

STRENGTHENING FRONTLINE HEALTH SERVICE DELIVERY IN MP

Evidence from retrospective assessment of TAF's AAA and
MNCHN interventions

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REPORT BRIEF

Background

India has made substantial progress in Maternal, Neonatal, Child Health, and Nutrition (MNCHN) over the past two decades. An increasing number of women are now accessing institutional care, and child health indicators have shown steady improvement. While the Maternal Mortality Ratio (MMR)¹ of India has declined, it still stands at 97 per 100,000 live births². Madhya Pradesh (MP) exemplifies one of the most pressing concerns in this regard. The state reports an MMR of 173 per 100,000 live births², which is India's third-highest, and an under-five mortality rate of 49 per 1,000 live births³. These health outcomes are underpinned by systemic bottlenecks in healthcare access, data recording, service quality, and responsiveness of the healthcare system, particularly for the vulnerable population.

To address these bottlenecks in MP, the Antara Foundation (TAF) partnered with the Women and Child Development Department and the Department of Public Health and Medical Education to implement an intervention package under the '**Akshita Program**', focusing on the provision, quality, and coverage of MNCHN Services. This report presents the findings from a retrospective assessment of key outreach-focused interventions under the Akshita Program, namely the **AAA Platform** and the **MNCHN Capacity-Building**, conducted by Quantum Consumer Solutions Pvt. Ltd.

AAA Platform is TAF's flagship intervention, which brings together the ASHA worker, Anganwadi worker and Auxiliary Nurse Midwife (collectively referred to as AAA) at the village level for better review, planning and knowledge sharing on MNCHN services. This aims to improve inter-departmental coordination and data synchronization as they often serve the same beneficiaries. MNCHN Capacity Building intervention includes classroom training and handholding support to supervisors and Community Health Workers (CHWs), enhancing their knowledge, skills, and on-the-ground best practices. The two interventions support outreach by improving data quality, microplanning, and peer learning, while also strengthening existing service delivery platforms, such as Village Health, Sanitation, and Nutrition Days (VHSNDs)⁴ and Home-Based Newborn Care (HBNC) visits.

¹Maternal Mortality Ratio (MMR) is defined as maternal deaths per 100,000 live births for women of reproductive age (15-49 years)

²SPECIAL BULLETIN ON MATERNAL MORTALITY IN INDIA, Sample Registration System, 2018-2020

³National Family Health Survey, 2019-2021

⁴VHSND serves as a village-level platform for the provision of public health services to all sections of the population, especially to marginalized and vulnerable communities.



Objective of the Study

TAF's AAA Platform and MNCHN Capacity Building interventions are designed as complementary pillars, each supporting the overall goal of improving maternal and child health outcomes in Madhya Pradesh. The AAA Platform serves as an action-oriented intervention, enabling CHWs to efficiently carry out field activities such as high-risk beneficiary identification and planning for service delivery (ANC check-ups, Home-Based Newborn Care (HBNC) visits, and Follow-ups). The MNCHN Capacity Building program supports this process by enhancing CHWs' knowledge and skills through structured training sessions, mentorship, and hand-holding visits.

The objective of this study is to understand how the AAA Platform and MNCHN Capacity Building interventions have contributed to improvements in the provision, quality, and coverage of MNCHN services across the intervention area. A secondary objective is to also capture learnings about the scalability and sustainability of these interventions within the existing public health system, which involves building local capacity and gradually transferring program responsibilities to government cadres.

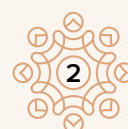
Research Methodology

A **retrospective Outcome Harvesting (OH)** methodology was used, combining both qualitative and quantitative data. A retrospective method was necessary since the program did not collect baseline data on the attitudes of CHWs and supervisors at the time of its inception. The method facilitated comparison between past and present conditions through recollection, rather than direct measurement of past conditions.

The study was done across **Chhindwara, Betul and Seoni**, where the program had been running for at least three years at the time of the study. The intervention geography consisted of all 15 intervention blocks⁵ and comparison geography covered all non-intervention blocks of the three districts.

Overall, the study collected data on **22 outcomes** of the interventions, which were categorized under **seven key themes** [refer to table 1].

⁵In the Indian administrative system, a block is a sub-division of a district, an intermediate level of governance between the district and the village. TAF works with health blocks, which are administrative units within the public healthcare system that serve as the centre for referral from the villages. Generally, a health block covers the same area as an administrative block.



Themes	1	Coverage and quality of services provided to beneficiaries has been enhanced
	2	Right and timely identification and management of highest-risk cases
	3	Quality of data and Inter-department synchronization
	4	Better coordination among AAAs
	5	MNCHN knowledge and skills improvement among CHWs
	6	Perception on training sessions and training material
	7	Improvement in empowerment and soft skills

Table 1: List of themes covering 22 outcomes

Quantitative data on the knowledge, attitude and practices of the CHWs were collected through **800 surveys** in intervention and comparison geographies. The sample size was statistically estimated from the total population of stakeholders (N=8,150) within TAF's reach, ensuring adequate representation of the three cadres, while considering a margin of error and response rate. **Qualitative data** on the implementation experience of TAF interventions were gathered through **52 discussions** with CHWs and supervisors (including IDIs, FGDs, and Triads) in intervention geography.

Key Findings

The study highlighted that the AAA Platform and MNCHN Capacity Building interventions contributed to an improvement in coverage of essential MNCHN services, prioritization of high-risk beneficiaries⁶ and better supervisory skills among Community Health Officers (CHOs)⁷ and supervisors. The CHWs and supervisors who participated in the classroom training found it engaging and very helpful. Some of the findings from the study are listed below:

⁶High-Risk beneficiaries include women with high-risk pregnancy, and children who are either malnourished or need medical attention.

⁷Community Health Officer (CHO) is a cadre at the sub-health centre level. CHOs are responsible for providing services under the Comprehensive Primary Health Care Package.

Community Health Workers Reported More Accuracy in their Data Records

85% of CHWs in the intervention area reported greater uniformity in the data of mothers and children across departments. This has led to increased confidence among CHWs in data accuracy, as supported by field observations. 74% of CHWs in the intervention geography reported increased confidence in matching data, compared with 58% in the comparison geography. Supervisors and CHOs confirmed that 75% of CHWs demonstrated excellent data-matching and data-updating skills after engaging with the AAA platform.

Collaboration and Coordination among CHWs Led to Better Coverage

The two interventions contributed to increased beneficiary coverage, as reported by 75% of CHWs. 47% of CHWs in the intervention geography prepared their due lists⁸ together a month before VHSNDs, compared to 28% in the comparison geography, indicating improved microplanning and mobilization skills. 85% of CHWs also reported improved coordination with their peers and credited the Akshita Program, which showed them that working together is the most effective approach, as their roles and activities complement each other. While the CHWs mentioned that the program enhanced coordination among them, they also pointed out the challenge of conducting AAA meetings (a session conducted once a month under the AAA Platform by CHWs in the village) on high-caseload days at VHSNDs.

Akshita Program set practical examples for Supportive Supervision

Supervisors and CHOs found the Akshita Program to be 'very helpful' in improving their supervision skills, especially in formulating strategies for VHSND meetings and HBNC visits. A clear indicator of this was the increase in monthly learning sessions: 98% of supervisors in intervention geography conducted these sessions, compared to 82% in comparison geography. 81% of supervisors reported that their knowledge and performance have improved since the program began, and 80% felt more confident in their ability to train and mentor CHWs. Overall, 95% of supervisors and CHOs found the program's training components practical, engaging, and more effective than those of other similar programs they had participated in.

Beneficiaries received improved and informed attention

The microplanning component of the AAA platform focuses on prioritizing service outreach for mothers and children at higher risk. This joint planning led to improvements in the referral of high-risk cases: 90% of ANMs in the intervention geography identified and referred high-risk

⁸Due list is a format given to ASHA to prepare a list of all beneficiaries due for MNCHN services in the upcoming VHSND. This format helps with the mobilization of beneficiaries for VHSND.



pregnant women and children to the nearest health facility, compared to 64% in the comparison geography. CHWs linked this improvement to the increase in the quality of their counselling services after Akshita Program's implementation.

Supervisors and CHOs also observed a positive shift in sentiment among community members regarding VHSNDs. Furthermore, examples shared by CHWs in qualitative discussions showed that the program positively influenced their ability to manage complex health situations and respond to community health needs with greater effectiveness.

Innovative intervention tools contributed to better planning and service delivery

AAA Platform and MNCHN Capacity Building interventions provide each village with tools for planning, review, and learning sessions. The tools include digitized village maps mounted in each Anganwadi Centre, Due lists, AAA Joint Reporting Format, AAA Minutes of Meeting Format, and MNCHN Flipbook. Among all the tools provided by the Akshita program, the MNCHN flipbook⁹ was identified as the most helpful. 77% of ANMs and 81% of supervisors found it to be 'highly useful' for providing healthcare services to beneficiaries. The use of these tools, including synchronized data and colour-coded Bindi on village maps, led to more accurate tracking of high-risk cases. This is supported by a key finding that 81% of CHWs in the three intervention geography reported an increase in the number of timely referrals following the introduction of these tools. Additionally, 79% of ASHAs in these blocks planned home visits to the prioritized beneficiaries, which was 25 percentage points higher compared to 54% in comparison geography.

Recommendations

The study revealed a positive contribution of the Akshita program in MNCHN service delivery. The following recommendations were shared, which can be incorporated into the program design and implementation to sustain the effectiveness of the two interventions:

- Mentorship programs could be extended by introducing a Master Trainer Program to equip CHOs and supervisors with the skills needed to lead and mentor CHWs.

⁹MNCHN Flipbooks were developed as visual aids for different cadres of FLWs, including ASHAs, ANMs, and supervisors. This tool provided role-specific guidance, making complex MNCHN concepts more understandable and applicable.

- Currently, only ANMs, CHOs, and Supervisors participate in direct classroom trainings, then pass on the knowledge to ASHAs and AWWs (through a cascade model). To further improve knowledge and skills at grassroots, ASHAs and AWWs could also be included in direct MNCHN training sessions.
- TAF should consider developing integrated training sessions where CHWs receive holistic training that combines operational skills from the AAA Platform and knowledge building from the MNCHN Capacity Building intervention.
- TAF can also consider phasing out tools that have fulfilled their initial objectives, like the AAA Joint Report, and reimagining others to enhance the efficiency of the AAA Platform process. For example, voice recordings of AAA meetings via the ODK platform¹⁰, could replace tools such as the AAA Minutes of Meeting. Implementing similar digital solutions would decrease the paperwork load while still preserving important insights. The Village Map tool can be replaced with a digital tool that automatically updates from Due Lists, given its resource-intensive nature in its current form.
- TAF should consider initiating early community engagement activities to support CHWs' efforts, rather than waiting until the supply side fully matures. A recognition program could be introduced to motivate beneficiaries to advocate for healthcare services within their communities, further boosting the demand for services.
- While the two outreach interventions have improved coverage and increased risk identification, there is now a need to further streamline real-time referral systems to alert health officials about high-risk cases and contribute to their timely management. A high-risk tracking dashboard can also be created and made available to supervisors to support the referral process.

To read the full report, refer to [QCS Primary Research Report for TAF](#)

¹⁰AAA Open Data Kit (ODK) is an online checklist to collect information of every AAA meeting.

