



Improving the Coverage and Quality of Village Health and Nutrition Days

October 2012

Background

Village Health and Nutrition Days (VHNDs) are a major initiative under the National Rural Health Mission (NRHM) to improve access to maternal, newborn, child health and nutrition (MNCHN) services at the village level. Across the country, VHNDs are intended to occur in every village once a month usually at the *Anganwadi* Centre (AWC) or other suitable location. AWCs are a central feature of the Ministry of Women and Child Development's flagship Integrated Child Development Services (ICDS) programme. VHNDs provide a basket of health and nutrition services and counselling to the community on a pre-designated day, time and place. VHNDs require convergent actions from the Department of Health and Family Welfare (DHFV) and the Department of Women and Child Development (DWCD) at state, district and block levels to plan, implement and monitor the programme. Accredited Social Health Activists (ASHAs) along with *Anganwadi* Workers (AWWs) are responsible for mobilising the community for VHNDs, with support from *Panchayati Raj* Institutions (PRIs), and holding health education sessions. Auxilliary Nurse Midwives (ANMs) provide maternal, newborn and child health services such as antenatal care (ANC) and routine immunisations. AWWs provide growth monitoring services and referral of children with severe acute malnutrition in addition to distributing supplementary nutrition. The presence of all three frontline workers (i.e. AWW, ASHA and ANM) is critical for the provision of the intended package of services at VHNDs.

The Governments of Jharkhand (GOJH) and Uttar Pradesh (GOUP) requested the USAID-funded Vistaar Project to provide technical assistance to improve the coverage and quality of VHNDs.

In 2007, the Government of India (GOI) issued guidelines for VHNDs that detail the roles and responsibilities of each frontline worker and list the services to be provided during VHNDs (Box 1)¹.

Box 1: Services to be provided during VHND

- Register all pregnant women
- ANC check-ups for the pregnant women registered
- Identify pregnant women left out from services and provide them services
- Identify and refer cases of severe anaemia and pregnant women with obstetric emergencies
- Full immunisation for children under one year
- Identify children left out and provide immunisation services
- Distribute Vitamin A solution to children
- Weigh all children and monitor weight on growth chart
- Distribute supplementary nutrition to underweight children
- Refer children with severe acute malnutrition (Grades 3 and 4)
- Distribute medicines to patients with tuberculosis. Prepare malaria slides and give malaria medicine
- Provide family planning services to eligible couples (oral contraceptive pills and condoms) and refer for other services
- Refer cases of malaria, tuberculosis, kalazar, leprosy, children with disabilities
- Organise group session for health education and counselling
- Reach services to most vulnerable populations

When the Project started its work at the district level in December 2008, needs assessments and baseline survey showed that in both Uttar Pradesh (UP) and Jharkhand, VHNDs were not being organised regularly and when they were conducted, VHNDs primarily offered only routine immunisation and supplementary nutrition instead of the full package of services, often without the presence of all three frontline workers. The initial assessments (Box 2) also pointed to the need for coordination between DHFV and DWCD and better supervision and monitoring systems.

Box 2: Key Findings of the Baseline Survey and Performance Needs Assessments (2008-2009)

- Sixty-five percent of ASHAs in UP and 52 percent of *Sahiyyas* in Jharkhand said that no VHND had been held in their village in the three months prior to the survey
- The most common VHND activities mentioned by AWWs who had attended VHNDs in the baseline were immunisation and distribution of supplementary nutrition in both UP and Jharkhand
- Frontline workers lacked role clarity
- Frontline workers did not have essential equipment, supplies and skills to provide the full range of VHND services
- Monitoring and supervisory practices did not focus on whether VHNDs were taking place as scheduled and/or as per the GOI guidelines and there was no comprehensive monitoring tool in use
- Functional forums did not exist at the district and block levels where the two departments (DWCD and DHFW) could work together to effectively operationalise VHND
- There was low community awareness and participation in VHNDs

Scale of Technical Assistance

The Project provided technical assistance to GOUP and GOJH at scale to strengthen VHNDs. The Project's technical assistance was focused in 15 districts in Jharkhand (Chatra, Deoghar, Garhwa, Giridih, Godda, Gumla, Hazaribagh, Jamtara, Khunti, Koderma, Latehar, Pakur, Ramgarh, Sahebganj and Simdega) and eight districts in UP (Azamgarh, Banda, Bulandshahr, Chitrakoot, Gonda, Kaushambi, Saharanpur and Varanasi), covering 18,770 and 12,310 villages in Jharkhand and UP respectively (Table 1). The Project-supported districts are geographically spread across the two states, and collectively, these districts have a population of 39.8 million and are home to over 33.2 million rural residents². The Project contracted with non-governmental organisations, Catholic Relief Services and MAMTA Institute for Mother and Child in UP and Vikas Bharti and Ekjut in Jharkhand, to support these interventions, especially at the district and block levels.

Table 1: Scale of Technical Assistance

Scale of Technical Assistance ³	Jharkhand	Uttar Pradesh
Number of districts	15	8
Number of blocks	116	94
Number of Medical Officers	596	496
Number of ICDS Supervisors	395	471
Number of AWWs	20,592	18,177
Number of ANMs	3,814	2,230
Number of ASHAs/ <i>Sahiyyas</i>	23,220 [#]	14,294
Number of villages (Revenue/census villages)	18,770	12,310
Rural population covered	14,727,569	18,433,625

The Project did not provide any direct capacity-building support to *Sahiyyas* in Jharkhand.



Technical Assistance Approaches

Based on the findings of the assessments (Box 2), the Project's technical assistance for strengthening systems for VHNDs focused on the following key approaches:

- Facilitating orientation on VHND guidelines and joint planning
- Strengthening monitoring and supervision of VHNDs
- Promoting convergence and use of data to drive programme improvements
- Increasing community awareness and participation in VHNDs
- Integrating equity and gender focus in all systems strengthening efforts

Facilitating Orientation on VHND Guidelines and Joint Planning

Orienting district- and block-level functionaries on VHND guidelines: The Project team supported the orientation of district- and block-level functionaries on their roles and responsibilities according to VHND guidelines for providing role clarity and avoiding duplication of work for better service provision and coverage. In both the states, at the district level, the Project team worked with the Chief Medical Officer (CMO), District Programme Officer- ICDS, Deputy CMOs, Child Development Project Officers (CDPOs), District Programme Manager (DPM) - NRHM, Health and Education Officers, and District Community Mobiliser-NRHM. At the block level, the Project team worked with the Medical Officer in-Charge (MOIC), CDPO, Medical Officers, and ICDS Supervisors of AWWs (referred to as Lady Supervisors in Jharkhand and *Mukhya Sevikas* in UP).

Revising microplans for VHNDs: During the district orientation programme, the departments identified the need to evolve the existing routine immunisation microplan into a VHND microplan. In UP, the Project facilitated a joint review of the microplans by the MOIC and the CDPOs in all blocks, involving all the three frontline workers and their supervisors to identify the most appropriate site for VHND that was accessible for marginalised populations. This joint review process resulted in the identification of several missed populations and geographic areas, which were included in the revised microplans. The revised microplans also incorporated the names of the AWWs, a change from the earlier practice of mentioning only names of the responsible ANMs and the ASHAs. Both departments

shared the revised microplans with their workers. In Jharkhand, the ANM took the lead in developing the microplan for her area with assistance from the AWWs and *Sahiyyas*. The block-level DHFW and DWCD officials collated information to ensure that areas were not missed, that there was no overlap, and that one frontline worker had only one session scheduled for her on any designated VHND.

Orienting frontline workers on VHND and microplan: In UP, the Project developed a structured three-hour module for orienting frontline workers on VHND. The Project assisted in developing capacity-building sessions and training two trainers for each district, who in turn trained a total of 391 *Mukhya Sevikas* as Master Trainers. These *Mukhya Sevikas* trained the AWWs on VHNDs during their routine monthly meetings. Capacity-building on VHND focused on establishing role clarity among the frontline workers and expectations for service provision and reporting. Medical Officers and Health and Education Officers (in UP) and Extension Educators (in Jharkhand) held similar sessions with ANMs during their monthly meetings. In Jharkhand, the Project team used a less structured approach to orient the frontline workers on VHND, which focused on sharing VHND guidelines and system strengthening ideas with the district leaders.



Strengthening Monitoring and Supervision of VHNDs

Strengthening monitoring systems: Expanding the number and quality of services provided during VHNDs required improved monitoring of VHNDs with regular observation and on-site supervision. DHFW and DWCD formalised monitoring requirements by modifying the field rosters of the supervisors and fixing a minimum number of VHND observations that a supervisor is required to make in a month. The Project promoted supportive supervisory practices and encouraged the supervisors to appreciate good performance, identify gaps and help frontline workers to improve their performance through demonstrations and on-site capacity-building. The supervisors also identified factors affecting services delivered at VHNDs, such as the lack of weighing scales and blood pressure equipment and helped to address these issues and enable corrective action.

Additionally, in UP, the Project team facilitated the formation of district and block-level VHND taskforces, which included representatives from DHFW and DWCD, and development partners to review the performance of both departments in implementing VHNDs according to the guidelines. These teams were responsible for making monitoring visits to VHNDs and wherever possible, taking immediate corrective measures on-site. These taskforces have been instrumental in further enhancing the focus on VHNDs.

Introducing VHND monitoring checklist: The Project team introduced a comprehensive monitoring checklist for DHFW and DWCD supervisors to use during their supervisory visits. This checklist was adapted from the routine immunisation checklist issued by GOI to which the Project team added a



section to capture additional indicators on services and quality of care during VHND. Based on NRHM guidelines, the checklist includes critical indicators related to supplies available, services including counselling provided, and presence of all three frontline workers. It also tracks participation from community groups such as PRIs and mothers' groups and the presence of beneficiaries from disadvantaged groups.

Strengthening monthly block and sector meetings as fora for VHND-related discussion: Monthly sector meetings of AWWs served as an important platform for supervisors to address programmatic issues, including VHNDs, in both states. In Jharkhand, these monthly sector meetings were restructured to include a manageable number of AWWs for each Lady Supervisor. At the sector meetings, the supervisors shared gaps observed based on their own observations during VHND monitoring visits. In UP, monthly meetings of ASHAs were also used as platforms to share VHND analysis and make programmatic corrections with the frontline workers. In Jharkhand, the block-level monthly meetings involving Medical Officers and ANMs that are organised by DHFW served as platforms to share and use VHND-related data with ANMs. In UP, VHND data was also shared and discussed at the district-level meetings of the departments of HFW and ICDS on a monthly basis for making the necessary programme corrections.

Promoting Convergence and Use of Data to Drive Programme Improvements

Monthly VHND convergence review meetings at district and block level: During the joint VHND orientation exercise, both departments expressed the need for a periodic convergence meeting among the departments at the block and district level. Therefore, the Project team worked with district officials to facilitate the institutionalisation of monthly review and coordination meetings of the two departments. The monthly convergence meetings were conceptualised as fora to discuss progress and resolve issues related to the availability and quality of services during VHNDs. In UP, the Project assisted the CMO/MOIC and the CDPO (DWCD) to take the lead in building these convergence meetings. In Jharkhand, the two departments converge at the District Health Society (DHS) meeting under the chairmanship of the District Collector (DC) for VHND programme review.



At the district level, efforts were targeted at revamping convergence meetings for which there was a provision but which were not functional, and also initialising such meetings where there were none. Over a period of time, meetings have been regularised and institutionalised in all the Project-supported districts with review of VHNDs being the core agenda item at this platform. At the block level, MOICs and CDPOs along with other Medical Officers posted at the block and additional Primary Health Centres, ICDS Supervisors and Lady Health Visitors (wherever present) review the status of VHND in block-level convergence meetings. District and block officials maintain and review meeting minutes to track whether corrective action has been taken.

Initially, these meetings focused on issues relating to organising VHNDs as per the microplan. As VHND roll-out was systematised in the districts, the focus shifted to quality issues, especially the availability of different services as defined in the NRHM guidelines.

Use of data for programme improvements: The monitoring checklists filled by supervisors during their visits to VHNDs form the basis for the data reviewed at convergence meetings. The Project introduced a simple and user-friendly Microsoft Excel-based spreadsheet tool for analysis of VHND data collected through the monitoring checklists and built the capacity of designated government staff in data analysis in many districts.

Review of VHND indicators has helped the departments to make timely decisions to improve the regularity of VHNDs and focus on quality issues. For example, regular feedback about weight monitoring not being done due to the lack of weighing scales led the departments to mobilise resources from alternative sources such as nearby schools. Similarly, feedback about ANC, especially abdominal examination of pregnant women not being done due to lack of privacy at the VHND site, led to creating a space with curtains for privacy where pregnant women could be examined. The review of data also led to the organisation of a 'catch-up round' of VHNDs in the event that VHNDs could not take place on the regular pre-designated days.

Increasing Community Awareness and Participation in VHNDs

In UP, the Project facilitated orientation of district and block PRI functionaries on VHND guidelines and their role in planning, implementing and monitoring VHNDs. Additionally, members of the Village Health Sanitation and Nutrition Committee (VHSNC) and Mothers' Committees were also oriented on VHND and their roles to encourage community participation in VHNDs. In Jharkhand, DHFW and DWCD teams also oriented Panchayat and VHSNC members on VHND in many districts, although this did not happen in all districts.

Integrating Equity and Gender in All Systems Strengthening Efforts

Although India's health system has considerable reach, it is characterised by uneven quality, effectiveness, and unequal access for large proportions of the population such as the poor, scheduled castes and tribes and those living in remote rural areas. Women with the least resources often suffer the most from poor health and nutrition. Recognising that equity and gender are important determinants of health status, NRHM accords priority to improving equity in service outreach.

The Project's technical assistance incorporated an equity and gender focus in the design and implementation of all its systems strengthening efforts. The Project ensured a review of all capacity-building efforts, job aids and tools to incorporate an equity and gender focus. In the support to VHNDs, there was a special focus on increasing the awareness and utilisation of VHND services by vulnerable and disadvantaged populations through revision of micro plans to expand coverage, orientation of frontline workers and the inclusion of specific questions in the monitoring checklist to capture information on participation by disadvantaged groups.

Monitoring and Evaluation

The Project established a Management Information System (MIS) to capture process and output-level data during July 2009 - March 2012 in all Project-supported districts. The Project also contracted an external research agency and an expert to conduct a qualitative study from September to October 2011 to validate and better understand successful trends indicated from Project MIS data. These studies were conducted in two districts each in Jharkhand (Gumla and Koderma) and UP (Banda and Saharanpur).

For evaluation, the Project team contracted external agencies to conduct a baseline survey in December 2008-February 2009 and an endline survey in January-March 2012. These surveys were conducted in all eight Project-supported districts of UP and five districts of Jharkhand (Godda, Gumla, Khunti, Koderma and Sahebganj) and respondents included pregnant and recently delivered women, household decision-makers, DHFW and DWCD officials, supervisors and frontline workers from both departments. The endline survey collected some supplemental data on VHNDs (where there was no baseline data). The results presented in the following section draw on these extensive sets of data.



Results from Uttar Pradesh and Jharkhand

Pregnant women, mothers and children attended VHNDs and received a range of MNCHN services. VHNDs were held more regularly in Project-supported districts with all three frontline workers participating. Convergence between DHFW and DWCD at district and block levels contributed to strengthening VHNDs.

Increased number and quality of VHNDs

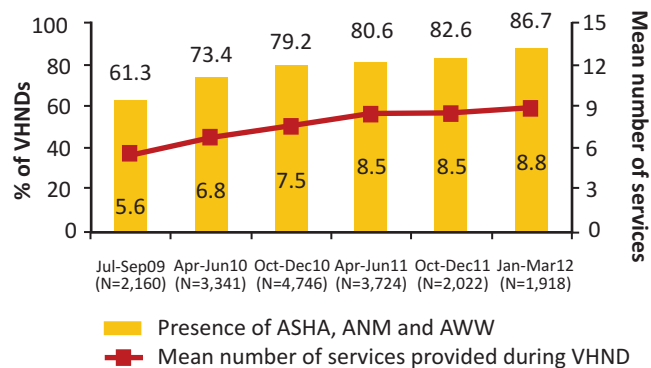
The number and quality of VHNDs improved as measured by regularity of VHNDs, participation of all three frontline workers and number of services available.

In UP, at baseline, 65 percent of ASHAs and 36 percent of AWWs reported that no VHNDs had been held in their village in the previous three months. In contrast, 92 percent of ASHAs and 89 percent of AWWs reported that three or more VHNDs had been held in their village in the previous three months at endline.

In Jharkhand, at baseline, 52 percent of *Sahiyyas* and 22 percent AWWs reported that no VHNDs had been held in their village in the previous three months. In contrast, 75 percent of AWWs reported that three or more VHNDs had been held in their village in the previous three months at endline.

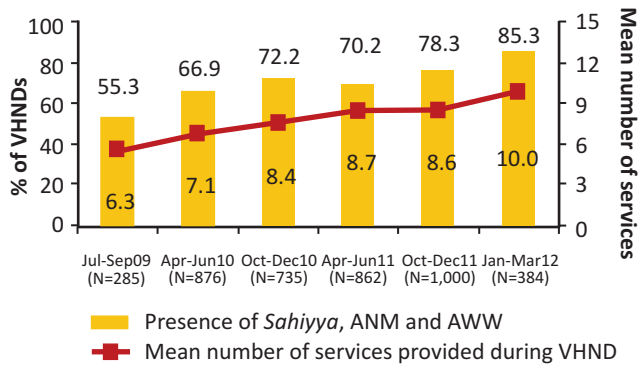
In UP, VHNDs held as per microplan increased from 68 percent to 91 percent according to Project MIS data across all districts. Over the same period, VHND sessions at which all three frontline workers (AWWs, ASHAs and ANMs) were present increased from 61 percent to 87 percent. The mean number of services offered during VHND increased from 5.6 to 8.8 (Figure 1). This shows a substantial improvement from the baseline survey during which frontline workers reported that activities were largely limited to immunisation and distribution of supplementary nutrition when VHNDs took place.

Figure 1: Presence of frontline workers and mean number of services provided during VHNDs, Uttar Pradesh



Similarly, in Jharkhand, VHNDs including the presence of all three frontline workers (AWWs, *Sahiyyas* and ANMs) increased from 55 percent to 85 percent and the mean number of services offered during VHND increased from 6.3 to 10.0 (Figure 2). The endline data corroborated these findings from Project MIS.

Figure 2: Presence of frontline workers and mean number of services provided during VHNDs, Jharkhand



The endline data also showed that service providers know what role they were expected to play at VHNDs. The qualitative study reports that the three frontline workers carried out most of the activities as a team indicating that training and microplanning resulted in role clarity and this in turn was reflected in improved coordination and service delivery during VHND. AWWs reported taking care of nutrition-related aspects at the VHNDs, such as weighing of children, maintaining growth charts, and distributing take home ration (THR). They also reported orienting mothers about the growth status of their children, and counselling pregnant and lactating women on nutrition.



Box 3: Qualitative Study Quotes

“The three of us sit together and make a list (of mothers and children needing services) in advance. We also inform people in advance. We ensure that there is supplementary nutrition, a weighing scale, growth charts, immunisations, are available.”

ANM, Focus Group Discussion, Uttar Pradesh

“We (AWWs), along with ANMs, weigh children and prepare growth charts. Growth charts are kept at the AWC. The *Anganwadi* Helper informs the beneficiaries about the VHND session and reminds them to come on time.”

AWW, Focus Group Discussion, Jharkhand

“The ANM does health check-ups of those present and carries out immunisations. The AWW mainly gives supplementary nutrition and counsels mothers of malnourished children. The ASHA sees who has come to the VHND and who has not. She matches names (of mothers) in her register with that of the AWWs.”

District Community Mobiliser, Key Informant Interview, Uttar Pradesh

The qualitative study and endline surveys indicate that DHFW and DWCD officials appreciated improvements in strengthening VHNDs through VHND microplanning, convergence, and monitoring. Frontline workers and their supervisors also appreciated these improvements.

Widespread awareness of VHNDs and services offered

VHNDs attracted pregnant and lactating women and adolescent girls from the villages. Awareness was widespread: in UP, 88 percent of currently pregnant women knew of VHNDs, while the comparable figure for Jharkhand was 96 percent. The vast majority of these women in both states knew both the date and location of VHNDs in their area (67% in UP and 85% in Jharkhand). Knowledge of the services available was similarly high.

High levels of participation in VHNDs

Pregnant and recently delivered women attended VHNDs in great numbers and received a variety of services. Seventy-five percent of recently delivered women in Uttar Pradesh and 89 percent in Jharkhand had availed services during VHNDs (Figures 3 and 4). District-level findings demonstrate that women attended VHNDs in nearly the same proportion in all of the surveyed districts suggesting that efforts to strengthen VHNDs occurred at scale. Participation levels were comparatively less in Gonda (52%) and Azamgarh (63%) in UP, but in all other districts in both states, VHND participation levels among recently delivered women were above 75 percent and as high as 98 percent.

Figure 3: Recently delivered women in Uttar Pradesh who participated in VHNDs during pregnancy at endline

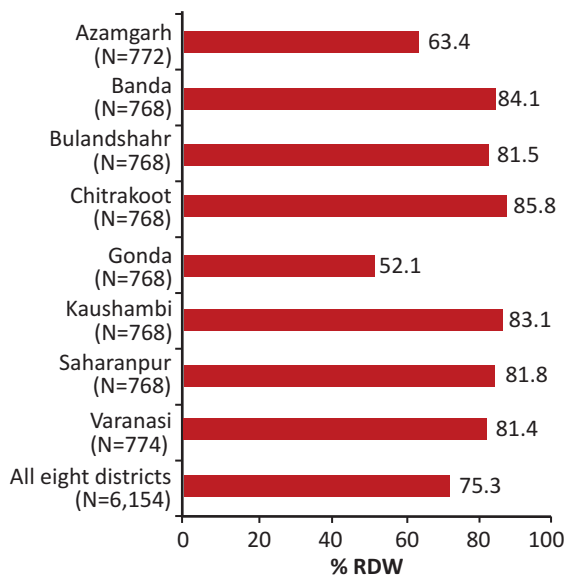
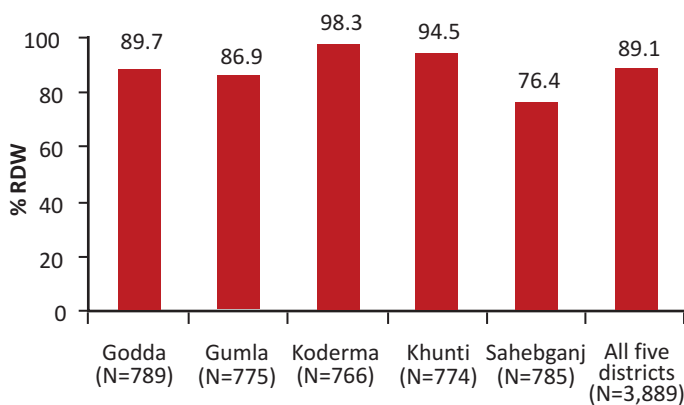


Figure 4: Recently delivered women in Jharkhand who participated in VHNDs during pregnancy at endline



Increased range of VHND services used by pregnant and recently delivered women

Women reported receiving many services at VHNDs during their pregnancy including tetanus toxoid (TT) immunisations, iron and folic acid (IFA) tablets/syrup, and weight monitoring. Since VHNDs are also a platform for providing health information and counselling, it was encouraging to note that nearly 47 percent of recently delivered women reported participating in group discussions on health care issues in UP during their pregnancy. This figure was significantly lower in Jharkhand (6%) (Table 2).

Table 2: Recently delivered women's utilisation of VHND services during pregnancy at endline

Services availed during pregnancy	% RDW	
	Uttar Pradesh	Jharkhand
Received TT injections	98.2	80.0
Received IFA tablets	78.7	51.9
Weighed	51.2	56.6
Blood pressure measured	20.5	33.6
Abdominal check-up done	26.3	32.3
Participated in group meetings/discussion on health issues	47.2	6.2
Number of recently delivered women who participated in VHND	4,717	3,889

One of the services provided during VHNDs is the provision of supplementary nutrition. All districts have improved access to supplementary nutrition over the evaluation period. Increased number of recently delivered women received supplementary food in Jharkhand (36% baseline to 72% at endline) and in UP (18% baseline to 42% at endline).

The qualitative study reported that some gaps could be observed in delivering the full range of VHND services with quality. These gaps were usually systemic such as irregular supply and replenishment of drugs and equipments, and shortages of frontline workers and supervisors. Until such operational issues are addressed, it will be difficult to deliver the desired range of services with quality.

Reaching disadvantaged groups

VHNDs are intended to reach all segments of the community, especially disadvantaged groups. The endline results highlight increased inclusion of marginalised populations in accessing services. From an equity and gender perspective, women from all socio-economic segments attend VHNDs. In fact, women from lower socio-economic segments and lower levels of education were most likely to attend VHNDs. In UP, recently delivered Muslim women were comparatively less likely to attend VHNDs (64%) than recently delivered Hindu women (77%). In both states, participation was highest among scheduled castes/scheduled tribes compared to other groups. Households from all living standards accessed supplementary food in roughly similar proportions.

Community groups' growing engagement in supporting VHNDs

Orienting PRI representatives and VHSNC members increased their participation in promoting and monitoring VHNDs. For example in UP, some *Gram Panchayats* used their untied funds to undertake wall writing to promote VHNDs. About half of AWWs and ASHAs surveyed in the endline reported that promotional activities for VHND had taken place in their area. The most common promotional activities were banners or wall writings which announce the VHND. To sight an example, the *Gram Pradhan* of *Attara Grameen* (Banda district) convened the first VHSNC meeting in his area on health and reviewed the barriers to providing VHND services. The VHSNCs agreed to use untied funds to buy weighing scales for monitoring the growth of children during VHNDs. This initiative led to the CMO issuing a Government Order permitting the use of VHSNC funds for



purchasing essential equipment required for VHND. In other cases, primary school children had taken out *prabhat pheri* (rallies) on the day of VHND to inform and mobilise the community to seek services and VHSNC members used their untied funds for community mobilisation activities like beating of drums (*duggi*) to draw the attention of the community. These efforts likely contributed to the high levels of awareness and participation in VHNDs reported earlier.

Stronger systems to support VHNDs at district and block levels

The Project worked to establish sustainable systems to successfully operationalise VHNDs. In the endline surveys, DHFW and DWCD officials cited significant improvements in VHND planning, implementation and monitoring. Respondents from both departments frequently pointed to improved convergence, improved microplanning, improved attendance of frontline workers at VHNDs and improved service quality as the resultant outcomes. Nearly all officials mentioned the district- and block-level convergence meetings as a good platform for coordinated planning.

District officials were aware of the monitoring checklist and increased use of data for programme review. DWCD supervisors pointed to many advantages in using the checklist, including ensuring that monitoring is structured, consistent and covered all important topics. For example in UP, 82 percent of *Mukhya Sevikas* were aware of the monitoring checklist and 78 percent had used it. On average, a *Mukhya Sevika* had used the monitoring checklist eight times in the last three months suggesting that use of the checklist has been well established within the government system.



Regularising supervision of VHNDs appears to have occurred at scale. Among frontline workers interviewed at endline, 74 percent indicated that they received supervision during VHNDs at least once in the last three months in Uttar Pradesh and 47 percent of AWWs reported the same in Jharkhand. In UP, ANMs mentioned that supervisors checked on the availability of vaccines, reviewed the tally sheet and helped with problem-solving. According to ASHAs and AWWs, supervisors reviewed registers and records and helped with client mobilisation. In Jharkhand, most of the ANMs and AWWs reported receiving supervisory support on maintaining registers, on-the-job training in weighing and mobilising the community.

Costing

The Project conducted a cost analysis of these VHND strengthening activities using the technical assistance approaches described above in one district in each state to better understand what it would cost for other districts to replicate these approaches and results. The analysis indicated, for example, that in Kaushambi district in UP with eight administrative blocks where approximately 1,400 VHND sessions were held per month, the activities undertaken to strengthen performance of VHNDs amounted to an estimated annual cost of Rs. 3,260,747 or Rs. 194 per VHND session per year. The strengthening activity that required the most time (and therefore, staff cost) was improved monitoring of VHNDs as this was an ongoing activity. This activity represented 78 percent of the overall effort and expense. There will be a



variation in these costs if these activities are replicated in other districts depending on the number of blocks and VHND sessions in each district.

A key insight from this cost analysis was that the involvement of staff who were already government employees represented 99 percent of the costs identified at the district level. The VHND strengthening processes described in this brief generally do not require additional expenditures from the government, and entail only effective use of staff time. By primarily utilising its existing resources in an efficient manner, the government can achieve high-performing VHNDs.

Challenges and Lessons Learned

Systems strengthening leads to programme improvements at scale: It is important to strengthen multiple systems to achieve improvements in VHNDs. Efforts focused on orienting managers and frontline workers to the guidelines and their roles, strengthening supervision, using a structured checklist to monitor VHNDs, using data for programmatic decision-making and ensuring platforms for convergence. All of these aspects collectively contributed to increasing the coverage and quality of VHNDs.

Inter-departmental convergence at various levels facilitates quality improvement: Convergence meetings institutionalised at the block and district level have proved a very effective mechanism for improved planning, monitoring and in

addressing gaps in VHND services. Joint problem-solving is improving the quality of VHND. Visible improvements at the field level have encouraged government officials to continue with these convergence meetings on a regular basis.

Building capacity in use of data improves programmes: District and block officials appreciated the value of VHND data to analyse performance gaps. They adopted the VHND monitoring checklist and issued Government Orders to the supervisory cadres to use it regularly to monitor VHND performance. Data were used at convergence meetings for making programme corrections which demonstrated the value of using data at all levels. The use of data to generate effective dialogue among stakeholders results in continuous programme improvements.

Supporting frontline workers is critical for ensuring VHNDs are reaching the community with needed services: The Project-supported districts to ensure frontline workers knew their roles and responsibilities during VHND and received the support they needed from supervisors to perform these functions. Supervisory support from ICDS supervisors and ANMs helped AWWs and ASHAs to appreciate the importance of their roles and helped them with problem-solving and motivation. Supervisory visits contributed to improved performance of

frontline workers, who are motivated by the fact that someone cares about their performance.

Integrating an equity and gender focus ensured that VHNDs benefit disadvantaged groups: DHFW, DWCD and the Project emphasised the need to reach disadvantaged women and children by incorporating indicators in data collection and monitoring processes and using this information to improve coverage of villages that include disadvantaged groups. Participation data showed that women from all segments participated in VHNDs, with those from disadvantaged groups such as scheduled castes/tribes participating at the same or higher levels as other groups.

Supervisory activities need to be budgeted and prioritised: Barriers to strengthening supervisory processes need to be addressed. Obstacles to systematically providing supervision include lack of public transport to reach remote *Anganwadi* centres, vacancies in supervisory cadres, insufficient funds being programmed for supervisory visits and competing priorities for supervisors' time. State- and district-level leadership could address many of these barriers to sustaining strong supervisory systems.



Vision

IntraHealth International believes in a world where all people have the best possible opportunity for health and well-being. We aspire to achieve this vision by being a global champion for health workers.

Mission

IntraHealth empowers health workers to better serve communities in need around the world. We foster local solutions to health care challenges by improving health worker performance, strengthening health systems, harnessing technology, and leveraging partnerships.

For more information, visit www.intrahealth.org

The Purpose of the Vistaar Project

To assist the Government of India and the State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn, and child health and nutritional status

Conclusions

The joint efforts of the Project and DHFW and DWCD in Jharkhand and UP to improve VHNDs contributed to increased access, use and quality of health and nutrition services at VHNDs.

The Project's technical assistance and collaboration with district officials has demonstrated the importance of supporting government priorities and building on existing platforms and systems in order to achieve results. Strengthening systems to ensure orientation on VHND guidelines and joint planning, effective use of monthly meetings for programme review and problem-solving, enhanced provision of supportive supervision and use of data for monitoring and decision-making have contributed to increased number of VHNDs held as per plan, presence of all three frontline workers and expanded coverage to

include more underserved populations. Measurable improvements have been made in the number of ANC, child health and nutrition services provided during VHNDs. Participation levels of pregnant and recently delivered women and their children were high. These achievements demonstrate that systems can be improved at scale with minimal additional costs resulting in better access and use of services for women and children.

In May 2012, GOUP decided to replicate this strategy at scale in 28 high-burden districts (with high maternal mortality ratios) across six divisions of the state as an innovative effort under NRHM. The approach described in this paper can be replicated in other high focus states of India to strengthen VHNDs as effective platforms for expanding maternal, nutrition and child health services to reach vulnerable rural populations.

IntraHealth International, Inc. is the lead agency for the Vistaar Project. For more information on the Vistaar Project, see: www.intrahealth.org/vistaar

Technical assistance partners:



¹Adapted from Monthly Village Health and Nutrition Day Guidelines for AWWs/ASHAs/ANMs/PRIs. February 2007. National Rural Health Mission; Ministry of Health and Family Welfare, Government of India

²Census of India 2011, Provisional Population Tables

³NRHM-Project Implementation Plans (2010-11), and from the offices of the Chief Medical Officer (CMO) and District Programme Officer (DPO) of district headquarters.

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