NITI Aayog

BIU Behavioural Insights Unit of India

OPERATIONAL GUIDELINES FOR THE IMPLEMENTATION OF THE **COUNSELLING CARD**

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Operational Guidelines for the Implementation of the Counselling Card

Since 2018, the Centre for Social and Behaviour Change has been working on enhancing the consumption of Iron and Folic Acid (IFA) tablets among pregnant women. In this context, five interventions were designed and tested, out of which two demonstrated an impact. However, the results of the Randomised Control Trial (RCT) highlight that implementing both the interventions together may reduce their effectiveness. The choice of intervention is at the discretion of the implementer.

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LETTER FROM THE VICE CHAIRMAN, NITI AAYOG

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Azadi Ka Amrit Mahotsav

Maternal health is a critical priority of the Government of India, as envisioned in the National Health Policy 2017, because it is a determinant of a society's overall development. India is also committed to the Sustainable Development Goals (SDGs), where maternal health and the nutritional needs of pregnant women have key targets.

However, anaemia poses a severe threat to maternal and child health outcomes. The Government of India has committed itself to reducing the prevalence of anemia among pregnant women from 50% in 2016 to 32% in 2022. The Ministry of Health and Family Welfare under the Anaemia Mukt Bharat strategy runs several interventions to combat the problem of anaemia in the country and one of them is to provide free Prophylactic Iron and Folic Acid (IFA) supplementation to pregnant women and lactating mothers. The strategy also includes an intensified year-round behaviour change communication campaign to mitigate the problem of anaemia.

However, in addition to strengthening IFA supply chains, it is crucial to identify and resolve demand-side challenges OR user-centric behavioural barriers to achieve the end goal of reducing the incidence of anaemia. These behavioural barriers can and do affect the uptake and consumption of the IFA tablets among pregnant women.

In the spirit of behaviour change and to overcome the behavioural barriers associated with IFA tablets, the Behavioural Insights Unit at NITI Aayog designed and tested two behavioural interventions - the counselling card and the goal-tracking calendar - that can be integrated within the existing health framework of India.

I am pleased to introduce the operational guidelines for effective integration of the counselling card within the existing health ecosystem of the country. The given intervention aims at improving adherence to the consumption of IFA tablets among pregnant women by making the side effects of the tablets salient. The guidelines present a step-by-step guide for the implementers and relevant stakeholders to successfully integrate the counselling card while retaining its behavioural features.

On behalf of NITI Aayog, I would like to express my deep gratitude to all the frontline health workers and block officials who work tirelessly to provide maternal health services and for sharing their valuable inputs in the creation of the intervention and the guidelines. I am greatly thankful to Shri Parameswaran Iyer, CEO of NITI Aayog and Shri Amitabh Kant, former CEO of NITI Aayog for their guidance in the creation of the operational guidelines and the Aspirational Districts Programme team for their inputs and support. I congratulate the BIU team for their tremendous effort in creating the guidelines and bringing behavioural change to the forefront of policy-making.

(Suman Bery)

स्वच्छ भारत
एक कदम स्वच्छता की ओर

FOREWORD BY THE CHIEF EXECUTIVE OFFICER, NITI AAYOG

The World Health Organisation (WHO) recognises anemia as a "serious global public health problem that particularly affects young children and pregnant women". One of the indicators under the Sustainable Development Goal of Zero Hunger (Goal 2) is the percentage of pregnant women between the ages of 15 - 49 years who are anemic. The Government of India is committed to reducing this percentage to 50% of its base value in 2015-16 by 2025.

Towards the achievement of the same goal, NITI Aayog has supported the Behavioural Insights Unit in the creation of behavioural interventions which aim towards overcoming behavioural barriers in the uptake and consumption of IFA tablets among pregnant women. The NITI Aayog has also sanctioned a project to reduce the prevalence of anemia in five aspirational districts.

This document provides guidelines for the integration of one such behavioural intervention-the counselling card. Following these guidelines, the intervention may be incorporated within the country's health ecosystem such that the behavioural features of the intervention are retained. Emphasis is laid on the behavioural features as they are significant in successful implementation of the intervention and achieving the desired outcome. The guide is useful for stakeholders at all levels of governance as it recommends roles that each stakeholder can play in this process.

Even though these guidelines are focused on the scale-up of the counselling card, they serve as a template for stakeholders in other sectors aiming to develop and incorporate behavioural interventions.

I congratulate the Behavioural Insights Unit team led by Dr. Shagata Mukherjee, for their commendable effort in putting together these guidelines.

Shri Parameswaran Iyer
CEO, NITI Aayog
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HOW TO READ THIS

Behavioural Insights and Public Policy

Traditional approaches to economics and policy-making have assumed that human beings are rational actors who make rational decisions to maximise their economic benefits. However, in reality, people often make choices that are detrimental to their well-being, such as smoking or rash driving. Behavioural science moves away from the traditional assumption of rationality to understand why people make the decisions they do in real life. It includes insights from economics, psychology and other social sciences to deconstruct decision-making in human beings, along with insights from the larger field of behavioural sciences.[1]

A behavioural approach to public policy is underscored by the fact that people make imperfect decisions and that the decision-making process is riddled with biases. It seeks to explore behavioural barriers of inaction (or undesired actions) to design solutions that can make it easier or more natural for people to follow a specific behaviour. As such, leveraging behavioural insights can help to design and implement more citizen-centric policies.[2] For example, children's immunisation is influenced by the availability of the necessary infrastructure and resources and their parents' motivation to complete the immunisation cycle. Borrowing insights from economics, psychology, and neurosciences, a behavioural lens can provide a realistic understanding of how people may respond to an intervention. Taking the above example forward, it may be likely that parents are hesitant to vaccinate their children as they are not fully aware of its benefits and side effects. A behavioural approach will explore why parents may not be vaccinating their children in the presence of physical and human infrastructure and design potential solutions to alleviate parents' concerns.

In countries such as the United States of America and the United Kingdom, behavioural economics has been used in policy-making across sectors such as agriculture, finance, environment, health and nutrition (Sunstein and Reisch, 2018). For instance, the UK introduced tax prompts leading to timely payments by more citizens by simply adding the line "most people pay their tax on time" in letters to taxpayers.[3] By leveraging people's desire to conform to what the majority around them are doing (paying taxes on time, in this case), the Behavioural Insights Team in the UK demonstrated how social norms can be leveraged to drive behaviour change.[4]

The increasing adoption of a behavioural approach in public policies creates a unique opportunity for India. On the one hand, India could learn from other countries' experiences, while on the other, emerge as a leader in the space of behavioural public policy in the Global South.

[1] Kochhar, C., Shah, S., Dua, P. D., Kapur, S., & Prasad, U. (2022). Behaviour Change. Development Monitoring and Evaluation Office (DMEO) and Behavioural Insights Unit of India, NITI Aayog, Government of India. Retrieved June 20, 2022, from https://csbc.org.in/images/niti/download/Behavior-Change-Report.pdf

[2] John, Peter and John, Peter, Behavioural Approaches: How Nudges Lead to More Intelligent Policy Design (August 14, 2015). Forthcoming in Contemporary Approaches to Public Policy, edited by Philippe Zittoun (LET- - -ENTPE, University of Lyon) and B. Guy Peters (University of Pittsburgh), Available at SSRN: https://ssrn.com/abstract=2604377.

[3] Halpern, D., & Sanders, M. (2016). Nudging by government: Progress, impact, & lessons learned. Behavioral Science & Policy, 2(2), pp. 53–65.

[4] Larkin, Chris and Sanders, Michael and Andresen, Isabelle and Algate, Felicity, Testing Local Descriptive Norms and Salience of Enforcement Action: A Field Experiment to Increase Tax Collection (April 29, 2018). Available at SSRN: https://ssrn.com/abstract=3167575.

Working at the intersection of behavioural science and public policy across multiple sectors, the NITI-BIU has developed operational guidelines to scale behavioural interventions to improve the Iron and Folic Acid (IFA) consumption among pregnant women.

About the guidelines

While the Government of India has a robust ecosystem to provide free Iron and Folic Acid (IFA) tablets to pregnant women, incorporating behavioural interventions that target pregnant women's IFA related consumption behaviours will amplify the uptake of the IFA tablets.

These behavioural interventions are-the counselling card and the goal-tracking calendar. The counselling card is a tool to be used by the Frontline Health Workers which makes information on the side effects of IFA tablets and their management salient. The goal-tracking calendar is a tool to be used by pregnant women as it provides them with a salient reminder to consume the IFA tablets and demonstrates their progress visually.

The current document serves as a guideline to operationalise the use of the counselling card which has been created after extensive consultations with pregnant women, frontline health workers and, block, state and national level officials. The guideline lays down the step-by-step process by which the counselling card can be scaled up within the existing health machinery. The roles and responsibilities of national, state, district, and block level officials have been recommended to successfully incorporate the behavioural interventions.

The success of any intervention requires continuous monitoring and evaluation to identify and solve implementation related barriers. This becomes even necessary for behavioural interventions such as the counselling card so that their behavioural features are retained and continuous improvements are made to their design and delivery. In this regard, the guideline introduces the Responsive Feedback approach, which encourages implementers to refine the intervention based on the feedback and progress on the ground.

Lastly, similar to this document, another set of operational guidelines have been created for the scale-up of the goal-tracking calendar **The NITI-BIU strongly recommends the adoption of either of the two interventions and not both of them together.** Rigorous randomised evaluation has shown that the effectiveness of the interventions reduces when they are implemented together. The choice of the intervention is at the discretion of the implementer.

ACKNOWLEDGEMENTS

The operational guidelines for the integration of the counseling card within the existing health machinery have been prepared after numerous consultations with district, block officials, and frontline health workers. We are deeply thankful to the District Magistrates, Civil Surgeons, and their teams of West Singhbhum, Simdega and Bokaro districts of Jharkhand, Medical Officers in Charge, Block Programme Managers, and all the frontline health workers from the Bandhgaon, Kolebeira and Peterwar blocks for their valuable time and inputs.

We are deeply grateful to Shri Suman Bery, Hon'ble Vice Chairman, NITI Aayog and Dr. Rajiv Kumar, former Vice Chairman, NITI Aayog, for entrusting us with this work. We are thankful to Shri Parameswaran Iyer, CEO of NITI Aayog and Shri Amitabh Kant, former CEO of NITI Aayog, for their constant guidance. We would also like to acknowledge Shri Rakesh Ranjan, Mission Director of the Aspirational Districts Programme, and his team at NITI Aayog, stakeholders from the Ministry of Health and Family Welfare and the Department of Public Health and Family Welfare in Maharashtra for their invaluable inputs and support.

Lastly, we are greatly thankful to our research partner, the Centre for Social and Behaviour Change, for their leadership in designing the intervention and their support in conducting the qualitative study in Jharkhand.

LIST OF ACRONYMS

AMB	Anemia Mukt Bharat
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BPM	Block Programme Manager
BTT	Block Training Team
CHC	Community Healthcare Centre
CMO	Chief Medical Officer
CS	Civil Surgeon
CSBC	Centre for Social and Behaviour Change
DAMBU	District Anemia Mukt Bharat Unit
DoHFW	Department of Health and Family Welfare
DPC	District Programme Coordinator
FLHW	Frontline Health Worker
HMIS	Health Management and Information System
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
MoHFW	Ministry of Health and Family Welfare
MCHTS	Mother and Child Health Tracking System
MOIC	Medical Officer In Charge
NAMBU	National Anemia Mukt Bharat Unit
NCEAR - A	National Centre of Excellence and Advanced Research - Anemia
NFHS	National Family and Health Survey
NITI - BIU	NITI - Behavioural Insights Unit
PHC	Primary Healthcare Centre
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyaan
PW	Pregnant Women
RCH	Reproductive and Child Health
RF	Responsive Feedback
SAMBU	State Anemia Mukt Bharat Unit
SC	Sub Centre
VHSND	Village Health, Sanitation and Nutrition Day

CHAPTER 1: INTRODUCTION

As per the World Health Organisation, "anemia is a condition in which the number of red blood cells or the haemoglobin concentration within them is lower than normal. Haemoglobin is needed to carry oxygen and if you have too few or abnormal red blood cells or not enough haemoglobin, there will be a decreased capacity of the blood to carry oxygen to the body's tissues."[5] Fatigue, weakness, shortness of breath, and dizziness are some common symptoms of anemia.

Over the years, there has been an increase in the prevalence of anemia in women. As of 2019-20, 57% of women in the reproductive age group (15-49 years) are anemic as compared to 53.1% in 2015-16.[6] Similarly, as of 2019–20, 52.2% of pregnant women in India are anemic as compared to 50.4% in 2015-16. [7]

The disease is associated with significant adverse maternal and child health outcomes. Intrauterine deaths are 3.7 times more likely among anemic women, prematurity is four times more likely, and low birth weight is 1.9 times more likely among infants born to anemic mothers as compared to mothers who are not anemic.[8] Twenty percent of all maternal deaths can be directly attributed to anemia and another 50% are indirectly related to it.[9]

To reduce the incidence of anemia across various target groups including pregnant women, the Ministry of Health and Family Welfare (MoHFW) launched the Anemia Mukt Bharat (AMB) strategy in 2018. The AMB strategy builds upon Government of India's (GoI) previous Iron and Folic Acid (IFA) supplementation initiatives including the National Iron Plus Initiative (NIPI) and Weekly Iron and Folic Acid programmes (WIPS). India's National Health Policy (2017) recognised the need to have a multi-pronged strategy rather than scattered programmes with the aim of intensifying efforts to address all causes of anemia across all age groups and bring down the prevalence of anemia. In this context the AMB strategy was launched with a more robust and operational accountability framework than previous programmes.[10] The AMB strategy focuses on six interventions:

- Prophylactic IFA supplementation
- Deworming
- Intensified year round Behaviour Change Communication (BCC) campaign
- Testing and treatment of anemia esting and treatment of anaemia
- Mandatory provision of IFA fortified foods
- Intensifying awareness, screening and treatment of non-nutritional causes of anemia in endemic pockets

[5] WHO (n. d.). anemia. Retrieved 15 May 2022, from https://www.who.int/health-topics/anemia#tab=tab_1
[6] National Family Health Survey (2015-16, 2019-20)
[7] National Family Health Survey (2015-16, 2019-20)
[8] Lone, F., Qureshi, R., & Emanuel, F. (2004). Maternal anemia and its impact on perinatal outcome. Tropical Medicine And International Health, 9(4), 486-490. doi: 10.1111/j.1365-3156.2004.01222.x
[9] Anand, T., Rahi, M., Sharma, P., & Ingle, G. (2014). Issues in prevention of iron deficiency anemia in India. Nutrition, 30(7-8), 764-770. doi: 10.1016/j.nut.2013.11.022

Specifically for IFA supplementation, the AMB strategy targets children between 6-59 months, school children between 5-9 years, school going adolescents between 10-19 years, out-of-school adolescent girls between 10-19 years, women of reproductive age, pregnant women, and lactating women.[11] Focusing on pregnant women, the strategy provides for the distribution of IFA tablets starting from the fourth month of pregnancy. However, the uptake and adherence to the consumption of IFA tablets among pregnant women remains low. As of 2019-20, only 26% of pregnant women consumed the recommended dosage of IFA tablets for 180 days.[12] Even though this figure marks an increase in consumption by 11.6 percentage points since 2015-16, it is still low.[13]

In this context, the Ashoka University's Centre for Social and Behaviour Change (CSBC) in partnership with Research Triangle Institute (RTI) International,[14] conducted a diagnostic study in 2018 to identify behavioural barriers in the uptake of IFA tablets. Through a comprehensive barrier mapping exercise, five key behavioural areas that could be targeted to trigger change were identified. They are:

There is a lack of adherence to the consumption of IFA tablets as their side effects may deter the pregnant women from continuing their consumption.

Low priority is attached to the IFA tablets. There is also forgetfulness in taking the tablet. This is because anemia is not perceived as a health condition and, by extension, IFA tablets as not considered a necessity.

The consumption of IFA tablets is deprioritized as the benefits of taking IFA tablets including reduced risk of iron deficiency, development of a healthy baby and timely delivery are not readily visible and clear to pregnant women (non-salient benefits of IFA tablets).

Low preference for taking IFA tablets due to the prevalence of traditional health beliefs and norms. Women think that their nutritional habits are working and the need for consuming IFA tablets for the health of the mother and child is not salient. Women also feel that the IFA tablets make their child bigger and harder to deliver, darken their skin color and increase the possibility of miscarriages.

There is a lack of trust in IFA tablets since they are provided for free by the government.

[10] Intensified National Iron Plus Initiative (I-NIPI)- Operational Guidelines for Programme Managers, MoHFW, 2018
[11] Intensified National Iron Plus Initiative (I-NIPI)- Operational Guidelines for Programme Managers, MoHFW, 2018
[12] National Family Health Survey (2019-20)
[13] National Family Health Survey (2015-16, 2019-20)
[14] RTI International is a non-profit organisation headquartered in North Carolina, United States of America. From RTI, Edmond Baron, Aditi Roy and Jon Poehlman were involved in the diagnostic study with CSBC.

Based on these barriers, five interventions were designed and tested. One of these was the counselling card.[16] The **counselling card** is designed to be **used by the Frontline Health Workers (FLHWs) to counsel pregnant women** on the management of IFA side effects. It was tested to be effective in increasing the consumption of IFA tablets in a lab-in-the-field experiment in Haryana (2018) and a Randomised Control Trial (RCT) in Madhya Pradesh (2019) conducted by CSBC.[17, 18]

Further, in 2022, the Behavioural Insights Unit at NITI Aayog (NITI-BIU) in partnership with The Curve conducted a qualitative study in the West Singhbhum, Simdega, and Bokaro districts of Jharkhand to understand the efficacy and sustainability of the counselling card when integrated within the AMB strategy, or scaled up within the existing health machinery of the country.

This document serves as an operational guideline for the implementation of the counselling card within the AMB strategy. Since the distribution of IFA tablets falls under the purview of the AMB strategy, the counselling card may be integrated within the same. This guideline has been created based on the findings from a qualitative study conducted by the NITI-BIU as well as consultations with national, state, and district level stakeholders. It lays down the key features of the behavioural intervention and the operational steps involved in its effective implementation including estimation, delivery, distribution, training, and monitoring. The guideline also recommends integrating the **Responsive Feedback** (RF) approach in the implementation of the intervention and offers actionable ways for the implementers to refine the intervention based on continuous feedback and progress on the ground.[19] Behavioural interventions, such as the counselling card, depend on the behaviours of both the FLHWs and the pregnant women, which can vary from region to region. In this case, it is recommended that the RF approach is adopted to ensure that the intervention is correctly delivered and has the greatest impact.

The guideline is meant to provide a framework for effective scale-up of the counselling card and facilitate its implementation through different stages of programme delivery.

[15] Since 2018, the Centre for Social and Behaviour Change has been working on enhancing the consumption of IFA tablets among pregnant women. In this context five interventions were designed and tested, out of which two demonstrated an impact. However, the results of the RCT highlight that implementing both the interventions together may reduce their effectiveness. The choice of intervention is at the discretion of the implementer.
[16] The other intervention that was designed and tested was the goal-tracking calendar to be used by pregnant women to help in the recall of daily IFA tablet consumption and self monitor the behaviour of IFA tablet consumption. This guideline only focuses on the counselling card.
[17] A lab-in-the-field experiment is when the lab is taken to the field and the lab experiment is conducted in the natural environment of the subjects. This is different from field experiments as they are conducted entirely in natural settings such that at times the respondents may not even be aware that they are a part of the experiment.
[18] The experiment in Haryana was conducted in Sonipat and the RCT in Madhya Pradesh was conducted in Vidisha and Hoshangabad.
[19] To learn more about the Responsive Feedback approach, the reader is encouraged to visit https://the-curve.org/resources/. Further, guidance and resources can be accessed here, including a free e-Learning course developed by the Harvard School of Public Health and Geneva Learning Foundation.

CHAPTER 2: COUNSELLING CARD

A. Introduction to the counselling card

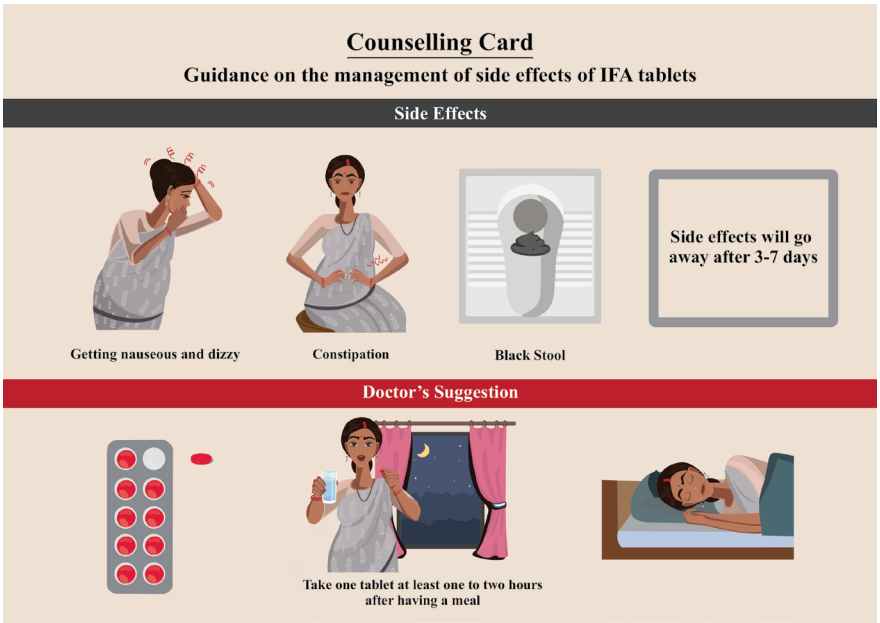
Under the existing health machinery, IFA-related counselling to pregnant women may be delivered through the Village Health Sanitation and Nutrition Days (VHSNDs) and the Pradhan Mantri Surakhsit Matritva Abhiyaan (PMSMA) on the 9th of every month. The consumption of IFA tablets is often associated with side effects including dizziness, constipation, and black stools. In the absence of appropriate counselling, pregnant women may stop consuming the tablets if they experience the side effects, thus leading to a lack of adherence to their consumption.

To combat the lack of adherence to the consumption of IFA tablets, **the counselling card makes information on the side effects of IFA tablets and the management of the side effects salient such that there is:** (refer to Figure 2.1)

- A reduction in the surprise element of side-effects of IFA tablets and associated likelihood of pregnant women stopping the consumption of IFA tablets.
- Increased knowledge about the consumption of IFA tablets and its value perception among pregnant women.

The counselling card may **be used by the Auxiliary Nursing Midwives (ANMs) and Accredited Social Health Activists (ASHAs) (with guidance from ANMs)** every time the IFA tablets are distributed to women in their second or third trimester of pregnancy and during home visits.

Figure 2.1: The Counselling Card



B. Implementing the counselling card

Implementation by Auxiliary Nursing Midwives

It is proposed that ANMs be the **primary users** of the counselling card as they are responsible for the distribution of IFA tablets to pregnant women during Antenatal Care (ANC) visits. The ANMs may use the card for counselling **every time the IFA tablets are distributed to pregnant women in their second and third trimesters.** They may refer to the script attached in **Annexure 2** while delivering the intervention.

Implementation by Accredited Social Health Activists

The ASHAs may play a supportive role in using the counselling card and may use the same under the following circumstances:

- Under the guidance and instructions from the ANM.
- During home visits to reiterate key messages and reinforce the behaviour of IFA tablets' consumption.

During counselling, the ASHAs may refer to the script attached in **Annexure 2**.

Responsive Feedback Approach

In order to ensure the successful implementation of the counselling card and retain its behavioural features stakeholders may adopt the RF Approach. The RF approach allows for ongoing and systematic data collection on priority indicators, regular review and feedback for timely course correction (refer to Chapter 4 for more details).

Broadly, the steps involved in the RF approach are:

1. **Convene stakeholders:** The first step in ensuring successful implementation is for all involved stakeholders to learn and work together as a team such that decision making and program iteration can happen smoothly. For example, learnings from the ground can be discussed in district and state level review meetings for program iteration. Chapter 4 details out a suggested mechanism for all relevant stakeholders to work in a collaborative manner.

2. **Identify assumptions:** The successful usage of the counselling card is dependent upon the completion of certain activities. For example, the effective delivery of the counselling card requires that the ANMs or ASHAs use the counselling card in the prescribed manner, which is a critical assumption.

3. **Develop learning questions:** The learning questions enable the implementers to understand if certain critical activities are being implemented. For example, during VHSNDs reviews, designated officials and the nodal officials can use the VHSND checklist to capture if the ANMs are carrying all their materials.

4. **Seek evidence:** These are the data collection methods that can answer the learning questions. The data may be collected through existing portals, such as the Health Management Information System (HMIS).

5. **Evolve:** This is the stage wherein the findings from the data collection process are assessed and decisions are made regarding changes to implementation.

C. Delivery Platforms for the counselling card

The counselling card may be used:

- At all sites of distribution of IFA tablets. These include VHSND, the ANC check-up under PMSMA on the 9th of every month and walk-in visits to sub-centres by pregnant women.
- During home visits by ASHA workers.

Table 2.1 below presents the steps involved in the usage of the counselling card.

Table 2.1: Collection and usage of counselling card

Steps	Roles and Responsibilities	
	ANM	ASHA
Collection of the counselling card	The ANMs may collect the counselling cards from the Community Healthcare Centre (CHC) or Primary Healthcare Centre (PHC) and store the same at their sub-centres If it is not available, the ANM may access the digital version of the counselling card **here**	The ASHAs may collect the counselling cards from the ANMs
Usage of the counselling card	The ANMs may carry the counselling card at all sites of distribution of IFA tablets to women in the second and third trimester of pregnancy. These include: ■ VHSND ■ ANC check-up on the 9th ■ Walk-in visits to the sub-centre	■ The ASHAs may carry the counselling card at all sites of distribution of IFA tablets (VHSND, ANC check-up on the 9th, walk-in visits to sub-centre), and use the counselling card as per the guidance and instructions received from the ANMs ■ The ASHAs may carry the counselling card during home visits to reiterate key messages

D. Training on the usage of the counselling card

To retain the **behavioural effectiveness** of the counselling card, it is crucial for the ANMs and ASHAs to understand the importance and usage of the card. It is recommended that the training on the card is interactive and engaging such that the ANMs and ASHAs are able to use the counselling card comfortably and deliver its key messages to pregnant women. As such, the training guide attached in **Annexure 3** may be used for training. Moreover, while using the counselling card the ANMs and ASHAs may refer to the script attached in **Annexure 2** which will be printed on the back of the intervention.

E. Specifications for the counselling card and its usage

Table 2.2 below highlights the non-modifiable and modifiable specifications for the design and usage of the counselling card, from the objective of retaining the behavioural effectiveness of the card.

Table 2.2: Usage specifications

	Non-modifiable	Modifiable
Design of the counselling card	■ A prototype of the counselling card is attached in **Annexure 1**. The technical information presented on the card should not be changed. This includes the side effects of IFA tablets and doctor's guidance on the consumption of IFA tablets ■ The script included in **Annexure 2** maybe be printed at the back of the card in the local or official state language	■ It is recommended that the card is printed on an A4 sheet (8 ¼ X 11 ¾ inches) of 300 GSM. However, these specifications may be modified based on budgetary constraints ■ The language on the card may be changed as per the local context ■ The pictures on the card may be modified as per the local context
Usage of the counselling card	■ The card is not a take-home tool	

CHAPTER 3: ROLES AND RESPONSIBILITIES

It is proposed that the counselling card be integrated within the framework of the AMB strategy. However, state departments and district administrations may choose to integrate the card within any other anemia-related scheme.

A. Implementing Ministry/Department

At the national level, MoHFW may be the implementing ministry and at the state level, the Department of Health and Family Welfare (DoHFW) may be the implementing department. Within the concerned ministry/department, Anemia Mukt Bharat Units that have been established under the AMB strategy may hold responsibility for the implementation.

B. Estimation and Printing

As per the existing structure of the AMB strategy, the State Anemia Mukt Bharat Unit (SAMBU) may:

- Estimate the number of counselling cards based on the number of ANMs and ASHAs in each district. Please note that each ANM and ASHA must be given at least one counselling card.
- Design and/or print the counselling card based on the recommendations made in Table 2.2.
- Share the counselling cards or prototype and specifications with the district administrations.

C. Storage and Delivery

The counselling cards may be stored and delivered in the following ways:

- **District level:** The counselling cards may be stored at the warehouse/storehouse of the district hospital or its equivalent.
- **Block level:** The supply of counselling cards and their corresponding instructions may be shared with the relevant block-level health officer such as Block Health Officer and Medical Officer in Charge (MOIC). The relevant health officer may collect and store the materials at the warehouse of the CHC or PHC.
- **Sub-centre level:** ANMs may collect the counselling cards from their CHC or PHC warehouse or storehouse and store them at their respective sub-centres. They may share the card with the ASHAs working with them.

D. Training

The training guide attached in **Annexure 3** may be used to train the ANMs and ASHAs. The training may be conducted as per the training architecture in the concerned state.

The ANMs and/or ASHAs may refer to the script printed at the back of the counselling cards to counsel the beneficiaries.

E. Implementation and Course Correction

The ANMs and/or ASHAs may be responsible for the last mile implementation. They may use the counselling card at the time of distribution of IFA tablets and during home visits.

To ensure the retention of the behavioural feature of the counselling card and continuous course correction in its implementation, the adoption of the RF approach is recommended (refer to **Chapter 4** for more details). It may be adopted as follows:

- **State level:** The SAMBU or the relevant state authorities may discuss the implementation progress and challenges and suggest recommendations on a half yearly basis.
- **District level:** The Chief Medical Officer (CMO) or Civil Surgeon (CS) or an equivalent district officer may discuss on the ground challenges and suggestions to the design and implementation of the intervention in district level meetings on a quarterly basis.
- **Block level:**

  • The MOIC or an equivalent block officer may identify and assess the ground challenges and suggestions based on feedback from FLHWs and other stakeholders in monthly block review meetings.

  • Reviewing officers may observe the usage of the counselling card by the ANMs/ASHAs at sites of distribution of IFA tablets (data collection methodology recommended in **Chapter 4**).

Table 3.1 presents the detailed roles and responsibilities of each stakeholder across governance levels.

Table 3.1: Roles and responsibilities

Roles and Responsibilities	Stakeholders		
	State	District	Block
Estimation and Printing	The *State Nodal Officer* under AMB or Official managing IFA distribution may ensure that: ■ Specifications given in Table 2.2 are followed in the design of the card ■ Number of counselling cards required by districts is estimated accurately ■ Printed and translated cards are delivered to the districts or a prototype along with printing specifications are shared with the districts	The *Chief Medical Officer or Civil Surgeon or an equivalent district officer* may ensure that: ■ Counselling cards are received from the state or printed as per the prototype and printing specifications shared by the state ■ Printed cards are delivered to the blocks ■ If only the district is scaling the intervention, the number of counselling cards required should be estimated by the relevant department in the district administration	N/A
Storage and Delivery	N/A	The *Chief Medical Officer or Civil Surgeon or an equivalent district officer* may ensure that: ■ Counselling cards are stored securely in the warehouse of the district hospital or its equivalent once received by the state ■ The counselling cards are delivered to the blocks	*The Medical Officer in Charge or an equivalent block officer* may ensure that: ■ Counselling cards are received from the district and stored in the warehouse of the community healthcare centre/primary healthcare centre ■ The counselling cards are shared with the ANMs ■ The ANMs may collect the counselling cards from the *community healthcare centre or primary healthcare centre* and store the same at sub - centres. They may share the same with ASHAs
Training	Training may be conducted as per the state architecture		

Implementation and Course Correction	The *State Anemia Mukt Bharat Unit or the relevant state authorities* may discuss the implementation progress and challenges and suggest recommendations on a half yearly basis	The *Chief Medical Officer or Civil Surgeon or an equivalent district officer* may discuss on the ground challenges and suggestions to the design and implementation of the intervention in district level meetings on a quarterly basis	■ The *Medical Officer in Charge or an equivalent block officer* may identify and assess the ground challenges and suggestions based on feedback from FLHWs and other stakeholders in monthly block review meetings ■ Reviewing officers may observe and record the usage of the counselling card at sites of distribution of IFA tablets ■ The ANMs may use the counselling card to counsel pregnant women at the time of distribution of IFA tablets through antenatal care platforms including VHSNDs, ANC check-ups on the 9th and walk-in visits to sub-centres ■ The ASHAs may use the counselling card under the guidance and instructions provided by the ANMs and during home visits ■ Both ANMs and ASHAs may refer to the script printed on the back of the counselling card to counsel pregnant women

CHAPTER 4: RESPONSIVE FEEDBACK

Given that the counselling card is a behavioural tool, it is recommended that implementation takes into account how users and FLHWs are responding. The RF approach requires the implementers to identify and assess ground realities and implementation constraints.[20, 21] The findings can be used to inform and improve implementation on an ongoing basis.

The RF approach aims to collect timely feedback for planners and implementers, such that appropriate changes can be made to the interventions while they are still in progress. There are other similar approaches, such as adaptive management, feedback loops/mechanisms, and rapid cycle innovations which have been developed. The RF approach is similar to them but also builds on these approaches to offer an integrated, systematic, and systemic method to improve outcomes. In brief, it:

- Calls for eschewing silos and engaging all stakeholders in the design, execution, and maintenance of an intervention
- Encourages an explicit theory of change that continuously questions and tests assumptions driving the interventions
- Recommends built-in data collection methods to periodically test assumptions and adapt changes based on the data
- Advocates periodic pause and reflect sessions to engage all stakeholders on the intervention

Using the Responsive Feedback approach, a Learning Agenda for the implementation activities has been outlined. Tables 4.1 and 4.2 present the learning questions mapped against key program activities, proposed methods of collecting data and the role of stakeholders responsible for executing the proposed methods to answer each learning question.

On the basis of priority, it is recommended that the approach proposed in Table 4.1 is adopted to review the card's performance. Table 4.2, proposes an additional mechanism that may be adopted depending upon feasibility. Both the methods tap into the already existing process of the AMB programme and other RCH processes. However, it is upon the discretion of the implementers to modify or add to the various columns of the tables.

[20] Under RFM, this is undertaken through Learning Questions, which present opportunities to ask questions about factors potentially affecting the success of the interventions.
[21] To learn more about the Responsive Feedback approach, the reader is encouraged to visit https://the-curve.org/resources/. Further, guidance and resources can be accessed here, including a free e-Learning course developed by the Harvard School of Public Health and Geneva Learning Foundation.

Table 4.1: Primary learning questions and proposed methods*

Assumptions	Learning Questions	Method(s)	Stakeholders	Responsibility
Activity: Pregnant women are exposed to the IFA counselling at VHSND camps or PMSMA ANC visit or sub centres or home visits				
1.1 ASHA/ANMs use the counselling card in the prescribed manner during IFA counselling	Does the ASHA or ANM carry the counselling card with her?	**The monitoring template attached in Annexure 4** may be used to record data. It may be incorporated in any of the existing templates such as the VHSND checklist	Reviewing Officer	Data may be recorded by officials who are reviewing or observing the sites of distribution of IFA tablets
	Is the ASHA or ANM using the counselling card as trained?			
	Are IFA tablets being distributed to women in their second and third trimester?	Health Management and Information System (HMIS) and the Mother and Child Health Tracking System (MCHTS) or Reproductive and Child Health (RCH) Portal	ANM or ASHA or BPM	ANMs or ASHAs fill weekly and monthly reports. The data from the reports is collated to be uploaded on the portals by the office of the MOIC or an equivalent block officer
		VHSND checklist	Reviewing Officer	Data is recorded by officials reviewing or observing the VHSNDs
	Under what circumstances are IFA tablets not being distributed?	The status of IFA tablets distribution in a block is discussed during monthly review meetings, chaired by the MOIC or an equivalent block officer and attended by the BPM (or an equivalent block officer) and ANM	MOIC or an equivalent block officer	In monthly block meetings, the MOIC or an equivalent block officer holds the responsibility of discussing the implementation as an agenda item, problem solving and measuring change or improvement on a monthly basis
1.2 The counselling card is acceptable among different types of beneficiary groups (for example, educated versus uneducated pregnant women)	Do all pregnant women accept and understand the counselling in the same manner? If not, what are these differences?	The implementation of the counselling card in the block may be an agenda item in the block level monthly review meeting, chaired by the MOIC or an equivalent block officer and attended by the BPM (or an equivalent block officer) and ANM	MOIC or an equivalent block officer	In monthly block meetings, the MOIC or an block equivalent officer will hold the responsibility of discussing the implementation as an agenda item, problem solving and measuring change or improvement on a monthly basis
	What kinds of challenges need to be overcome to make the counselling card acceptable across all kinds of beneficiaries?			

*ANM: Auxiliary Nurse Midwife, ASHA: Accredited Social Health Activist, BPM: Block Programme Manager, HMIS: Health Management and Information System, MCHTS: Mother and Child Health Tracking System, MOIC: Medical Officer In Charge, VHSND: Village Health, Sanitation and Nutrition Day

Table 4.2: Secondary learning questions and proposed methods

Assumptions	Learning Questions	Method(s)	Stakeholders	Responsibility
Activity: ANM or ASHA carry counselling cards with them for sharing information on anemia during monthly VHSND camps or PMSMA ANC visits / sub centres or home visits				
1.1 ANM/ASHA finds the card easy to use	Does the ANM or ASHA find it easy to use the card and convey information? If no, why not? What improvements can be suggested?	The implementation of the counselling card in the block may be an agenda item in the block level monthly review meeting, chaired by the MOIC or an equivalent block officer and attended by the BPM (or an equivalent block officer) and ANM	MOIC or an equivalent block officer	In monthly block meetings, the MOIC or an equivalent block officer will hold the responsibility of discussing the implementation as an agenda item, problem solving and measuring change or improvement on a monthly basis
	Do the ANM or ASHA feel discouraged from using the card? Under what circumstances? What improvements can be suggested?			
Activity: Pregnant women adhere to the consumption of IFA tablets				
2.1 Pregnant women consume IFA tablets	Are pregnant women consuming IFA tablets?	Monthly report prepared by the ANMs or ASHAs may be used to record the data	ANM or ASHA	ANMs orASHAs fill monthly report wherein data on the consumption of IFA tablets may be recorded

While the above list of questions are recommended, implementers may collect data on as many questions as relevant and feasible. Once collected, it is suggested that the data and feedback from the field may be discussed at regular frequency at the district and state-level to identify course correction, if required. Some of the proposed avenues for the same have been listed below:

- Findings that may impact the implementation of the intervention **may be collated by the MOIC or an equivalent block officer** and discussed at district-level monthly review meetings every quarter.
- Suggestions and solutions from the discussions at district level monthly review meetings **CMO or CS or an equivalent district officer** and presented to the SAMBU or the relevant state authorities every six months, where progress and suggestions to the design and implementation of the intervention may be discussed.

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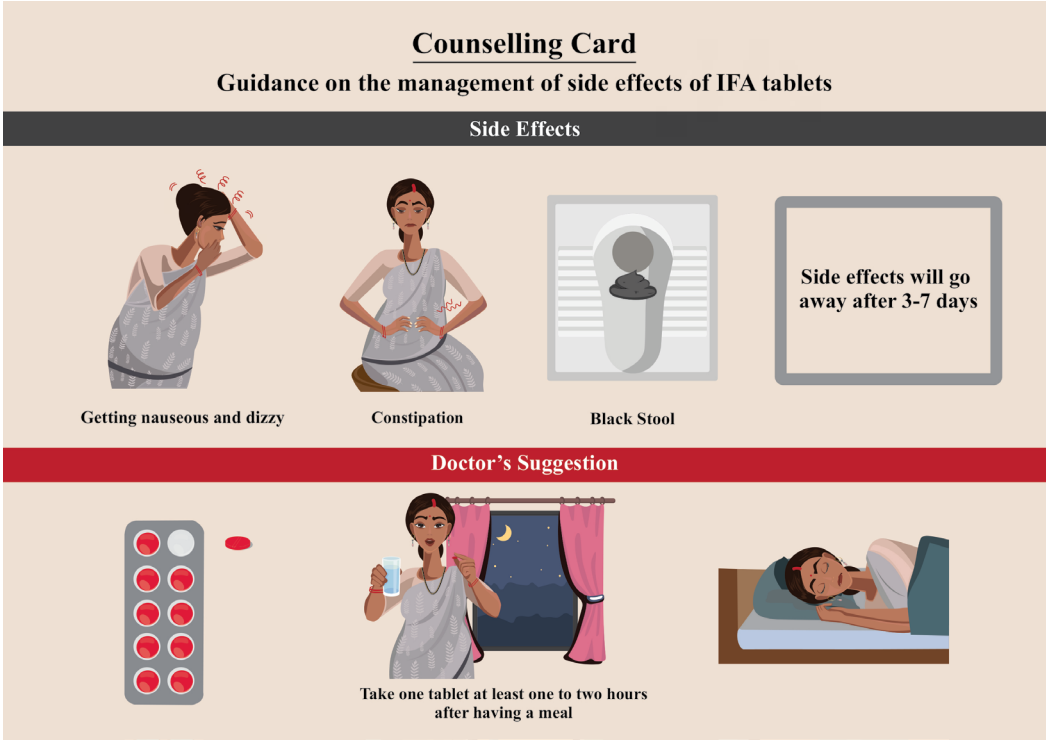
ANNEXURE

Annexure 1: Counselling card



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Annexure 2: Script for FLHWs

From the fourth month of pregnancy till a child is 6 months old, women must take the IFA tablet every day. Sometimes, if pregnant women are anemic then the IFA tablet must be consumed twice a day. Even if they are not anemic, they should take the IFA tablet once a day during pregnancy and 6 months after their delivery, along with Vitamin C rich foods to increase the absorption of iron. The tablet should be taken at least one to two hours after having a meal. If they do this, it will benefit both mother and child. The woman will grow stronger and the child will be healthy. It will also help a pregnant woman have a smooth delivery.

At the beginning of a course of IFA tablets, a woman might experience some side effects for a few days. You might feel nauseous and dizzy, or constipated, or start to see a black stool when you go to the toilet. Do not worry too much about these effects, as they can be reduced and usually go away after a short time. The best way to reduce these effects is simply to take the IFA tablet on an empty stomach soon before you go to sleep at night. This way, you allow your body to rest and you won't feel the side effects as much. You should stop feeling the side effects after 3-7 days.

Annexure 3: Training guide

Part A: Training FLHWs

1. Distribute the counselling card to each FLHW.

2. Ask the FLHWs and discuss why the consumption of IFA tablets is important for pregnant women to prevent anemia/low haemoglobin.

3. Ask the FLHWs: What are some common reasons why pregnant women stop consuming IFA tablets? Probe them on side-effects being a common reason why.

4. Explain that this counselling card is made so that pregnant women are clearly informed about the common side effects of taking IFA tablets. This prevents them from being alarmed when they occur and that they understand that it is normal to experience them for a few days in order to reap the long-term benefits of IFA tablets.

5. Explain the side effects and the doctor's prescribed method of consuming IFA tablets using the counselling card.

6. Instruct the FLHWs to show this card to pregnant women and talk through its content every time that they provide IFA tablets and counselling on anemia and during home visits. The explanation should be provided using the images on the card. After counselling, FLHWs should ask the pregnant woman to check if she has understood the key information and resolve any questions she may have.

7. Remind the FLHWs to always carry the counselling card at all sites of distribution of IFA tablets and during home visits.

Part B: Roleplay/demonstration exercise

1. Instruct the FLHWs to organise themselves into groups of 2-3 members each.

2. Ask them to take turns posing as FLHWs and pregnant women and perform a mock counselling session as would take place in a VHSND camp or any other site where counselling is possible. They will occupy separate areas of the room to carry out these activities. Each FLHW should get the chance to demonstrate the counselling card in this manner.

3. The FLHWs playing themselves are to think about how they would introduce the counselling card to a pregnant woman, and how they would conduct the activity to get her attention and ensure her understanding. The FLHWs posing as pregnant women are to think of relevant and common questions to ask in response to the counselling.

4. Ask a couple of groups to perform their roleplay in front of the large group to display interesting questions from pregnant women and good delivery by FLHWs.

5. Observe the following during the roleplaying session:

- FLHW displays the card to the pregnant woman
- FLHW emphasises on side-effects of taking IFA tablets
- FLHW conveys all the information on the card correctly
- FLHW checks for the pregnant woman's comprehension and answers questions

Part C: Post-training exercise

This exercise is to check if FLHWs have understood the key features of the behaviourally-informed materials.

1. Ask the FLHWs to select the most important feature of the counselling card, by raising their hand when their preferred feature is called out. Call out the features in the following order and count the number of hands raised for each answer out of the total group:

a. Doctor's prescribed method of taking IFA tablets

b. Description of side effects

c. Images of pregnant women

d. Benefits of IFA tablets

2. Correct/validate their responses by reiterating that the (b) description of side effects is the most important feature of the counselling card, followed by (a) the doctor's prescribed method.

Annexure 4: Monitoring template

Name of observer					
Designation of observer					
Date of visit					
Village name	FLHW observer (ASHA/ANM)	Is the counselling card available? (Yes/No)	Did the FLHW use the counselling card? (Yes/No)	Rate the quality of counselling (0-3)	List points of feedback for FLHW

Counselling Rating Criteria
0 = No counselling provided
1 = Counselling covers IFA consumption/adherence
2 = Counselling covers both IFA consumption and side-effects
3 = Counselling covers both IFA consumption and side-effects, and encourages questions from pregnant women

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