in designing the HBNC voucher.

It involved the following steps:

Step 1

Planning and evaluation: Continuous interactions were carried out between NHM and UNICEF C4D to plan this pilot initiative. The groups also discussed the evaluation design which would be conducted simultaneously to assess the potential of the initiative.

Step 2

Design, pre-test, and printing of HBNC vouchers and sensitisation of health workers: As part of pre-testing, UNICEF C4D presented the voucher to the community and service providers before the actual rollout of the intervention. Based on findings from the pre-testing (based on community feedback):

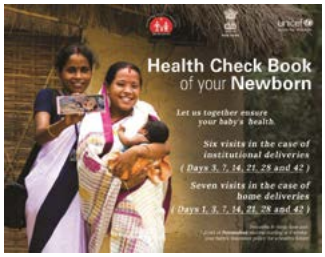
- The back cover and photographs depicting the *ASHA* activities were finalised
- The number of counterfoils per leaflet were increased from two to three; one for the mother, one for the *ASHA* worker, and one for submission to the peripheral health centre

Step 3

Communication material development and display in health institutions as well as at Village Health and Nutrition Day (VHND): As an endeavour to promote social equity within the scope of this initiative, the communications team prioritised the need to have different versions of the voucher and posters to suit the needs and expectations of different marginalised communities in the state. It was envisaged that maintaining an equity focus would amplify the adoption and acceptance of the voucher among different distinct communities residing in Assam.

Step 4

Rollout of the pilot: UNICEF undertook the Voucher and Communication approach, apart from capacity-building and supportive supervision of FLWs who implemented the initiative.




An *ASHA* worker during a home visit.

Dipali Phukan, a primary healthcare worker, hands the HBNC voucher to a patient.

Action

The pilot was initiated in 2014 and implemented for six months in Golaghat, Assam – one of the six High Priority Districts (HPD)[8] identified in the state. UNICEF conducted Capacity Building (CB) of FLWs on home-based counseling for HBNC where they were trained on the use of vouchers and how to, in turn, train mothers about the same.

As part of the HBNC voucher programme, an FLW is mandated to visit a newborn six to seven times in the first 42 days post-delivery (six times in case of institutional delivery and seven times for home delivery) and provide the following services: weigh the child, measure the temperature, counsel the mother on breastfeeding, kangaroo-mother care, immunisation, and handwashing. If needed, she issues referral slips for the child, mother, or both for their treatment in the block hospital.

The voucher contains seven[9] leaflets, each of which is triple perforated and corresponds to *ASHA* visits during the first 42 days. Information on the different activities to be performed by *ASHA*, different government schemes[10], facilities available, entitlements under RMNCH+A (Reproductive, Maternal, Neonatal, Child, and Adolescent Health) scheme, and essential newborn care are detailed in the communication material. Mothers delivering at hospitals are oriented about newborn care services provided by *ASHA*s through HBNC vouchers.

The process of the visit and use of HBNC was designed as follows:

- On each visit, the *ASHA* is expected to perform the activities listed on the voucher.
- At the end, if satisfied with the services, the mother hands over one signed counterfoil to the *ASHA* and retains a copy.
- Upon completion of all visits, the *ASHA* submits all leaflets at the block health centre and is paid ₹250 per child as an incentive for her work.
- The *ASHA* is mandated to make home visits as part of HBNC on the following days:
  - 1st, 3rd, 7th, 14th, 21st, 28th, and 42nd day of childbirth for children born at home
  - 3rd, 7th, 14th, 21st, 28th, and 42nd day of childbirth for children born in an institutional facility

Communication material included posters with details about the voucher and healthcare practices for infants, which were developed and displayed in the health sub-centres. The HBNC voucher has additional Information, Education, and Communication (IEC) material which includes photographs that highlight entitlements and scheduled visits.

This is an empowering instrument to both the *ASHA* as well as the mother — *ASHA* can validate the home visits conducted and the mother can identify what to expect during home visits and keep track of stipulated visits. The intent of the voucher is to improve the accountability of *ASHA*s towards service delivery and enable them to communicate more effectively with mothers and caregivers. This promotes better community knowledge and awareness in newborn care, stimulating increase in demand. It also helps create a sense of shared responsibility between the *ASHA* and mother/caregiver of the newborn.

Results

UNICEF, in partnership with Assam Medical College and Hospital, Dibrugarh, conducted a programme assessment study to understand the effectiveness of the voucher initiative. Prior to the rollout of intervention, a baseline study was carried out in **88** selected health sub-centres of the district. Within each health sub-centre, a cluster of seven infants less than two months of age were selected. The mother and *ASHA* of each of these infants were interviewed at the time of the baseline study, and the findings of this baseline survey were compared and analysed with the results drawn from the post-intervention evaluation study.

Key changes observed as a result of this intervention among mothers/caregivers, *ASHA*s, and the government system — when compared to the baseline — were as follows:

Change in mothers and caregivers

- Statistically significant[12] improvement in knowledge among mothers and caregivers regarding various government schemes and the available services for newborn care.
- Significant improvement in knowledge regarding availability and importance of Iron Folic Acid (IFA) tablets, deworming, postnatal checkups, birth registrations, vaccinations, and weighing of the child.
- Improvement in knowledge of the *ASHA*s' visit schedule for home-based newborn care improved after the implementation of the HBNC voucher system.

Table 1: Knowledge-change results from programme assessment study

Description of Indicator	Baseline	Endline
Knowledge about services to be received from *ASHA*	66.7%	99.2%
Availability and importance of IFA tablets	78.7%	98.6%
Importance of postnatal checkup	46.6%	93.1%
Information on vaccination	66%	97.1%
Exclusive breastfeeding	89.3%	97.4%
Weighing of the child	73.5%	94.9%

Mothers were encouraged to use institutional facility for childbirth.

Change in *ASHA*s

Approximately 8,000 FLWs were trained on home-based counselling about newborn care. As per the study, the knowledge level of *ASHA*s showed statistically significant improvement following the implementation of the voucher system.

Description of Indicator	Baseline	Endline
Birth preparedness	18.4%	84.1%
Infant feeding practices	20.1%	91.8%
Infant feeding practices	40.2%	96.7%
Care of young infants	10.9%	85.7%

Table 2: Knowledge change results in *ASHA*s from programme assessment study

Mothers and caregivers are now more aware of government schemes and their entitlements.

The strong focus on communication skills has helped strengthen the IPC skills of FLWs. This has, in turn, helped them:

- Communicate effectively with mothers about newborn care with the help of communication materials to ensure continuum of care.
- Build trust in mothers and community members about their capacities through effective and quality service delivery.

Change in government health system

- Schedule of actual HBNC home visits conducted by *ASHA* was streamlined to a considerable extent.
- There's an increase in institutional deliveries and decrease in home deliveries, which could be attributed to the improved level of knowledge and awareness among mothers and families regarding various government schemes listed on the voucher.

Transformative Change

The initiative has been able to establish an osmotic relationship between supply and demand — it empowered FLWs with communication aids to report and substantiate their work, as well as interact and engage better with the communities and rigorously follow up on visits. Mothers and caregivers have also been empowered through the initiative with improved knowledge on neonatal health, associated complications, care-giving practices, entitlements from the public schemes and access to healthcare.

The Government of Assam has acknowledged the positive outcomes of this pilot intervention and scaled it to all 32 districts of the state, with subsequent inclusion of the initiative into the State Programme Implementation Plan (PIP) 2015-2016. The HBNC voucher has been included as a standard monitoring format for the supervision of FLWs to ensure provision of quality home-based care services for newborns.

The HBNC voucher innovation from Assam found a place among the 60 innovations and good practices included in the 'Good Practices across the Globe' document released at the Call to Action summit in 2015.

Following the success and acceptance of the initiative in Assam, the Government of Rajasthan[13] has also recognised the utility of vouchers in monitoring service delivery and improving accountability of FLWs, and has decided to replicate the HBNC voucher system.

"The Home-based Newborn Care voucher is a simple yet powerful communication tool which empowers both the community and the Frontline Workers (FLW). It helps engage and involve the community more in newborn healthcare. It helps FLWs execute their role better, and know of the earnings they are entitled to. The HBNC programme was appreciated by the government, and it has now been scaled across all districts in Assam. UNICEF C4D has yet again brought an innovative solution that helps us improve the health scenario in our district."

Mrs. Laya Madduri
Deputy Commissioner, Dibrugarh district, Assam

In Summary

The Government of Assam, in partnership with UNICEF, initiated Home-based Newborn Care (HBNC) to address the issue of high NMR and IMR rates in Assam. It aimed to strengthen the existing programme by establishing a community-led monitoring mechanism for the scheduled home visits by *ASHA*s. Here's a blueprint of how the intervention was rolled out in 2014 for six months in the district of Golaghat.

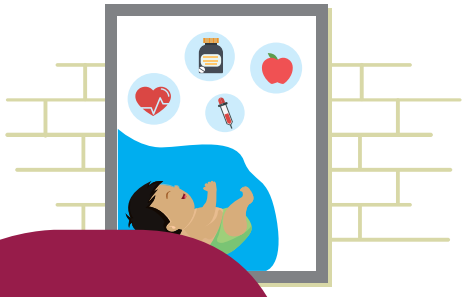
Action

Capacity Building on home-based counseling was conducted for FLWs, where UNICEF trained them on the use of HBNC vouchers and delivering the same to mothers.

Through the voucher, FLWs counseled mothers on various care practices like breastfeeding, kangaroo-mother care, immunisation, etc.

An FLW was mandated to visit a newborn six to seven times in the first 42 days post-delivery — six times in case of an institutional delivery, and seven if home-based.

At the end of every visit, the mother handed over a signed counterfoil to the ASHA which was then submitted at the block health centre. As an incentive, the ASHA was paid `250 per child for her efforts.



Communication and awareness on the intervention was done through posters detailing the voucher and healthcare practices, placed in health sub-centres.

Results

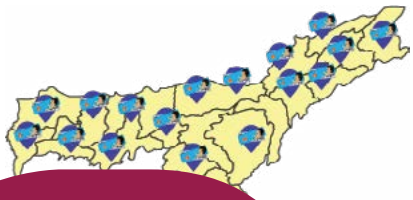
Change in mothers and caregivers: There's a significant improvement in the knowledge among mothers and caregivers on the available government schemes and services for newborn care. They are now also better informed about the *ASHA* visit schedule.

Change in ASHAs: About 8,000 FLWs were trained, as a result of which their knowledge level showed statistical improvement. They communicated effectively and built trust about their capacities through effective and quality service delivery.

Change in government health system: Through the intervention, the *ASHA*s' HBNC home visit schedule was better streamlined. Institutional deliveries also saw an increase — a change that can be attributed to improved knowledge.

Transformative Change

Through the voucher and communication aids, FLWs are now better empowered to interact and engage with the communities, as well as report and substantiate their work apart from following up on their visits.



The positive outcomes of the intervention have led to it being scaled to all the 32 districts of Assam, and included in the state PIP. The voucher innovation has also found a place among the 60 innovations included in the Good Practices Across the Globe document.

Mothers and caregivers have also been empowered — with improved knowledge on neonatal health and relevant practices. They're also aware of the public schemes and access to healthcare that are at their disposal.

Caselet

Lakshmi Medha, aged 22, is mother to two boys. The younger one, Ayush, is a healthy 3-month-old infant. When he was just 7 days old, Shanta Kurmi – the ASHA of the village – visited Lakshmi to check on the infant. She identified signs of jaundice, mobilised an ambulance, and quickly referred her to the hospital. Ayush underwent blood transfusion at the government hospital and, following proper treatment, had a speedy recovered. Lakshmi believes that her ASHA visited Ayush on the 7th day after his birth because of the voucher's reminder, as a result of which her child's life was saved.

References

[1] http://www.who.int/mediacentre/factsheets/fs333/en/

[2] http://apps.who.int/gho/data/node.sdg.3-2-viz-3?lang=en

[3] Per 1,000 live births; Sample Registration System (SRS) Survey, 2015

[4] Accredited Social Health Activist (*ASHA*)is the health activist(s) in the community who create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services.

[5] https://www.unicef.org/publications/files/APR_2015_9_Sep_15.pdf

[6] National Family Health Survey-4 (NFHS-4)

[7] NHM is the flagship programme of the Ministry of Health and Family Welfare's (MoHFW), Government of India.

[8] To ensure equitable healthcare and to bring about sharper improvements in health outcomes, the bottom 25 percent of the districts in every state according to the ranking of districts based on composite health index have been identified as High Priority Districts (HPDs). This health index is developed by Ministry of Health and Family Welfare.

[9] For babies born in an institutional facility, only six leaflets are relevant and used.

[10] Schemes included were *Janani Surakshya Yogana* (JSY), through which *ASHA* escorts a pregnant woman to facility, provision for getting cash incentives, financial assistance scheme for mother (*Mamoni*) and girl child (*Majoni*), knowledge about JSSK (*Janani Swasthya Surakshya Karyakram*) and *ADORONI* scheme for providing free services for transportation from home to facility and back to home, including free medicines etc.

[11] Mahanta TG, et al. Effectiveness of introducing home-based newborn care (HBNC) voucher system in Golaghat District of Assam, Clin Epidemiol Glob Health. (2015), http://dx.doi.org/10.1016/j.cegh.2015.08.002

[12] The P value, or calculated probability, is the probability of finding the observed, or more extreme, results when the null hypothesis (H 0) of a study question is true. A p-value of less than 0.05 indicates a strong evidence for null hypothesis indicating a statistical significance.

[13] http://www.dnaindia.com/jaipur/report-rajasthan-to-adopt-assam-model-to-curb-neonatalmortality-rate-2492375

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