

Zindagi Aayi
Khushiyan Laayi
Sure Start Ke Sang



A-9, USO Road, Qutub Institutional Area, New Delhi-110 067
T: +91 11 26530080 - 88, F: +91 11 26530089
info@path.org
www.path.org





Sure Start: Saving lives of mothers and newborns in Maharashtra City-specific intervention models in Maharashtra

Background

The Sure Start project was about saving the lives of mothers and newborns in Maharashtra and Uttar Pradesh, India. PATH and our partners implemented Sure Start in Maharashtra from 2007 through 2011. Our objective was to influence behaviors at the individual, family, and community levels to improve maternal and newborn health (MNH). The project strengthened community systems to facilitate effective community action.

Innovative, community-based surveillance of eligible women provided opportunities for health counseling and ensured early registration of pregnancy (during the first 12 weeks). Health workers conducted structured home visits to change behaviors of women and family members. Behavior change communication was based on each woman's specific needs. Health workers provided key messages about MNH during a minimum of three antenatal home visits and two postnatal visits.

Sure Start catalyzed sustainable improvement in maternal and newborn health (MNH) through effective community action in the urban slums of seven cities (Mumbai, Navi Mumbai, Pune, Nagpur, Nanded, Solapur, and Malegaon) in Maharashtra, covering a population of 1.6 million. In Maharashtra, besides the Common Minimum Programme that was implemented in all the intervention cities, the Sure Start project has worked on eight innovative models in maternal and newborn health in urban slums of seven cities (Nagpur has two innovative models – Emergency Health Fund and Prepaid Card). The project has partnered with NGOs, medical educational institutes, public health training institutes, and municipal corporations to operationalize the program strategies. These city-specific interventions in the areas of health financing, quality of care, volunteerism, convergence and public-private partnership had a positive impact on maternal and newborn health (MNH).

This document details each of the models adopted by Sure Start in Maharashtra and the interventions done in each city for improved maternal and newborn health outcomes.

For more information on Sure Start, please look up <http://www.path.org/projects/sure-start.php>

Contents

Sure Start: Saving lives of mothers and newborns in Maharashtra City-specific intervention models in Maharashtra	3
Sure Start in Solapur - The Volunteerism Model	4
Sure Start in Navi Mumbai - Public-Private Partnership Model	6
Sure Start in Malegaon - Quality of Care Model	8
Sure Start in Mumbai - Quality of Care Model	10
Sure Start in Nanded - Community-Based Health Insurance Model	12
Sure Start in Pune - The Convergence Model of Maternal and Newborn Health and HIV	14
Sure Start in Nagpur - Emergency Health Fund and Prepaid Card Models	16

Sure Start in Solapur The Volunteerism Model

Solapur city has a trilingual culture and poses great communication and cultural challenges in terms of awareness-raising around maternal and neonatal health (MNH). Along with dismal poverty, aggravated in part by the closures of many hand and power loom spinning units, and illiteracy, MNH behaviours were very poor, with most deliveries occurring at home. Recognizing these problems, an innovative model was developed to help improve care-seeking for MNH.

PATH along with its lead project partner HALO Medical Foundation (HMF) identified four local colleges of social work, arts, and commerce, along with the Solapur University Department of National Social Service, the municipal corporation, and individual experts to form a consortium to implement the PATH Sure Start project within a slum population of 200,000 in Solapur.



Sure Start:
Mobilizing Self Help Groups in Solapur for improved MNH

Model: Volunteerism

The Solapur model, based on 'building social capital through volunteers', concentrated on developing and motivating volunteers to build their MNH knowledge base and "adopt" pregnant mothers to ensure proper antenatal, postnatal, and newborn care. In Solapur, Sure Start project aimed at mobilizing the community through women's self-help groups (SHGs) and student volunteers to help shoulder women's responsibility for MNH. Volunteers and SHGs acted as change agents, and through their involvement in Common Minimum Programme activities, worked to improve women's MNH status. The primary role of the student volunteers and SHGs was to support project staff in campaign and event activities, as well as to conduct surveys and surveillance in the community.

Objective

- Develop and test a strategy of using volunteers to mobilize the multilingual communities of Solapur to increase uptake of MNH care.

Key processes

Identification and selection of volunteers

Invitations were sent to various colleges, Solapur University, and SHGs to volunteer for the programme. Over a period of four years (2007–2010), a total of 1,634 volunteers were trained in behaviour change communication (BCC). These volunteers provided support to 200 women's SHGs involved in the programme.

Capacity-building of volunteers

The volunteers were trained in MNH using interactive methods, including identification of antenatal care needs and evaluation of antenatal care by SHGs. The capacity of Auxiliary Nurse Midwives and Anganwadi Workers was built into MNH services in order to improve the quality of services.

Linkages with other stakeholders

Linkages were established with local ambulance companies to ensure subsidized transport for women to deliver in hospitals. Linkages and referral systems were established with the municipal corporation health department and Integrated Child Development Scheme for accessing hospital services through effective collaboration. In addition, the local cable television network was involved in disseminating information on the role of SHGs in health care.

Community mobilization; adoption of antenatal care

Identification of women for antenatal care was done by the volunteers, and the information was passed on to the local SHG and facilitator. Thereafter, the process of adoption was initiated. SHGs were tasked with following up with the women until 42 days after delivery. Each SHG was expected to provide support for 5 to 15 pregnant women. Trained SHGs imparted knowledge to the women using BCC on identification of danger signs during pregnancy and linked them with the health post and an Auxiliary Nurse Midwife.

Project monitoring

Monitoring of volunteer activities was conducted by project facilitators, subcoordinators, and the volunteer coordinator. The agency contracted by PATH to provide technical assistance—the Institute of Health Management, Pachod—also monitored the BCC inputs. Two methods were used for evaluation of the antenatal care support provided by SHGs:

- Assessment of SHG knowledge of the ten points of antenatal, postnatal, and newborn care.
- Assessment of feedback from the women as to their satisfaction with the services provided by the SHGs.

Achievements

- A network of 170 SHGs with knowledge on MNH care is now available in Solapur city.
- A total of 12,000 pregnant women were adopted during the project period.
- The volunteerism model was accepted by Solapur Municipal Corporation, and financial provision for the model has been provided.

Impact

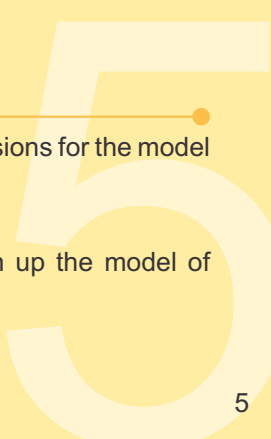
- Positive changes were observed in the attitudes of the volunteer students toward community welfare. Students were very satisfied with the technical knowledge they received from the project, including field experience and audio and video presentations.
- According to municipal staff, the project brought more community attention and response to MNH. It increased the level of awareness in the community and motivated people to provide voluntary services. Institutional deliveries also increased.
- All indicators for care during and after pregnancy, including breastfeeding practices, showed significant improvement because of the awareness generated by Sure Start.
- The model showed that volunteerism and use of local female workers can contribute immensely to improving behaviours around MNH. Female volunteers showed commitment, and women were satisfied with the services they received from the volunteers and the community.
- Good practices during pregnancy have significantly increased in Solapur.

Lessons learned

- Income generation is the primary focus of SHGs; therefore, introducing MNH care as a new task, including motivation and capacity-building, was a difficult undertaking.
- Initially, the student volunteers were more interested in the campaign than in conducting community visits (in addition to their academic work load). It was difficult for project staff to change their mindset.

Sustainability

- The project was handed over to Solapur Municipal Corporation, which agreed to adopt and make provisions for the model of SHGs adopting pregnant women.
- HMF has mobilized funds from other donors to sustain the Sure Start intervention.
- With the support of HMF, the Solapur University Department of National Social Service has taken up the model of involvement of female student volunteers in MNH.



Sure Start in Navi Mumbai Public-Private Partnership Model

Navi Mumbai is the world's largest planned city, at more than 162 square kilometres and with a population of more than 7 million (Census 2001). Ten percent of the total population is migrant and 20 percent reside in slums. Development resulting from establishment of new industries and additional infrastructure and new construction have given rise to increased migration to the city, and the municipal corporation has recognized the need for developing specific strategies to reach out to migrant populations. Good health infrastructure with adequate human resources was found to be inadequate to address key issues like demand generation, community mobilization, service utilization, and provision of high-quality care for maternal and newborn health (MNH). The PATH Sure Start project aimed to fill these gaps and cover all slums and low-income areas of the city.



Sure Start: Mobilizing community - based Organizations for improved MNH behaviour in Navi Mumbai

Model: Public-private partnership

PATH and Navi Mumbai Municipal Corporation (NMMC) conceptualized the city model to enable the private and public sectors to equally share the responsibility of managing public health in the city. Partnerships with organizations like the Social Advancement Through Health Initiative, Navi Mumbai Obstetric and Gynaecological Society, Indian Academy of Paediatrics, Indian Dietetic Association (IDA), Yog Vidya Niketan, and community-based organization (CBO) - Developing Initiatives for Social and Human Action (DISHA) were established to draw upon their respective expertise. The NMMC/Sure Start project initiative implemented the Common Minimum Programme (CMP) component in Navi Mumbai as with all city projects in Maharashtra. In addition to the CMP, the project undertook initiatives to improve the access and quality of health services. Interventions focused mainly on four levels: (1) household level: demand generation through behaviour change communication; (2) community level: outreach to antenatal/postnatal care clinics; (3) Urban Health Post level: specialist clinics for high-risk cases, interface with maternal and child health, and monthly yoga and nutrition clinics; and (4) maternal and child health hospital level: regular referral and use of protocol for newborn and obstetric care.

Objective

- Enable public-private partnership for improving and strengthening the quality of MNH services at the facility and outreach levels.
- Achieve nongovernmental organization (NGO) participation in community mobilization and supportive supervision for NMMC outreach of MNH services.

Key processes

Formation of a consortium

The PATH Sure Start project created a consortium of all the organizations working in health in the area as well as other professional bodies. Consortium members were involved in demand-creation activities, development of standard management protocols for services to ensure that the quality of MNH services provided by consortium members could be improved uniformly, and provision of comprehensive services to the community according to the standard protocols. A referral system was established so that Urban Health Posts could refer patients to maternal and child health hospitals. Formal and informal meetings and consultations were held with consortium members every three months to ensure that collaboration continued and strengthened; discussions related to demand and supply of services and other community issues.

Demand-creation activities

The project imparted training to link workers, CBOs, and consortium NGO field staff so that effective and coordinated demand-creation activities could be undertaken at the household and community levels. Community Health Workers at the Urban Health Posts supported, supervised, and coordinated with the link workers. Community-level information, education, and communication activities like street plays, puppet shows, and special events were organized, and meetings of pregnant women included instruction on how to care for newborns, to bring about necessary behavioural changes.

Strengthening MNH service quality

Standardized management protocols were developed for MNH services at all levels, and all partners involved in services were trained in the protocols to ensure provision of high-quality care to patients. The referral system and partnership with private facilities were built to improve accessibility of services.

Expansion of services

A consortium of private, voluntary, and public- and private-sector service facilities, including CBOs, was formed to increase demand for and access to services. Tertiary health facilities (First Referral Units) were strengthened, including MNH services such as antenatal care, examinations, treatment (including normal and Caesarean delivery facilities), and specialized services for newborn care (including incubators). Weekly antenatal care clinics were also set up at Urban Health Posts. Dietary counselling and monthly yoga clinics for antenatal care cases were conducted by experts at the health posts.

Achievements

- Twenty community groups were established and linked with NMMC.
- A total of 26,823 pregnant women were examined in 131 clinics. Subsequently, 2,728 high-risk cases were referred to specialist clinics in 20 health posts, which also managed care for 732 newborns.

Impact

- Partnership with all the facilities was established. This will have a long-term positive impact on accessibility of the services and demand-creation activities in the area.
- Development of and training on standard management protocols for all service levels was very useful for strengthening the quality of MNH services. NMMC will continue to orient the staff of all service units/facilities to ensure sustainability.
- Demand for MNH services has increased and so has the accessibility and utilization of available facilities. This has led to improvement in two indicators of increased care-seeking for MNH: the number of institutional deliveries and adequate birth weight.
- The project emphasized the importance of a good diet. Several tools like a diet chart, a flip chart, and a portable exhibition were developed for counselling at the Urban Health Post level. These tools continue to be used.

Lessons learned

- Community-level services and appropriate referrals can reduce the burden on secondary- and tertiary-level facilities, and improve the utilization of services.
- Partnership with the private sector can add value to public health services, which strengthens faith in public health facilities.
- Community groups are the key elements in community mobilization.

Sustainability

- Link workers, appointed by NMMC for every 3,000 population and trained on MNH by the Sure Start project, will continue to perform surveillance and behaviour change communication activities.
- New initiatives like outreach to antenatal/postnatal care clinics and the referral system have been institutionalized as systemic changes in the health department, and are being supported by NMMC.
- Other initiatives like the specialist and IDA clinics are continuing through Reproductive and Child Health Phase II funds provided by NMMC.
- Sure Start and NMMC have made efforts to link the CBOs with various government departments and programmes to sustain their momentum.

Sure Start in Malegaon Quality of Care Model

A considerable proportion (45 percent) of the population of Malegaon lives in slums which are predominantly Muslim. Female literacy is quite low, at about 35 percent for the city overall and lower in the slums. Poor housing, lack of adequate sanitation facilities, shortages of piped water, large family sizes, and unhealthy practices related to antenatal, postnatal, and newborn care and a high percentage of home births are some of the issues prevalent across the slums in Malegaon that were well analyzed before determining a maternal and child health (MNH) model specific for the area. It was observed that people were reluctant to access public health services, since they either perceived the services to be insufficient or deficient in quality, or health staff were reportedly rude to patients.



Sure Start: Developing Quality of Care Platform in Malegaon

Model: Quality of care

PATH Sure Start activities focused on demand generation, including specific focus in Malegaon on increasing utilization of the public health system by implementing client satisfaction norms and developing a quality of care platform, a common platform of the Malegaon Municipal Corporation where community representatives can discuss service provision-related issues.

PATH, along with Swaasthya, a Delhi-based nongovernmental organization (NGO) and the lead partner in Malegaon, targeted a population of 50,000, organized project slums into smaller units, and conducted unit behaviour change communication activities. A cluster group was established in each area. The cluster groups served as platforms for development and monitoring of client satisfaction norms in addition to forums for community members to discuss health service-related issues.

Objective

- Ensure better-quality services in public health facilities.
- Build the capacities of municipal corporation staff for high-quality MNH services and community mobilization.
- Develop mechanisms to facilitate a continuous dialogue between the community and service providers by institutionalizing client satisfaction norms.

Key processes

Development of client satisfaction norms

Quality of care standards were addressed from client perspectives. Client satisfaction norms (CSNs), developed in collaboration with Malegaon Municipal Corporation, were posted in two Urban Health Posts and two hospitals. Members of the cluster groups helped to ensure that the CSNs benefited the communities. Monitoring of CSN implementation included observation by project staff and feedback from the community through exit interviews on the services received, waiting time, staff behaviour, home visits, and group meetings.

Formation of a quality of care platform

The opinion leaders from the six cluster groups met regularly to discuss service delivery issues at municipal corporation facilities. At the city level, a quality of care forum was established, where all issues related to Urban Health Post services were discussed in detail. Members of the forum included representatives from the Integrated Child Development Scheme (ICDS), the Medical Officer of Health, health post staff, and Sure Start project staff.

Development of a community-based referral system

A referral system was developed wherein women were referred and tracked based on their accessibility to the services provided by the government. Referral token cards related to specific needs were given to pregnant women by Community Health Workers. Different-colour codes were used for each cluster to facilitate tracking of the mothers. A box was kept in each facility where these cards were dropped. The project team collected the cards and tracked the pregnant women according to the services they had received.

Achievements

- A total of 90 community members participated in meetings about the quality of care in two health posts, in partnership with Malegaon Municipal Corporation.
- A meaningful platform for accountability of public health services was created in the form of periodic meetings between providers and the community.
- A memorandum of understanding was signed with Malegaon Municipal Corporation, and the capacities of municipal corporation staff were enhanced through community mobilization (Auxiliary Nurse Midwives and link workers), resulting in effective delivery of MNH services.

Impact

- Demand-creation activities increased the demand for services from the public health system.
- Utilization of MNH services increased.
- Exit interviews suggested that the satisfaction levels of users increased over time.
- Several community-based groups were formed and became involved in MNH activities; they have continued activities.
- Care-seeking behaviour in Malegaon improved significantly, perhaps as a result of use of the referral tokens.
- ICDS became an active partner in MNH activities.
- The model helped coordinate the efforts of private-sector NGOs and medical facilities and public-sector health and ICDS departments for improving the coverage and quality of MNH services in the slum areas of Malegaon, demonstrating that such coordination could be successful and the accessibility of services could be improved.

Lessons learned

- The quality of services can be improved by community participation and monitoring.
- Common platforms for providers and the community help to resolve service-related issues.

Sustainability

- Malegaon Municipal Corporation plans to carry forward and scale up feasible Sure Start interventions throughout the entire corporation.
- The municipal corporation intends to propose Sure Start project intervention activities under the Reproductive and Child Health project implementation budget for the next plan year.
- The corporation is keen to carry forward the training modules and capacity-building tools with existing staff, covering all facilities through the Reproductive and Child Health budget.
- The cluster groups formed under the Sure Start project will be utilized for community mobilization activities of future programmes.

Sure Start in Mumbai Quality of Care Model

The PATH Sure Start project in Mumbai was implemented in collaboration with SNEHA (Society for the Natal Effects on Health in Adults), a lead partner in Mumbai city in the 'N' ward, covering parts of Ghatkopar and Vikroli, with a slum population of 200,000. Limited accessibility and poor treatment at public health facilities led to dependence on private health facilities. Inappropriate referrals led to increased workload for referral hospitals. And lack of decentralization led to crowding at the maternity hospitals, affecting the quality of care. In addition, lack of a good road from remote areas made transport at night in cases of emergency very difficult.



Sure Start's
Community Resource Centre in Ghatkopar, Mumbai

Model: Quality of care

In addition to behaviour change communication (BCC) and demand creation through home visits, the Mumbai Sure Start maternal and neonatal health (MNH) project focused on the quality of health care and its standardization in both the public and private sectors by introducing clinical protocols, establishing the referral system, and making information on health facilities available to the community through Community Resource Centres. The entire process for achieving high-quality care in the public health system was conducted jointly with the Municipal Corporation of Greater Mumbai (MCGM) by developing clinical protocols for all levels of the public health system. The project also facilitated establishment of antenatal/postnatal clinics at the Urban Health Post level. The quality of services was monitored through joint periodic meetings with Urban Health Post staff and exit interviews with clients/patients.

Objective

- Increase the availability, accessibility, appropriateness, and acceptability of public and private health services for pregnant women and newborns.
- Reduce maternal and neonatal mortality through appropriate and timely referrals.

Key processes

Preparation of protocols and referrals, and their use for accessible, high-quality services

Jointly with MCGM, clinical protocols were prepared for high-quality care at different levels of MNH services. Different facilities (public and private) were identified for their capabilities/capacities at the different levels. These facilities and the staff were oriented to the clinical protocols for necessary services. A referral system was created, keeping capacity of different service facilities in view. As a result, the workload of maternity hospitals was reduced and the quality of care improved.

Establishment of Community Resource Centres

Community Resource Centres were established for providing information on MNH care, vaccination, immunization, clinic hours, outpatient services in public hospitals, and availability of general practitioners in nearby areas. Centre staff/volunteers were trained within the context of programme implementation.

Establishment of antenatal and postnatal clinics

The PATH Sure Start project conducted training for health post staff to motivate them to establish antenatal/postnatal clinics. This was followed by training on clinical skills necessary for provision of services in the clinics. SNEHA and Sure Start ensured equipment availability and completion of documentation at the clinics.

Training and capacity-building

Trainings were carried out for Urban Health Post staff, targeted general practitioners, and Community Health Volunteers on aspects related to MNH services, including BCC. Auxiliary Nurse Midwives were trained on MNH care with a focus on regular check-ups and dietary requirements. Field staff were trained in BCC; counselling and communication; information, education, and communication; microplanning and participatory methods; breastfeeding; MNH basics; sexual and reproductive health; self-awareness; and precautions during pregnancy.

Coordination, communication, and linkages

Strong communication channels were set up between the project team, field staff, SNEHA management, and MCGM staff. The project established regional referral linkages and organized regular meetings for the regional referral system. Regular meetings were conducted between the referral hospitals to review monthly referrals, discuss issues and resolve them, analyze feedback and results, and maintain the communication network among the stakeholders.

Achievements

- Four Community Resource Centres were established through community participation.
- Antenatal/Postnatal care clinics were started at the Urban Health Post level, providing greater access to the community.
- Clinical protocols were accepted and implemented by the municipal facilities.

Impact

- Project inputs have yielded all-around conceptual clarity regarding MNH, including a more balanced perspective among providers and recipients.
- Community Resource Centres have become a resource in the truest sense. Pregnant women and their families visit the centres for all their information needs.
- Maternity home staff greatly appreciated the training they received on neonatal resuscitation and the Partogram.
- Significantly higher numbers of women are receiving antenatal services, including weight, blood pressure, and urine and blood checks. Reports from health workers of complications and good practices during pregnancy, like additional food, more rest, and contact during the third trimester, have greatly increased.

Lessons learned

- A community-based information centre helps to provide appropriate and timely access to services.
- Motivational training for health staff using the Appreciative Inquiry technique improves responsiveness and quality of services.

Sustainability

- All the facilities, including those in the public sector, have adjusted to the referral system developed by the project. Coordination has been built into facilities with different levels of MNH care services. This system of referrals and acceptance of referred patients by hospitals will continue beyond the project period.
- Several innovative systems were introduced, such as Community Resource Centres, clinic protocols for MNH services at different levels, and the referral system, that will continue to improve the MNH status of the community.
- Through the efforts of the Sure Start project and Community Resource Centre volunteers, the rate of access to the centres has tremendously increased.
- The centres can be used for other developmental programmes.

Sure Start in Nanded Community-Based Health Insurance Model

The border district of Nanded has a huge inflow of migrants from both Andhra Pradesh and Karnataka states. These are mostly unskilled labourers and daily wage earners (belonging to the unorganized sector, which is not covered by social security or insurance benefits). Nanded is a relatively new municipal corporation and has limited, inadequate, and overcrowded public health facilities. This results in lower utilization of maternal and neonatal health (MNH) services, especially during the antenatal period, further exacerbated by the poor economic situation, which results in a greater number of home deliveries than facility deliveries.



**Sure Start: Happy Beneficiaries of
Community-based health insurance scheme in Nanded**

Model: Community-based health insurance

Within this context, Shree Samarth Shikshan Prasarak Mandal (SSSPM) introduced the PATH Sure Start community-based health insurance (CBHI) model in the slums of Nanded city to provide more affordable, high-quality health care for 50,000 slum dwellers, and in turn, improve their care-seeking behaviours around MNH and encourage institutional deliveries.

The CBHI model—Apni Sehat Scheme—was launched in early 2008 and aimed to increase institutional deliveries, reduce MNH out-of-pocket expenses, and improve access to high-quality health care. The insurance programme started with a yearly premium of Rs. 450 (approximately US\$9) per family, covering antenatal check-ups, all hospitalization, including maternity and newborn care, limited transport, and treatment of illnesses, excluding outpatient expenses. Implementation by a community-based organization (CBO)—“*Refai Falai Anjuman*” and “*Indira Gandhi Mahila Sevabhavi Gat*”—created ownership among community members and empowered them in CBHI management.

Objective

- Introduce CBHI for MNH care within a target slum population of Nanded city.

Key processes

Needs assessment and design of the CBHI programme

SSSPM contracted with the Institute of Public Health (IPH), Bangalore, to provide technical assistance in the design of the CBHI programme. (IPH’s role was defined in consultation with PATH.) To understand community needs with regard to health insurance, meetings were conducted with community members to determine their socioeconomic status, behaviour toward MNH care, the health facilities available for MNH care, the cost of care, and facility utilization by the target group. The survey revealed that people were meeting their MHN care expenses by taking out loans from money lenders (at 2-3 percent interest per month); making adjustments in household expenses such as electricity, rent, school fees, and savings; selling assets like jewellery; etc. This clearly revealed a need for alternative financing for health care. Findings from this assessment and a health financing survey were used to design CBHI to meet community needs.

Creating mechanisms for implementing the programme

An implementation strategy for CBHI was prepared by IPH and the role of each stakeholder was clearly defined. SSSPM, the CBO, and service providers were oriented on their roles and responsibilities. A claims review and processing committee was formed, comprising the CBO and SSSPM.

Addressing the capacity-building needs of stakeholders

Stakeholder capacity-building was conducted by PATH and IPH using a two-fold strategy of formal workshops and on-the-job training, with a focus on social marketing, claims processing and settlement, and recordkeeping.

Formation of a service provider network

A service provider network was formed to establish the treatment to be covered by CBHI. Rates were negotiated with private service providers from the network. The CBO and SSSPM conducted joint visits to monitor the quality of services. SSSPM appointed service executives to facilitate patient admissions and discharges.

Project monitoring

Monthly stakeholder meetings were held to ensure progress on the implementation plan and to ensure continued enrolment of clients in CBHI. A management information system was developed and reviewed by SSSPM and PATH.

Achievements

- The CBHI programme reached 30,000 people residing predominantly in Muslim pockets of Nanded.
- CBHI benefited 664 families and 161 mothers and newborns.
- According to our data, institutional deliveries increased to 90 percent in 2011, compared to 60 to 70 percent in 2008. Antenatal care check-ups also substantially increased.

Impact

- Link workers appreciated the capacity-building training they received from the PATH Sure Start project, which will have a long-term positive impact on the activities of Urban Health Posts.
- The project sensitized community leaders and members about the importance of antenatal and postnatal care and institutional deliveries.
- There was a sharp increase in good practices, like extra food, rest, and contact during the last trimester of pregnancy.
- Several influential people, such as Maulanas (Muslim religious leaders), were involved in the project to advocate for CBHI and use of MNH services. This proved an efficient way to spread the word and gain support for CBHI and utilization of MNH services.

Lessons learned

- Community-based financing proved very helpful to families accessing MNH services.
- Setting up any community-based financing programme requires initial administration and technical support.
- Premiums for the poorest of the poor families need to be subsidized by an external agency.

Sustainability

- The project focused on developing a community-based health financing mechanism and strengthened existing community-based systems with the help of the CBO. The community will benefit from financial assistance with accessing MNH services.
- A city-level task force formed during the project period (comprised of government officials, the CBO, and nongovernmental organizations [NGOs]) continues to provide inputs to local CBOs/NGOs and to advocate for MNH care.
- The project built the capacities of frontline health care workers who remain available to provide community-level MNH support.

Sure Start in Pune The Convergence Model of Maternal and Newborn Health and HIV

In Pune, 43 percent of the population lives in 503 designated slum communities. Access to health care services by women and children in the slum areas is low, and the cost of care is relatively high compared to income levels. There are very few mechanisms for linkages between the public and private health services and slum dwellers, further reducing efficient and affordable access to maternal and newborn health (MNH) care.

Project Concern International (PCI) works in the city, mainly in the areas of HIV/AIDS, maternal and child health, disease prevention, water and sanitation, capacity-building, institutional strengthening, and livelihoods enhancement. Building on the wide spectrum of social programmes addressed by PCI, it was thought that convergence of the HIV and MNH “themes” would contribute significantly to the improvement of MNH status in the city. PCI along with PATH, implemented the Sure Start project through four consortium members: Sewadham Trust, the Snehdeep Foundation, the Deep Griha Society, and Bahujan Hitaya, to cover a slum population of 500,000.



Sure Start in Pune:
HIV Counselling Centre

Model: Convergence of maternal and newborn health and HIV

Sure Start focused on reducing maternal and newborn mortality rates and HIV among pregnant women—which leads to increased maternal and child morbidity—including the additional health care needs of HIV-positive pregnant women. A strategy was adopted to efficiently utilize resources available among different projects for the benefit of project management and the beneficiaries. The aim was to bring maximum interventions to the beneficiaries through the utilization of a common implementation mechanism. The convergence of resources available among different projects resulted in an increased number of individuals reached by the project with increased interventions and inputs.

Objective

- Raise awareness of HIV among pregnant women and motivate them to undergo HIV testing.
- Test the feasibility of convergence of HIV/AIDS and MNH for synergy in impact.

Key processes

Development of mechanisms to implement convergence

Consultations were conducted with various stakeholders and a mechanism for coordination was developed for coordination between the Sure Start and PCI teams. Overlapping project areas were identified and a joint implementation strategy was carried out through sharing of resources. Networking with available public and private health care services for MNH and HIV was conducted, and local Anganwadi Workers and voluntary counselling and testing counsellors in Monitoring of Maternal and Newborn Status (MOMS) committees were also involved for regular monitoring and follow-up in the community.

Capacity-building

Sure Start project staff were trained in HIV/AIDS by PCI, other consortium members, and with the help of nongovernmental organization PRAYAS. Training covered all aspects of the risks of HIV/AIDS, with emphasis on prevention of mother-to-child

transmission of HIV (PMTCT) and HIV testing during the antenatal period. PATHWAY (PCI’s home-based HIV care project) staff were also trained on MNH. Capacity-building programmes for members of MOMS committees, on health rights, HIV, PMTCT, and home-based care of HIV patients, were developed and implemented.

Implementation and review

Regular joint coordination meetings were held between the PATHWAY and Sure Start teams to monitor the quality of implementation and follow-up. The meetings provided information about pregnant women wanting to undergo testing, and efforts were made by Sure Start staff to equip these women and their families to seek appropriate MNH and HIV care, if required, including home-based care. Coordination was built between field workers so that intensive behaviour change communication (BCC) activities could be undertaken. Linkages were established between public and private service facilities so that women could be referred for necessary services.

Achievements

- A total of 52 MOMS committees are currently functioning in the project area to provide support for mothers, including H I V positive mothers.
- MOMS committee federations have been established, providing supportive supervision of the committees and establishing linkages with public health facilities.

Impact

- Integration of the staff of two programmes led to a large number of workers/stakeholders working intensively in BCC activities by visiting the homes of pregnant women. These activities led to increased awareness around MNH and HIV.
- Increased utilization of MNH services led to an increase in institutional deliveries, and thus, a decrease in the morbidity and mortality rates of mothers and children.
- Use of antenatal and postnatal services significantly increased.
- Coordination was built among the field workers, which helped them to motivate the women, demonstrating the importance of convergence around the BCC activities of all social programmes.
- The model demonstrated the important role of community-based organizations (CBOs) (MOMS committees, in this case) in creating awareness and expanding knowledge. CBOs should be motivated and then carefully monitored to become involved in social programmes, as they are instrumental in creating awareness in the community.

Lessons learned

- Well-defined data-sharing mechanisms between the project and public health facilities are required for convergence.
- It is difficult to track HIV-positive women in the community to provide support because of confidentiality.

Sustainability

- Relying on capacity-building of community members, linkages were established by community-based structures with public facilities. The health workers of Sure Start and PATHWAY are members of the community and have built their capacity around MNH and HIV, which will remain with the community.
- The MOMS committees are expected to take forward the MNH agenda. Committee members have been undergoing phased empowerment in terms of technical capacity-building on MNH and HIV. A federation of MOMS committees has been established for collective action on health issues.
- MOMS committees have been involved in dialogue with health facilities through regular meetings and have been raising community concerns and problems with the officials. Linkages of these committees have been established with many organizations that provide support to people living with HIV/AIDS.

Sure Start in Nagpur

Emergency Health Fund and Prepaid Card Models

Nagpur experiences considerable migration from neighbouring states, although the growth rate declined over the past decade. The current population of Nagpur city is around 2.1 million, of which the slum population is roughly 36 percent, housed in 427 slum pockets. In the remote areas near Nagpur, there is no outreach of health services. Access to medical care is limited, especially during the rainy season, with some slum pockets even physically inaccessible during the rains. People have to travel around 9-10 km in a rented private vehicle or auto rickshaw to reach a health care facility for medical care. Access to public facilities for maternal and neonatal health (MNH) care involves high expenditures for transportation, services, medicines, and user charges. Fifty percent of slum dwellers fall below the poverty line and cannot afford these expenditures, so they deliver at home or delay treatment, which can result in maternal and neonatal complications.



Sure Start:
Emergency Health Fund meeting in progress in Nagpur

Model: Emergency Health Fund and prepaid card

The PATH Sure Start project initiated two financing models in Nagpur—an Emergency Health Fund (EHF) and a prepaid card—to provide support for MNH among the city's slum population. Amhi Amchya Arogya Sathi (AAAS), along with two consortium members—Mure Memorial Hospital and the Indian Social Service Unit of Education—implemented the project to reach a slum population of 150,000.

Objective

- Develop a sustainable financing mechanism for improvement of health among mothers and newborns by creating an “Emergency Health Fund”.
- Provide quality MNH services at affordable rates by introducing a “prepaid card system”.

Emergency Health Fund structure

A total of 97 EHF groups were formed as part of the project. EHF groups are comprised of women who save and lend money for the emergency health needs of community members. The basic motive behind the formation of the EHF was to develop a long-term, structured financing mechanism for health emergencies of mothers and newborns at the slum level. EHF members were trained on savings and loan and recordkeeping procedures.

Each EHF consists of 10 to 20 women from self-help groups (SHGs) or non-SHGs. Each EHF has an elected officer whose role it is to manage and supervise the group.

- The initial membership fee is Rs. 15.
- Members save Rs. 45 to 50 every month.
- Each EHF has a joint bank account.
- EHF review is conducted during monthly meetings.

Key processes

Situation analysis

A detailed survey was conducted in 2008 to understand the existing status, function, and lending processes of various SHGs in the slums of Nagpur. From the survey, a list of SHGs was prepared by all three consortium partners. Several meetings were held in the project area to discuss the EHF concept.

Capacity-building of EHF groups

The Chalana Network is a state-level network of SHG trainers who provide capacity-building of SHGs in various regions. The network was instrumental in the formation of EHF groups in Nagpur by developing guidelines for implementation in early 2008 and building the capacities of officers of the Sure Start project to motivate SHGs to form EHF groups.

Establishment of EHF groups

EHF groups are groups of motivated women who came together with the intention of saving regularly to provide health-related loans. Lead partner AAAS conducted meetings with each group, during which EHF guidelines were provided. However, decision-making power remained in the hands of each group, which determined their own norms after mutual consultation, facilitated by lead partner staff.

Project monitoring

Field-level monitoring was conducted by Arogya Workers (Community Health Workers), who met with EHF members every month during review meetings and monitored their activities. Community Health Organizers attended EHF meetings every two months, and the EHF coordinator attended every four months. A monthly reporting format was established to maintain a management information system.

PATH Sure Start introduced the *Arogya Suraksha Card* (prepaid card) with a view to provide poor families with affordable health care, with an emphasis on MNH services. Mure Memorial Hospital a 165-bed, multi-speciality hospital centrally located in Nagpur and easily accessible to the target slum population, provides MNH services to families who have purchased the prepaid card for an annual fee of Rs. 10.

The *Arogya Suraksha Card* provides:

- 20 percent discount on antenatal care check-ups.
- 20 percent discount on normal delivery.
- 20 percent discount on hospitalization of a child less than one year of age.
- 10 percent discount on hospitalization of any family member.
- 50 percent discount on outpatient care for all family members.

Key processes

Kickoff meeting with Mure Memorial Hospital

Lead partner AAAS organized a meeting with Mure Memorial Hospital authorities. The purpose of the meeting was to explore the feasibility of implementation of the prepaid card for MNH care.

Needs assessment

Three hundred families were interviewed for a needs assessment to understand service utilization, expenditure patterns, willingness to participate, and expectations of the hospital. AAAS also conducted group meetings with community members. The key finding of the assessment was that 78 percent of the families interviewed had borrowed money from an SHG or relatives when there were illness episodes in the family.

Package development

The benefits package was developed based on the results of the needs assessment. A health financing expert from the Institute of Public Health provided input as well. The work was completed in joint consultation with Mure Memorial Hospital and AAAS.

Social marketing and enrolment

Mure Memorial Hospital engaged in social marketing through one-on-one contact with families and community meetings. During home visits, Community Health Organizers and Community Health Workers also conducted social marketing and enrolment.

Project monitoring

Monthly meetings were organized among Arogya Workers. Bi-annual meetings were organized among members of Mure Memorial hospital and Sure Start with support from PATH. These meetings were held to enhance coordination between the hospital and Sure Start workers.

Achievements

- 97 EHF's are functioning and have helped 1,160 families, including 127 mothers and newborns.
- EHF's have joined together and formed federations for collective action on MNH.
- A total of 800 families have purchased the prepaid card.

Impact

- Poor people who had been exploited by local money lenders have started taking loans from EHF's. This has not only allowed them to be independent, it has also provided security in the case of health problems.
- Most antenatal care indicators have improved and the percentage of women experiencing complications during pregnancy has declined; greater awareness has led to increased reporting of the complications.
- An Arogya Sakhi (a female Arogya Worker) became a friend of the women in the community and they developed faith in her. This led to an increase in the number of women taking part in social activities. Thus, the EHF's brought women to a common platform and built a bond among them.
- The security provided by the EHF's was accepted by the community, particularly by its more vulnerable members. They have deposited monthly instalments, taken loans, and returned them, mostly in time.

Lessons learned

- The initial plan was to bring together two to five SHGs to form an EHF. This was not possible, however, due to the heterogeneous nature of the communities among Nagpur's slum population and a lack of trust among the various SHGs.
- SHG members are from marginal families; hence, it was difficult for them to save money for health care, and they were not able to meet the needs of their members. Therefore, Sure Start provided seed money to support start-up of each EHF after assessing its capacity and motivation.
- Hospitals have to implement community-based preventive health care for implementation of programmes like the prepaid card system.

Sustainability

- Federations of EHF's have been created to link EHF's with suitable government programmes, insurance agencies, and charitable hospitals. All 97 EHF's have been organized into three federations, governed by a common body, to oversee the functioning of the member EHF's and provide guidance and support.
- The Arogya Sakhi residing in the project area helps to support the day-to-day functioning of the EHF's.
- Mure Memorial Hospital plans to continue use of the Arogya Suraksha Card system. Thus, this concept developed by the Sure Start project will continue to be operational.

