National Consultation on "Potential Role of Private Sector Providers in Delivering Essential Newborn Care in under-servied urban and peri-urban settings"

BOOK OF PROCEEDINGS

28 - 29 AUGUST 2012

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ACRONYMS

AARR	Average Annual Rate Reduction
AIIMS	All India Institute of Medical Sciences
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Angan Wadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
BCC	Behaviour Change Communication
BMGF	Bill and Melinda Gates Foundation
BPL	Below Poverty Line
CBHI	Community Based Health Insurance
CCSP	Comprehensive Child Survival Programme
CHC	Community Health Center
CII	Confederation of Indian Industries
CINH	Community Initiative for Newborn Health
CMP	Common Minimum Programme
CPMU	Corporation Project Management Unit
CPR	Couple Protection Rate
CSR	Corporate Social Responsibility
DHS	Directorate of Health Services
DLHS	District Level Health Survey
DoHFW	Department of Health and Family Welfare
DQAC	District Quality Assurance Committee
EBF	Exclusive Breast Feeding
EHF	Emergency Health Fund
ENC	Essential Newborn Care
ESIC	Employees State Insurance Corporation
FGD	Focus Group Discussion
FICCI	Federation of Indian Chambers of Commerce and Industry
FOGSI	Federation of Obstetrics and Gynecological Societies of India
FRU	First Referral Unit
GDP	Gross Domestic Product
GoI	Government of India
GoUP	Government of Uttar Pradesh
HBNC	Home Based Newborn Care

IAP	Indian Academy of Pediatrics
ICDS	Integrated Child Development Services
ICMR	Indian Council for Medical Research
IEC	Information Education and Communication
IFA	Iron and Folic Acid
IMA	Indian Medical Association
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
IT	Information Technology
IUD	Intra Uterine Device
IUGR	Intra Uterine Growth Retardation
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KGMC	King George Medical College
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
M&E	Monitoring and Evaluation
MCGM	Municipal Corporation of Greater Mumbai
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIS	Management Information Systems
MMR	Maternal Mortality Ratio
MNCHN	Maternal Newborn Child Health and Nutrition
MNH	Maternal and Newborn Health
MoHFW	Ministry of Health and Family Welfare
NBCC	New Born Care Corner
NBSU	New Born Stabilization Unit
NGO	Non-Governmental Organization
NICU	Neonatal Intensive Care Unit
NMMC	Navi Mumbai Municipal Corporation
NMR	Neonatal Mortality Rate
NNF	National Neonatology Forum
NPSP	National Polio Surveillance Programme
NRC	Nutrition Rehabilitation Center
NRHM	National Rural Health Mission

NSS	National Service Scheme
NSSK	Navjaat Shishu Suraksha Karyakram
NUHM	National Urban Health Mission
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Solution
PHC	Primary Health Center
PIP	Project Implementation Plan
PNC	Post-Natal Care
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RCT	Randomized Control Trial
RIMS	Real-time Institution Management System
RSBY	Rashtriya Sewa BimaYojana
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SCF	Save the Children Fund
SHG	Self Help Group
SNCU	Special Newborn Care Unit
SNL	Saving Newborn Lives
SQAC	State Quality Assurance Committees
SRS	Sample Registration System
STD	Sexually Transmitted Diseases
TBA	Trained Birth Attendant
TFR	Total Fertility Rate
TT	Tetanus Toxoid
U5MR	Under-5 Mortality Rate
UCD	Urban Community Development
UHC	Urban Health Center
UHI	Urban Health Initiative
UNICEF	United Nations Children's Fund
UPMSU	Urban Programme Management Support Unit
USHA	Urban Social Health Activist
UT	Union Territory
WCD	Women and Child Development
WHO	World Health Organization

PREFACE

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Preface

Over the decades India has moved towards a declining trend in Infant Mortality Rate. Despite this progress, the decline in Newborn Mortality Rate has shown significant signs of slowness and stagnation. NMR in India contributes to about two-thirds of all infant deaths and about half of under-5 deaths in the country. There has been a continuous dialogue about implementing incessant efforts to reduce the NMR, especially reduction of deaths within the first one week of life.

The National Rural Health Mission (NRHM) being implemented throughout the country seeks to provide accessible, affordable and quality health care services to rural population, especially the vulnerable sections. The NRHM operates as an omnibus broadband programme by integrating all vertical health programmes of the Department of Health and Family Welfare including Reproductive & Child Health Programme and various diseases control Programmes. The NRHM has emerged as a major financing and health sector reform strategy to strengthen States Health systems. Establishing a similar programme for the urban poor is the need of the day.

In the wake of increasing migration and growing urbanization, Government of Uttar Pradesh together with Save the Children (Saving Newborn Lives) and UNICEF focused on strategizing a continuum of care approach with an engagement of various stakeholders including the private sector for the urban poor. A national level consultation was the chosen modus operandi and was held in Lucknow on 28th and 29th of August 2012.

The Government of UP is pleased to present this report of "National consultation on the potential role of private sector providers in delivering essential newborn care in under-served urban and peri-urban settings". This consultation is the first in a series, a milestone that will play an instrumental role in developing necessary policy level mechanisms for urban health.

We look forward to a sustained and effective collaboration with bilateral, multilateral, private, non-governmental and other governmental partners in reducing the NMR and improving the urban health in the state of UP.

mukesh

Mr. Mukesh Kumar Meshram,
Mission Director, National Rural Health Mission,
Ministry of Health and Family Welfare,
Government of Uttar Pradesh, India

A NOTE FROM SAVE THE CHILDREN, INDIA

The changing demographics of India are rapidly influencing the health care requirements in the emerging urban scenario of the country. Immense efforts are being made in India under the National Rural Health Mission (NRHM) to address the issues of health care management and operations, capacity building and training of human resources, infrastructure, financial accessibility and quality of care primarily in rural areas. Amongst all of these, provision of and accessibility to both public and private care still remains a matter of concern for the urban poor.

The other area of concern vis-à-vis all of the abovementioned factors is the mortality rates among the mothers and under five children. Though, India has made progress with regard to both MMR, IMR and U5MR, the NMR continues to remain high. India bears the burden of contributing to 30% of the total neonatal deaths globally. The challenge of reducing NMR is no more restricted to the remote rural pockets of the country, but is equally difficult to manage in the poorer and inaccessible pockets of urban areas.

The rising needs of the urban poor settings pose a question with regard to the service provision in an unclear and unstructured health care scenario. The challenges demand an exploration of new mechanisms, partnerships and arrangements that responds to health care needs of the urban poor. The Government of Uttar Pradesh (Ministry of Health and Family Welfare) and UNICEF in partnership with Save the Children and Saving Newborn Lives led a national level consultation titled 'Role of Private Sector Providers in Newborn Care in Under serviced Urban and Peri-urban Setting' that highlighted these challenges and developed a road map which provides a scope for participation of various stake holders in the state so as to take forward the recommendations at the policy and programmatic level.

The consultation comprised of national champions of evidence, programmes and policy with regards to newborn care for the urban poor. The involvement of medical colleges, academic institutions, NGOs, Governments, Civil Society Organizations, donors etc. generated enthusiastic discussions through sharing of experiences and developed clear outcomes and recommendations that have already been presented to Government of Uttar Pradesh (GoUP). The Mission Director (MD), NRHM and IT advisor to the Chief Minister of UP shared their views in the consultation and are keen to take forward the agenda of newborn care in urban and peri-urban areas of the state.

It is significant to note that the recommendations have pertinently focused on developing a state and city level Governance Structures for Urban Health. The city initiatives and innovations in Uttar Pradesh, Maharashtra and Gujarat have definitely brought forth the evidences of effectiveness of BCC, KMC and other innovative strategies. It is important to note that the policy and programmatic recommendations will go a long way in ensuring the involvement of private sector providers and building a meaningful public-private partnership to improve the newborn health in urban areas.

I would like to extend my heartfelt thanks to Mr. Mukesh Kumar Meshram, Mission Director NRHM, GoUP; Mr. Amod Kumar, IT Advisor to the Chief Minister of UP; Ms. Adel Khudr, UP State Representative, UNICEF; Dr. Sanjay Pandey, Health & Nutrition Advisor, UNICEF UP; Dr. Hari Om Dixit, General Manager (Child Health), GoUP; Professor Vinod Paul, AIIMS; Professor Shashi Vani, P.S. Medical College, Gujarat; Dr. Vikas Kishor Desai, Former Director (RCH) & Add. Director (FW),

Govt. of Gujarat; Dr. Gita Pillai, UHI-USAID; Dr. Devendra Khandait, BMGF; Dr. Wasundhara Joshi, SNEHA, and all the other speakers and delegates. I also take the opportunity to extend my thanks to Dr. Rajesh Khanna, Kavita Ayyagari, Rajat Dawar, Dr. Laxmikant Palo, Pravin Sharma, Dr. Kumkum Srivastava, Nikita Arora and Dr. Benazir Patil for contributing in the preparations for this consultation.

The present book of proceedings captures all the processes followed during the consultation and reflects the way forward for the established partnership with the Government of UP.

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ACCEPTANCE OF RECOMMENDATIONS BY GoUP (Email)

From: Hariom Dixit [mailto:harishyam_9@yahoo.com]
Sent: Monday, September 17, 2012 4:08 PM
To: Rajiv Tandon
Subject: Re: Prefaces for the report

Dear Dr. Tandon

Pl. fined attached Preface letter signed by Mission Director.

This is to bring in your notice that in response to the recommendation provided by group during National Consultation meeting on "Potential role of Private Sector Providers in delivering Essential Newborn Care in under serviced urban and peri-urban setting", held on 28-29 August 2012, recommendation are being shared to D.G. Family Welfare and D.G. Medical Health for their comment and formation of committee for further action at the level of Govt.

Dr.Hariom Dixit
General Manager Child Health
MoHFW
GoUP

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

One-third of India's urban population resides in slums, their vulnerability being characterized by poverty, marginalization and powerlessness. Neonates born in urban poor settings are at high risk of death owing to multitudinous factors. Newborn care is sub-optimal amongst the urban poor in the country, yet scarcely documented. Challenges in addressing the needs of the newborns in urban poor settings exist not only at community level, but also at policy and programme levels. These challenges need to be addressed simultaneously without any further delay.

The Government of Uttar Pradesh (Ministry of Health and Family Welfare) and UNICEF in partnership with Save the Children and Saving Newborn Lives led a national level consultation titled 'Role of Private Sector Providers in Newborn Care in Under serviced Urban and Peri-urban Setting'. The two day event was organized in Lucknow, the state capital of Uttar Pradesh (UP) on 28-29 August 2012, and aimed to strategize the delivery of newborn care services for urban poor within the continuum of care approach and discuss the potential role of private sector providers in delivering newborn care in these settings.

The consultation was attended by a wide range of stakeholders which included experts from academic institutions, state and national governments, civil society organizations, donor partners, research institutes and professional bodies. Existing opportunities and lessons from successful experiences were shared, and discussions held in an open and participatory manner to explore opportunities for improving newborn care in urban and peri-urban settings. The consultation concluded with a set of recommendations (for policy, programme and research) which are given below:

Policy and Programmatic recommendations

An 'Urban Health Policy' for the state of UP and Operational Guidelines for its implementation within the existing State Health Policy should be developed. Key areas that need to be focused in this Urban Health Policy are:

- Separate governance structures and regulatory mechanisms for the Urban Health Programme
- Convergent action involving the corporate, public and private sector
- Setting up a Health Partners' Forum for effective convergence
- Development of comprehensive lead programmes through partnership with academic, professional agencies, Non-GovernmentalOrganizations (NGOs), socially committed private doctors, hospitals and city governments.
- Strengthening of the Integrated Child Development Services (ICDS) in urban areas
- Enhancing the competence of slum-based Trained Birth Attendants (TBAs) to improve home delivery practices and encourage hospital deliveries by linking them to affordable facilities
- Home based newborn care through the appointment of ASHA-like community link worker (USHA)
- Improving demand, household practices and service outreach through Behaviour Change Communication (BCC) strategies and using slum-based health volunteers and women groups
- Universal health insurance which is cashless, without any intermediaries

- Establishing slum-level health funds as a community risk pooling mechanism
- Medical Colleges as mentors for health facilities in urban areas
- Establish additional nursing and medical colleges
- Creating a Centre of Excellence for Urban Health Research and Innovations

Research recommendations

- Conduct review of literature to identify urban healthcare models in India, and evidence of their effectiveness in improving accessibility, availability, afford ability and quality of MNH with emphasis on essential newborn care. This would help in identifying best practices & evidence gaps, and assess the strengths and weaknesses of models.
- Formative research at individual and community level since the other two levels (policy and organization) would be covered while developing the urban policy:
- At individual level: research on existing knowledge and household practices regarding ENC, its relationship with socio-demographic characteristics of population, people's perceptions about pregnancy, newborn care, and health facilities/providers, out-of-pocket expenditure made during pregnancy.
- At community level: presence of community networks/groups and their potential for supporting ENC, identification of influential stakeholders and social support networks within the community (for health, education and economic problems), barriers to accessing services/ENC from both demand and supply side.
- Other potential areas of research (can be operational /translational/others)
- Mechanisms to promote demand for institutional delivery and ENC (financial and non-financial incentives, social marketing strategy or IEC/BCC campaigns)
- Use of eHealth and mHealth for improving quality of health services
- Community based trial of Kangaroo Mother Care
- Models for supportive supervision of front line health workers

The recommendations were submitted to the GoUP and accepted by them in principle with an agreement to take them forward within the state's health system and work towards improving newborn care among the urban poor. However one aspect which remained unclear was the potential role private sector providers could play in delivering health services for the urban poor newborn. This needs to be followed-up.

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INTRODUCTION

INTRODUCTION

Background

India contributes to around 30% of the global neonatal mortality burden. Of the 26 million babies born every year in India, about 1 million die before the age of one month. According to the Sample Registration System (SRS) 2010 report, neonatal mortality contributes to more than two-thirds of all infant deaths (NMR 33/1000 live births, IMR 47/1000 live births) and more than half of under-five deaths in the country (U-5MR 59 /1000). Though IMR has shown a steady decline over the last few years (from 58/1000 in 2004 to 47 /1000 in 2010), the decline in NMR has been disproportionately slow (from 37/1000 in 2004 to 33 /1000 in 2010).

There is a growing recognition that in order to reduce the infant and under five mortality rates in the country, a significant decline in neonatal mortality is required, especially during the early neonatal period. Under the Janani Suraksha Yojana (JSY) scheme of the National Rural Health Mission (NRHM), there has been a significant increase in institutional deliveries. In addition, the Integrated Management of Neonatal and Childhood Illness (IMNCI) and the Home Based Newborn Care (HBNC) programmes have been operationalized resulting in an increasing number of sick newborns presenting to district hospitals and other referral hospitals. The Government has also established Facility Based Newborn Care (FBNC) services at different levels of health facilities to provide essential new born care and care of the sick newborns, but these services have been found to be lacking within the continuum of care especially at the household level where many deliveries are still taking place.

With rapid increase in migration and urbanization, nearly half of the country's population is expected to reside in urban areas by the year 2030. There is an immediate need to look into the health issues of the urban population apart from the infrastructure issues. This is especially true for the urban poor since they are more vulnerable and worse-off than the rest of urban population, and even to the rural population for many indicators. Despite being 'considered' close to the public health facilities, their access to health is severely restricted due to a number of factors – inadequate infrastructure in urban slums, overcrowded facilities, lack of information about hospitals and services available, ineffective outreach processes, weak referral system, etc.

Re-analysis of the NFHS III data confirms the worse-off health status of the urban poor. The proportion of women aged 20-24 years who became mothers before age 18 was more than twice the overall urban average (25.9% vs. 12.3%) and similar to the rural average of 26.6%, while mothers receiving complete ANC visits was only 11% compared to overall urban average of 23.7%. More than half (56%) of deliveries among urban poor take place at home compared to the urban average of 32.6%. All the childhood mortality indicators among urban poor are higher compared to the urban averages – 72.7 vs. 51.9 for the U5MR, 54.6 vs. 41.7 for the IMR, and 36.8 vs. 28.7 for the NMR. Some of the childhood indicators among urban poor are worse off than the corresponding rural indicators and these include the proportion of children who did not receive complete immunization (60% vs. 58%) and the percentage of under-3 children who are underweight (47% vs. 45%).

In case of service delivery in the urban areas there is lack of clarity regarding ultimate responsibility of providing health services unlike the rural areas where the district administration is responsible for

service provision. In addition, lack of demonstrated political will to assume responsibility and accountability for urban services as well as absence of interdepartmental coordination between the Departments of Public Health, Urban Development, Medical Education, the Municipal Corporations and the local bodies have further made matters worse.

There is evidence that past programmes and approaches are not achieving the desired objectives and need refinement. Improving newborn care needs new ideas and new partnerships to ensure that the current opportunities are not wasted. One such initiative could be partnership with the private sector since they provide a large volume of health services in India, especially for the urban population including urban poor. The partnership can be explored to strengthen efforts for improving care seeking behaviour, utilization of low cost affordable health solutions, and ensuring increased access by the community. Collaboration with private providers with adequate skills can be engaged for franchising models to deliver health services. These include motives of the provider, scope and objectives of the partnership, policy and legal frameworks, techno-managerial capacity of governments and private agencies, incentives for private providers, stakeholder perspectives and explicit benefits to the poor. Though there has been continued assumption on private sector not being regulated and checked for its quality, it is important that the system of regulating both the private and public sectors be prioritized by way of establishing an accreditation system where both the public and private systems are regulated, developed and treated on equal footing to ensure standardisation of quality of care and evidence based approaches being adopted universally.

Aim and Objectives of the Consultation

This national consultation was held to strategize the delivery of newborn care services for urban poor within the continuum of care approach, and discuss the potential role of Private Sector Providers in delivering Newborn Care in these settings.

Its specific objectives included:

1. To develop an understanding regarding the situation of newborn care in urban and peri-urban settings
2. To highlight the challenges in the provision of ENC in these settings
3. To share evidence and experiences on engaging private sector providers in delivering newborn care (within Uttar Pradesh and from other States)
4. To identify possible role of private providers, including the informal private sector providers, in improving newborn care and to sensitize policy and programme partners
5. To set the agenda and build a coalition for partnership, policy and legal frameworks in light of the existing opportunities and lessons from successful experiences
6. To suggest a way forward.

PROCEEDINGS OF THE CONSULTATION

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The two-day consultation on "Potential Role of Private Sector Providers in Delivering Essential Newborn Care in under serviced urban and peri-urban settings"was held on 28-29 August 2012 in Lucknow, Uttar Pradesh. The detailed agenda is enclosed as Annexure 1.

DAY 1 (28 August 2012)

SESSION I: Inauguration followed by Introduction to Newborn Healthcare Services in Urban and Peri-urban settings

1.1 Welcome note and Inauguration

Dr. Rajiv Tandon, Senior Advisor - MNCHN, Save the Children, India

Dr. Rajiv Tandon welcomed the participants and shared the objectives and expected outcomes of the consultation. He spoke about the work that Save the Children had recently started in the arena of Health and Nutrition under the Saving Newborn Lives project which is funded by the Bill and Melinda Gates Foundation. He pointed out that despite the availability of low cost evidence-based interventions, newborn care is one of the key areas that remains neglected under the Government of India's child survival strategy. Though the government has focused on rural areas under NRHM, the urban population, especially the urban poor, are still ignored. There is a reason to believe that the health, nutrition and poverty indicators are as bad in urban poor areas as in rural areas. Though health facilities are available and accessible, home deliveries occur in significant proportions and neonatal mortality is higher than the rest of urban areas. Newborn health needs special attention in these areas. Most of the healthcare for the urban poor is provided by the untrained, unregulated private sector providers who are the first point of contact for many people. In such circumstances, there is an urgent need to review if there are any evidences or urban healthcare delivery models available in the country that focus on newborn health, especially the ones that involve private healthcare providers.

Lamp lighting during inauguration

Dr. Tandon recognized that identifying this is a difficult task indeed, however sharing of experiences by the experts invited for the consultation would help in generating the required evidence. He urged the participants to actively participate in the deliberations and hoped that the consultation would result in recommendations for policy and programmes which would be shared with the respective ministries for further action.

Dr. Tandon concluded his welcome address by expressing his gratitude to the Government of Uttar Pradesh and UNICEF State office of UP for their help and support in organizing the consultation. Special mention was made of the support given by the Mission Director, NRHM UP. He also thanked all the

experts and the participants for devoting their precious time to attend the event. He then requested all the distinguished speakers present on the podium to come together for the lamp lighting ceremony and officially inaugurate the event.

1.2 Child Health & Immunization: Views of Government of India

Dr. Manpreet Singh Khurmi, Consultant (Child Health), MoHFW

Dr. Khurmi started his speech by projecting the figures on the decline of IMR and U5MR in the country. He stressed on the fact that the decline in NMR has been disproportionately slow with a significant gender variation and urban-rural differential. Emphasizing the commitment of GOI to achieve the Millennium Development Goal (MDG) 4, he pointed out that while five States (Kerala, Delhi, Tamil Nadu, Maharashtra, West Bengal)have achieved the target U5MR of 38/1000 live births, twelve other States/Union Territories (UTs) have achieved the target IMR of 28/1000 live births. He further highlighted the following:

- Neonatal deaths contribute to more than half of the under-5 deaths in the country, and newborn care is central to GOI's strategy for reducing U5MR.
- The two key interventions for reducing NMR include Facility-Based Newborn Care (FBNC) and Home-Based Newborn Care (HBNC).
- Under the FBNC programme, Essential Newborn Care is being provided to all newborns delivered at a health facility through the establishment of Newborn Care Corner (NBCC) and training of health personnel in Navjaat Shishu Suraksha Karyakram (NSSK).
- The MoHFW has identified 17,000 health facilities with functional delivery points for establishing NBCCs, and priority is being given to those delivery points situated in the High Focus districts.
- FBNC also provides care to the sick newborn through the establishment of Newborn Stabilization Units (NBSUs) at First Referral Units (FRUs) and Special Newborn Care Units (SNCUs) at District Hospitals.
- Home based newborn care (HBNC) is a new initiative for which India has been lauded globally and consists of a series of home visits (six visits for institutional and seven for home deliveries) in postnatal period made by ASHAs for which they are given an incentive of Rs.250 per newborn. Till date, two hundred thousand ASHAs have been trained in Modules 6 and 7 which focus on HBNC.
- Janani Shishu Suraksha Karyakram (JSSK) scheme was introduced last year to ensure free health care entitlements to all pregnant women and newborn babies including free treatment, free referral, free diagnostic services including blood transfusion (if required) and free food during hospital stay.
- Another important thrust area is to reduce malnutrition which is a matter of national shame. The activities include detection of children with severe acute malnutrition (SAM) at the community level, referral and facility based management of children with complications at the Nutrition Rehabilitation Centres (NRCs). Currently there are 564 NRCs functional across 14 States. There is convergence between the two Departments of Health & Family Welfare and Women and Child Development (WCD) for community based management of children with SAM and moderate acute malnutrition, promotion of early initiation of

breast feeding for newborns delivered at health facilities, counselling and communication for exclusive breast feeding during home visits, detection of early growth faltering through community and facility based MCH contacts, IFA supplementation for children six months to 10 years and vitamin A supplementation for children six months to five years.

- As per District Level Health Survey (DLHS) 3, the percentage of children with diarrhoea receivingoral rehydration salts (ORS) is only 34 %. Hence ORS is being promoted along with Zinc for the management of Diarrhoeal diseases. Additionally behavioural interventions to improve hygiene and care-seeking practices are being undertaken.
- According to the Coverage Evaluation Survey 2009, 82.6% of children with ARI/fever sought treatment/advice. Efforts are being made to strengthen the capacity of the health workers for early diagnosis of pneumonia, administration of antibiotics (Cotrimoxazole) by the ASHA and Auxiliary Nurse Midwife (ANM), recognition of danger signs and prompt referral to a health facility.
- Immunization is one of the key focus areas for reducing U5MR. At present the proportion of fully immunized children is 61%. Activities undertaken to improve immunization include better targeting of newborn and infants for vaccinations through a large number of immunization sessions, establishment of 25,000 cold chain points in the country and vaccination against the seven vaccine preventable diseases. National Immunization Days and Sub-National Immunization Days for polio are conducted every year vaccinating millions of children. Catch-up campaign for measles has been initiated last year targeting 130 million children. While new Pentavalent vaccine has been introduced in two states, the Japanese encephalitis vaccination campaign has been conducted in 112 endemic districts covering 78 million children.

He also reflected on some of the achievements in key Child Health Initiatives at the National level:

- Operationalization of Facility-based Neonatal Care services including 388 SNCUs, 1,673 NBSUs and 11,458 Newborn Care Corners (NBCCs)
- Starting of 564 Nutrition Rehabilitation Centres
- Training of 5,33,999 workers in IMNCI, 69,514 in NSSK, 9,219 in F- IMNCI,1,500 in SNCU management. In addition 3 lakh ASHAs have undergone at least two rounds of Modules 6 & 7 training for the HBNC programme

In the end Dr. Khurmi emphasized that a number of strategies have been initiated by the MoHFW and there is no luxury of time now. There is also a need to look for evidence based experience, including clinical and user experience. Apart from this, Quality of care is the most essential element, however the issues around measuring the quality are equally challenging. Saving newborn lives is a priority and the GOI is looking forward to further consultations and discussions on improving services and practices.

1.3 Community Based Child Health: Reaching the unreachedin the urban India

Dr. Gaurav Arya, Health Specialist, UNICEF, UP

At the outset, Dr. Arya highlighted disconnect between the impressive economic growth of the country and the poor health indicators. Though India registered an impressive economic growth rate of 7.5 - 8.5% between 2000 and 2010, 37% of the population still live below the official poverty line, and

only 20% of people have access to reliable essential healthcare. He pointed out that nearly 49,000 infants have died during the year 2012 (till date) including 32,000 newborns. Most of these lives could have been saved by simple community based public health interventions. Neonatal health has been neglected for a long time and more so in the urban areas.

India's public spending on health is among the lowest in the world with per capita public expenditure on Health of only 43 USD. The total expenditure on health as a percentage of the gross domestic product (GDP) has increased to 1.2% but the increased investment is not reflected in improved healthcare .Every year 2.2% of the population is pushed into poverty due to medical expenses, and medicines account for 72% of the total private expenditure on health (out-of-pocket payments). In addition there are huge disparities in the health indicators with an urban/rural differential and also wide disparity amongst the rich and poor. A sharp fall in the child mortality rate (1-4 years) has resulted in a faster decline in U5MR, but the decline in IMR has been suboptimal because of slow rate of decline in neonatal mortality.

The condition and the health indicators of the urban poor are similar to that of the rural people. The rapid rate of urbanization is worrying since there is a lack of infrastructure and facilities to cater to the urban poor .In 2001, 28.6% of the total population was residing in urban areas but this figure is estimated to increase to 43.2% by the year 2021. The slum population has increased from 3.73 Crores in 2001 to 7.29 Crores in 2011. Despite proximity to health facilities, access to healthcare is severely restricted for the urban poor because of the inadequacy of the public health delivery system, lack of economic resources and their illegal status and residence in non-recognized clusters. The urban elite, nevertheless, get priority in all the services.

Dr. Arya emphasized that improving healthcare in India requires emphasis on investing in public health through the public sector and encouraging private sector investment, focusing on reaching the unreached through efficient and effective public health interventions in public and private domains, aiming to reduce the inequities, addressing the neglected public health conditions and diseases of diarrhoea, pneumonia, malaria, , and dealing with emerging public health challenges like accidents and injuries

There is an urgent need for strengthening the health systems. Macro-reforms are required for investment (short, medium and long term),and for developing partnerships (public-private, public-public and private-private). Micro-reforms are required for conducting needs assessment in the community, capacity development of health providers, rational deployment of staff, performance based incentives and utilizing the existing resources (financial and human) efficiently. Monitoring is improving and this needs to continue.

A large number of partners and stakeholders like self-help groups (SHGs), Panchayati Raj Institutions (PRIs), media, medical colleges, private healthcare providers are working for newborn child health. On the other hand, the community is getting empowered through the media and various partners. In UP, UNICEF has been working with various partners and has contributed immensely to public health. Given such a scenario, the way forward is to synchronize different health initiatives through the Health Partners Forum, develop common platforms for discussion, advocacy and policy dialogue, advocate through common messages, identify gap areas in community healthcare and provide niche and generic

support, work together with all stakeholders by sharing learning, and lastly and most importantly to Walk the Talk.

Dr. Arya emphasized that there is a need for strengthening the State Programme Implementation Plans (PIPs) especially for addressing newborn care in urban areas and every penny should be spent judiciously. He thanked Dr. Tandon for organizing this consultation since experiences can be shared and the agenda can be taken forward together for sustainable gains in all domains. He mentioned the Ten Commandments from the community based approaches which were developed based on the systematic review of the IMNCI literature including the Ekjut model in India.[1]

Dr. Arya concluded by quoting the words of Florence Nightingale "I collected my figures with a purpose in mind, with the idea that they could be used to argue for change. Of what use are statistics if we do not know what to make of them? What we wanted at that time was not so much an accumulation of facts, as to teach the men who are to govern the country the use of statistical facts "[2]

Experts sitting on the podium during inauguration (from left to right – Dr. Deoki Nandan, Dr. Hari Om Dixit, Dr. Vinod Paul, Dr. Devendra Khandait, Dr. Manpreet Khurmi, Dr. Sanjay Pandey)

[1]Adapted from: Integrated management of childhood illness: what have we learned and how can it be improved? Chopra et al. BMJ 2012

[2]Quoted in 'Measuring Up to the Measurement Problem: Christopher Scott, London School of Economics; PARIS 21

1.4 Bill and Melinda Gates Foundation (BMGF) plans for UP

Dr. Devendra Khandait, Programme Officer - State Programmes, BMGF

Dr. Devendra Khandait reflected on the magnitude of problems in urban health. He further raised some questions and issues:

- What is the evidence for cost effective interventions and the incorporation of new technology?
- How can the challenge of implementation be addressed for immunization or child health programmes or any other area of public health?
- How can the challenge of ensuring adequate coverage of effective interventions be met to bring about significant reduction of neonatal mortality? He referred to an article in the Lancet which had concluded that the combined use of all techniques (such as emollients, vitamin A, antibiotics, resuscitation and surfactants) can avert 50 to 60% of neonatal deaths provided there is 90% coverage. Hence this caveat of coverage always remains and is very important. There are multiple opportunities available and NRHM offers a huge platform.
- Once coverage is ensured how can the quality of the services be ensured? Which approach to follow – vertical or integrated, since there are merits and demerits of both the approaches
- As cultural factors play a major role in f the provision of newborn care at home and in the community, how can counselling be ensured for appropriate practices? A lot of issues are related to what happens in the community. The question is how the health workers (like the skilled birth attendants (SBAs) can be made good counsellors. The study of Shivgarh and Rae Bareilly in two different districts suggests that we cannot have the same Behaviour Change Communication (BCC) strategy for all the settings.
- How can preventive interventions be implemented? Literature suggests that by focusing on preventive issues, neonatal mortality can be reduced by 25 to 30%. Different approaches are required for different settings since what can work well in a setting with very high neonatal mortality, and where the main focus is on the preventive aspect, may not work well in another setting with a lower mortality where this aspect might already have been taken care of.
- Who owns the health issues in a particular urban area – the local bodies or the surrounding rural blocks? The urban population is reaching 30% and the problems are common.
- How can all the partners be engaged, especially the private health providers (whether formal or informal),to augment the resources since there will be always inequity in the distribution of resources and the need for them?
- What and who influences the pattern of prescriptions and cost of treatment given by the private providers, especially the informal providers, and how to engage with them? It has been observed that most of the treatment practices of these providers are guided by the prescriptions of the more famous practitioners in that area, and hence formal providers do have an indirect role in influencing the practices of informal healthcare providers. There needs to be a system which is a win-win situation for everybody. There are challenges to involving the private sector since any involvement means recognition, and the question is how to franchise, and issues of accreditation.

However these issues cannot be seen in isolation and emphasis should be on ensuring continuum of care. There is a need to be pragmatic on the costs of technology, tools and treatments, and an epidemiology driven intervention design may be developed.

Dr. Khandait concluded his talk with a hope that his teachers and colleagues present during the consultation would provide crisp and evidence-based recommendations which could be then used for policy recommendations and for scaling-up models.

1.5 Challenges in Urban Health in UP

Dr. Deoki Nandan, Chancellor, Santosh University, Ghaziabad, UP & Former Director National Institute of Health and Family Welfare, New Delhi

Dr. Deoki Nandan began by asserting a plea that we should not let our children die and prosperity will come only when newborns get good care. He also said that during the consultation, the discussions must focus on what needs to be done while looking at what is being done and what has been done successfully in the past.

Dr. Deoki Nandan suggested the following recommendations for urban healthcare and newborn care:

- Involvement of women from the community is a very crucial factor for ensuring success of the programme.
- The Government should give permission to private medical colleges to conduct institutional deliveries under the national programmes since there are inadequate public health facilities in urban areas(e.g. NOIDA)
- The lessons of both the successful interventions and the not so successful interventions should be incorporated in the programmes. Under the urban ICDS programme, the basic health services as well as the role and involvement of the neighbourhood committees has been neglected.
- There is a need for clarification on what is 'urban'. There are three types of urban areas apart from the 'Vikas Pradhikaran' or 'Nagar Nigam'. These are the typical urban slums, the metro culture slums for which services are difficult to provide as they are near railway stations and bus stands, and lastly the rural dominant slums.
- There is a need to involve the elected representatives for urban health and for this a single page flyer should be prepared under the expertise of Dr. Vinod Paul. In order to advocate the recommendations, a one hour meeting should be organized with the elected representatives at around mid day in the presence of media with a lot of publicity.
- Mapping of the facilities in the urban areas needs to be done by involving the National Polio Surveillance Programme personnel since dispensaries and health posts have already been created under their revamping scheme (and categorized as Type A to E).
- The Municipal Commissioner and Municipal health officers should be involved in all the discussions and planning for urban health. The roles and responsibilities of the public sector should be clear and should be disseminated to the municipalities.
- PPP should be'for the people'. The private sector should be given preference and invited to provide details of their involvement. A mapping exercise should be carried out – outpatient and inpatient based, showing the facilities run by the different providers.

- There is a need to revisit all the training programmes, and involve the private sector, medical colleges and nursing colleges.
- There is a need to create one platform and invite all the partners.
- In this consultation a 'list of doables' should be identified at all levels from the Directorate (Health and others) and Secretaries, since the State is committed for reducing neonatal mortality.

1.6 Best practices for addressing neonatal mortality in urban areas

Dr. Vinod Paul, Professor & Head, Department of Pediatrics, All India Institute of Medical Sciences, New Delhi

Dr. Vinod Paul spoke about the Best Practices for addressing Neonatal Mortality in urban areas. He gave an overview about the existing situation in the urban areas:

- Approximately 30% of the total population of India lives in urban areas and the numbers are rising exponentially.
- There are no programmes to slow down urbanization.
- The rural health indicators are better than those of the urban poor.
- The Urban Health Mission is still to be launched although this might be taken up in the 12thplan. Lack of an urban health policy is at the heart of the problems.

The advantages the urban areas have as compared to the rural areas:

- Presence of a vibrant private sector which opens up many opportunities provided the connect is there
- Distances are short hence can be negotiated quickly if the need arises
- There is greater access to media

Comparison of the average annual rate reduction (AARR) of IMR between the pre-NRHM (1990-2004) and the post-NRHM (2005-2010) era shows that while the reduction is more than double in rural areas and more than triple in the urban areas in India, figures for Delhi does not match the average reduction figures. The state of Uttar Pradesh has also shown improvement in IMR. He then described the seven best practices for addressing neonatal mortality in urban are as based on the existing interventions in India. Since limited research has been carried out in the urban health scenario, there is a need for undertaking more research by the scientific community. In the meantime, these seven best practices can be incorporated in the urban health programmes for improved outcomes.

The best practices were classified into demand side, supply side and both, and they have been tabulated as below:

TABLE 1: SEVEN BEST PRACTICES FOR ADDRESSING NEONATAL MORTALITY

S.No	Intervention	Present Situation	Issues to be addressed	Focus area for Best Practice
	SUPPLY SIDE			
1.	**Promoting deliveries in facilities**	SBAs have been provided in facilities as per GOI's policy for universal care at birth. Presently institutional deliveries constitute 73% of the total deliveries and this has had an effect on maternal mortality. But JSY has not made too much difference in the NMR, and the rate declined by only 2 points from 42 to 40 among those who went for institutional delivery.	Addressing the reasons why NMR is not declining despite high proportion of institutional deliveries and determining how we get it right. Quality of care is the main challenge – quality of people, resources and protocols. It is essential to determine the elements of quality and how quality can be ensured.	**Promoting deliveries in facilities - providing high quality of care**
2.	**Home-based postnatal contacts**	6 to 7 studies in rural settings (Gadchiroli, Shivgarh, Sylhet, Barabanki, Mirzapur, Haryana, Hala) have shown that home based postnatal visits can reduce NMR by 20%. This is also a good chance to promote exclusive breast feeding. An unpublished ICMR study in Barabanki shows 23% reduction in NMR if home contacts alone are undertaken.	We need to go forward from IMNCI. The ASHA model is good and a similar model of Urban Social Health Activist (USHA) worker in urban areas may be useful. Community link worker is important. Without such a worker, Home Based Neonatal Care cannot be undertaken.	**Home-based postnatal contacts - Need for an ASHA like worker**
3.	**Transportation**	In NRHM there are a lot of success stories for referral transport. There is evidence for effective transport of mothers, but the baby is not talked about. Hence we need to emphasize the need for the transportation of sick babies. Transportation is easier to tackle in urban areas than in the rural areas since facilities are better in urban areas.	Ready availability of transportation for both the mother and the newborn to the facility and from the facility to the home. Arrangement of rapid transport is very important for emergencies. Such mechanism for the transportation of sick babies should be clearly developed.	**Transportation for the mother and the sick babies**

S.No	Intervention	Present Situation	Issues to be addressed	Focus area for Best Practice
	DEMAND SIDE			
4.	**Financing**	Financing mechanisms are very critical to ensure accessibility of Public Health system since the existing mechanisms are not enough. Good thing is that funds/investment is available. **Voucher schemes**: Chiranjeevi scheme has saved more than 7000 lives through the use of private facilities. This scheme has many issues, but there is scope for improvement **Cash transfer (JSY):** The uptake of JSY has increased from 0.74 million in 2005-06 to 11 million beneficiaries in 2010. JSY has conditionality since it is for the poor and BPL, and many studies suggest a number of issues related to its implementation. **Insurance:** The RSBY is implemented by Ministry of labour and allows health insurance to the family through a small monthly contribution. A sum of Rs.30,000 is made available to the family with a swipe of a card. Countries like Brazil, Japan, China and Europe have cash less insurance.	Chiranjeevi scheme and JSY need to be improved and their issues resolved. There is a need for a better Insurance model since existing schemes: • Often do not cover pregnancy and newborn care • Provide fragmented health care and do not provide full coverage of needed services • There is delay in payments • Insurance companies take a high transaction fee of about 27% for the services in Insurance. These schemes fail to cover the most needy people, and there is a need to tailor them for the poor so that it becomes a poor man's insurance system	**Health Financing:** • **No user fees** • **Cash-less access** • **No inter mediary** • **Universal access**

S.No	Intervention	Present Situation	Issues to be addressed	Focus area for Best Practice
5.	**Behavior change**	Lack of knowledge and awareness regarding where to go for services is responsible for poor immunization. Behaviour change is very important and if it is not addressed, then further improvement will not occur. A Nepal study showed 30% reduction in MMR simply due to BCC.	Behaviour change activities should be at the end of the PIPs. It should be a big pillar. Media and other pathways should be used for behaviour change.	**Behavior change: Use of Media and other methods**
6.	**Community mobilization**	Community mobilization is very critical. In the UP Urban Health experiment, the power of communication was shown. For community mobilization, NGOs and link workers are the key as they connect the people to the facility. Women's groups are the key community mobilizers and we need to build on them. Polio campaign succeeded because of people's movement. This is a global best practice.	There is a need to build on the evidence generated through the Vistaar, Sure Start, SNEHA and UHRC models. A two pager needs to be developed for the orientation and awareness of PRIs. A flyer needs to be developed for the women PRIs so that they know what they have to convey to people. NGOs have a big role to play in this process of community mobilization.	**Community mobilization: Best practices to be adopted from the models of UHRC, SNEHA, Vistaar, and Sure Start, and involvement of PRIs and NGOs.**
	SUPPLY - DEMAND SIDE			
7.	**mHealth / eHealth**	mHealth /eHealth is the beginning of a revolution and no one can escape this technology. SMS services are used to send positive messages on health.. It does not have much effect but reinforces the counselling given by health workers. IT is our country's strength and should be used for something tangible.	It can be used for: • Health education and counseling • Consultation for Care seeking, Clinical decision-making and Follow-up of babies discharged from hospitals • Programme monitoring The only lacuna is that the approach and methodology has to be developed.	**mHealth / eHealth**

Dr. Paul discussed the various modalities of PPP in the profit and non-profit sectors which have a role in quality care at the facilities, transportation, behaviour change interventions and mHealth & eHealth. The non-profit sector has a big role to play in the implementation of ASHA like workers and community mobilization. It is important that policies are made for the private sector.

He further warned that it is necessary to accept the challenge and take actions for the urban poor, for if we do not act now India will achieve the MDG goals only by 2023which would be missing the time line by eight years. Dr. Paul ended his talk with a quote from Tom Morrison– "If we do not create the future then the present extends itself"

1.7 Child Health Programme in Uttar Pradesh

Dr. Hari Om Dixit, General Manager (Child Health), Govt of Uttar Pradesh

At the outset Dr. Dixit presented a comparison stating how UP has been lagging behind the other states with regard to IMR and NMR. Out of the 100 districts in the country with the highest IMR, 43 districts are in UP and the highest rates are seen in district Shrawasti (NMR of73 and IMR of 103). Large number of districts, larger populations, different types of communities and insufficient health staffing are some of the main challenges in UP.

A number of interventions have been undertaken in UP in last few years but there has been a lack of coordination amongst the agencies implementing these. Recently Development Partners Forum was formed comprising of UNICEF, SCF, PATH, MAMTA, Vatsalya, CARE and Vistaar. The forum conducts regular review of donor programmes in a coordinated manner and all programmes support the government schemes.

The IMNCI programme was introduced in UP in 2007 in the form of Comprehensive Child Survival Programme (CCSP) with the main aim of reducing infant and neonatal mortality rate.
The achievements of the programme:

- Seven SNCUs have been established and the plan is to operationalize 29 units by the end of March 2013. By November 2012, five more units will be functional.
- The state has focused on improving community participation activities through ASHAs, and Mamta has worked with the Village Health Nutrition and Sanitation Committees (VHSNCs) orienting them on their roles and the health rights of the people.
- A total of 16 NRC units (five at District Hospitals, six at PHCs/ CHCs and five in medical colleges) are functional in the state as of date. The target is to establish a total of 41 NRCs in the state of which 26 units will be established by the next year. The results for NRCs have been encouraging but these centres require a lot of staff.
- A process of Supportive Supervision(SS) has been established in 5 districts under the CCSP programme. CCSP trained functionaries of four districts were provided supervision in partnership with CHAI and in one district in partnership with AMU, through the support of UNICEF office in UP. Each district has a District Supervisor supported by Block Supervisors for this activity. The Block Supervisors provide SS to CCSP trained ANMs, who in turn provide SS to ASHAs and AWWs. They accompany the ANM and ASHA to the house of a newborn (or any young infant aged 0-2 months) to observe the process followed by them

for the assessment, classification (process of using the color coded booklet), identification of correct treatment (deciding what needs to be done for the particular newborn using the color coded booklet) and provision of treatment for the child including counseling of the mother/caretaker.

- The Field Supervisor too records the performance of ANM and ASHA using the supervisory tools. The Block Supervisor then guides, suggests and demonstrates the necessary actions required for carrying out complete and successful home visits to the newborn as per the CCSP protocol.
- The performance of ASHAs is subsequently categorized into either A, B or C category based on their skill, knowledge and performance levels. During a recent evaluation of 8,109 ASHAS, 23.4% (1897)were placed in Grade A.

A commendable achievement of the Supportive Supervision programme is that most ASHAs can identify PSBI (Possible Severe Bacterial Infection). For example in Lakhimpuri district, 100% of the ASHAs could identify PSBI.

The challenges of SS include providing immediate post-training support to ASHAs, ensuring the use of CCSP norms, carrying out refresher trainings, making available medicines and home visit formats with ASHAs, maintaining a constant focus on the Antenatal, Natal and Postnatal care, ensuring availability of ANMs at the sub-centre and supervision of ASHAs by the ANMs and meaningful monthly meetings.

He concluded by pointing out that besides the challenges of social, political and geographical diversity in UP, there is no village head or Pradhan in the urban areas (as in the rural areas). This poses problems regarding utilization the untied funds. The second challenge is to establish an urban health post for a population of 30,000 to 35,000.As a solution, the GoUP has proposed to convert the existing sub-centresin peri-urban areas with no Pradhan/local head to health posts with a MO, Staff Nurse, ANM and Safai Karamchari.

SESSION II:	Sharing of Evidence from other Urban Health Programmes Chairpersons: *Dr. Manpreet Singh (MoHFW, GOI) and Dr. Hari Om Dixit (GoUP)* Moderator: *Dr. Devendra Khandait, BMGF*

2.1 City Initiative for Newborn Health:

The Mumbai city initiatives for newborn health by the Society for Nutrition, Education and Health Action (SNEHA)

Dr. Wasundhara Joshi, Director, SNEHA

Dr. Joshi started her presentation by informing that the city of Mumbai has 19 million people living in an area spread across 233 square miles, but 55% of the city's population lives in slums. Their project 'City initiative for Newborn Health' began in 1999 under the guidance and leadership of Dr. Armida Fernandez (former Dean, Lokmanya Tilak Medical College, Mumbai) to address the chronic shortage of beds across Mumbai. The project was initially supported by UNICEF and then ICICI Foundation, and later the Welcome Trust. The research initiative was carried out from 2005 till 2009.

The overall purpose of the project was to generate demand through community participation followed by a response from the health system to the increased health demand.

The City initiative model for Newborn Health consists of two main areas:

- Community mobilization through community partnership and monitoring
- Quality of Care through strengthening primary care and strengthening referral

These steps have led to improved maternal newborn care and care-seekingamong the community, improved health care services resulting in increased uptake of these services and improved maternal newborn care and survival.

The initiative's progress can be described in detail as follows:

1. *Health systems' strengthening undertaken through nurturing partnerships.*
    - Participatory consultation conducted with all the newborn care service providers consisting of three super speciality teaching hospitals,10 general hospitals, 24 maternity homes and 30 health posts.
    - Continuous quality improvement cycles introduced along with primary care strengthening, development of Regional referral system and improvement in the Management Information System (MIS). BCC activities were initiated and Appreciative Inquiry was introduced. The whole process was truly participatory – there were many questions and it was important to listen to what the people and providers had to say.
    - City-wide referral mechanism strengthened with the help of Municipal Corporation of Greater Mumbai (MCGM). A total of 52 facilities were part of the referral chain. Facilitation was done by tertiary centers and communication improved at all levels. The links have shown improvements in the appropriate referrals from maternity homes to peripheral hospitals.
    - Monthly planning meetings were organized and together it was worked out how the initiative could be undertaken.

- Once the design was finalized, monthly meetings were organized by the teaching hospital and clarifications made regarding when and how to refer. Proper documentation and data presentation were encouraged.
- Quality was improved through continuous Quality Improvement cycles. Primary care was missing in Mumbai hence regular ANC was introduced.
- Appreciative inquiry was introduced for understanding what works and the reasons why it works.

2. *Community Intervention Trial*

The Community Trial was a cluster randomized controlled trial conducted in six Municipal wards and in 92 vulnerable slum clusters. Block random selection was undertaken and 48 slum clusters selected. An estimated population of 283,000was identified along with a vital event surveillance system. Random allocation was done in the slum clusters out of which 24 slum clusters were selected for intervention and 24 slum clusters were selected as control.

- Each cluster consisting of 1,000 populations had 10 local women's groups and each group was facilitated by a sakhi who was a local woman.
- Fortnightly meetings were held with focus on perinatal health.
- The process included seven phases consisting of discovery of the issues, awareness generation, energization, envisaging what should be the situation (dreaming), designing the intervention, service delivery and evaluation of the intervention.
- Women's Group Meetings: During these meetings the women were encouraged to talk about their experiences and stories. Various issues were discussed such as healthy babies, environmental hygiene, appropriate age at marriage, financial independence, improving quality of public care, safe pregnancy and good care, early identification and registration of pregnancies, hospital delivery, and spacing.
- Overall 235 group members helped 1,372 other women (that is, one woman reached out to six other women) in the form of giving information and advice, providing financial support, advising women to consult a doctor or hospital, accompanying women to hospital and giving premarital advice.

3. *Surveillance of vital events*

This activity was operationalized through an elaborate system consisting of a local female identifier, an interviewer, a woman resident, a supervisor, a project officer and a data entry officer

- The local female identifier was responsible for identification of an event (data collection) and assisted the interviewer in locating the participants.
- The interviewer was responsible for confirmation of the event with the support of a women resident and also for conducting interviews six weeks after birth.
- The Supervisor was responsible for cross checking the events and interviews, auditing hard copy data and conducting verbal autopsies.
- The Project Officer was responsible for conducting maternal verbal autopsies and cross checking data.
- The Data Entry Officer was responsible for data entry.

Learnings from the intervention

- Uptake of healthcare is high among the urban poor and rising steadily, while the mortality rates are falling.
- There is very little closeness amongst people in the urban areas and they like to maintain a distance from each other along cultural and ethnic lines. Hence the groups were not large and had limited connections and diffusion of knowledge.
- It was very difficult for the women to come to the meetings because they were very busy with their household work and other work. The women were not always pregnant women.
- Group members stumbled at dreaming and strategizing. They had a low opinion of their potential to leverage change and had concerns about the investment needed to enact the strategies. They liked learning things and had many concerns.
- The NMR was assumed to be 25 per 1000 live births since the Municipality did not maintain data. However during the intervention, we found that it was 20.
- Almost 50% of the women visit private sector health care providers. I It is easier to bring change in the private sector than in the public sector as there is a huge resistance to update knowledge in the public sector.
- Clients often remain in the same sector and with the same provider.

Achievements

- In the Public sector,5,628 women were registered of whom 4,541 women got antenatal care and 4,685 women delivered
- In the private sector 3,179 women were registered, 4,604 women received antenatal care and 2,978 women delivered.
- In maternity homes 1,754 were registered and 1,123 delivered.
- In the general hospital 2,260 were registered and 1,885 delivered.
- In the tertiary hospital 988 were registered and 1,227 delivered.
- Unregistered 954 and 1,708 delivered at home
- In 2007 the referrals from the Maternity homes to the tertiary hospitals were 58% since the tendency was to send women straight to tertiary hospitals. These referrals decreased to 38% in 2011 with the maximum difference in the last two years. The referrals from the Maternity homes to the peripheral hospitals increased from 38% to 60%.
- Improved care-seeking patterns for serious symptoms reflect a broader trend of care-seeking.
- Other Municipalities have invited SNEHA for extending the programme in their areas.

The biggest challenge of the project was how to ensure involvement of the unorganized illegitimate private sector for newborn care since they are available round the clock, speak nicely and softly with the community, and understand the culture.

Discussions:

Question 1: While SNEHA was doing the intervention was there any Government programme going on?

SNEHA: This intervention was before the initiation of JSY.

Question 2: Did migration and seasonality have any role?

SNEHA: Intervention was with stable population as there was only 14% migration within the cluster. Seasonality was not analyzed.

Question 3: Was there focus on other areas besides reproductive and child health (RCH)?

SNEHA: Outreach was only RCH focused. However, now SNEHA is looking at other areas.

Question 4: What was the reaction of hospitals for quality improvement?

SNEHA: The private hospitals were more open and have improved, but Quality check is not allowed in Government hospitals. After the first round of interactions they wanted us to work in referral and trainings, especially at the community level. A large component of training is on improving communication.

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Experts during the session

2.2 Behaviour change for care-seeking for sick newborns

Dr. Shally Awasthi, Professor, Dept of Pediatrics, King George Medical College, Lucknow

Dr. Shally spoke about the Indian Council for Medical Research (ICMR) funded project to see if behavior change can be brought about in care-seeking for sick newborn. This study was carried out since there was scarce quantitative data in UP on the socio-economic-cultural factors affecting newborn survival. The current evidence for the impact of interventions to promote newborn care-seeking among urban poor was limited in general and for UP in particular. Also postnatal health education trials for improving recognition (& labeling) of newborn danger signs and care-seeking among institutionally delivered mothers have not been reported in UP. Hence it was decided to conduct a study in UP and formative research was undertaken to understand the care- seeking behavior.

The research hypothesis was that a BCC intervention package delivered to urban poor mothers within 48 hours of institutional delivery could improve qualified medical care-seeking for sick neonates in urban Lucknow, UP.

The study design was a 'Before After' Intervention study, and its various stages and time lines included:

- During 2006-07: Formative Research consisting of review of literature, quantitative pilot study with 172respondents, and five focus group discussions (FGDs) with three in urban slums, one in the district hospital, and one at the RCH centre.
- From April 2007-October 2007: Before-Intervention Phase with enrollment from March to August 2007 & Follow-Up of the comparison group
- From June-July 2007: Design and pretest of the intervention
- From September 2007-April 2008: After-Intervention Phase with enrollment & delivery of intervention
- From October 2007-June 2008: Follow-Up of the Intervention group

A total of 1,020 neonates were enrolled - 510 in intervention phase and 510 in after intervention phase. Exclusion criteria included those neonates who required any resuscitation at birth or who presented with any clinically detectable serious congenital malformation or who were hospitalized for any morbidity immediately after birth or who were not the residents of Lucknow, or who were likely to move out of the city in the next one month. The study was conducted after obtaining Institutional Ethical Clearance from King George's Medical University and permission from relevant district authorities and the study is registered at www.clinicaltrials.gov with identifier NCT 00832143.

The various types of medical providers included the Government Providers (GPs), the Non-Government Qualified Consultants (NGCs) and the Non-Government Dispensers (NGDs) while the other group was the Traditional/Spiritual Healers.

Study Outcomes

1. Care-seeking behavior

- The primary outcome measure was qualified medical care-seeking for any neonatal illness. Sub-analysis was also carried out to evaluate the effect of the intervention on -
    a. Qualified medical care for illnesses listed in the IMNCI programme

b. Care-seeking from Government providers.
c. Any medical care (from GPs, NGCs or NGDs) for sick neonates.

2. Factors associated with care-seeking behavior

- Cultural factors ('local illness beliefs' leading to use of traditional/spiritual care and/or use of home remedies)
- Socio-demographic factors (parental education and occupation, gender of newborn, type of family, household income etc.) and underlying factors (such as prior antenatal care etc.) associated with 'qualified medical care' as well as 'any medical care' for sick newborns among the mothers of pre-intervention phase.

The study showed that the community was not happy with hospitals. They were happy with those who talked to them for longer duration and this was not linked to the quality of counseling. For ARI, digestive problems, eye/ear problems, jaundice, fever and skin troubles, the usual care given was home remedies, self-medication and traditional care. They used terms like "Sukharog" and perceived 'bulged fontanel'. They thought that neonatal illnesses were due to 'supernatural' ('Upri') causes and expressed that very little care was given at public hospitals since usually there was shortage of drugs and the quality of care was substantially poor. They valued counseling by the health provider as the most important factor to promote neonatal health.

Findings from the formative research:

- Half of the newborns had morbidity of which one fourth had IMNCI covered morbidity. Government facilities were visited only in case of septicemia. For pneumonia the community went to the unqualified private providers.
- The factors associated with medical and qualified care-seeking included the site where the study was undertaken (whether RCH centre or District Hospital), father's education, household Income, residence in a slum or non-slum area, and the number of antenatal care visits made. None of the newborn variables were found to be significantly associated with care-seeking. It was found that if the delivery was conducted at a RCH centre, family income was less than Rs.2500 per month and if less than three ANC visits had been made, it significantly predicted no quality medical care for the sick neonates. There was no relationship between the initial condition of the baby and the place where he/she was taken for a consultation.
- It was found that the combined mean out-of-pocket expenditure (OOPE) on all neonatal illnesses was Rs.545.7 The combined mean OOPE on all IMNCI illnesses was Rs.903.9, while for all non-IMNCI illnesses it was Rs.121.61
- Seventeen neonates were hospitalized of which five were hospitalized for septicemia, five for pathological jaundice, two for meningitis, two for necrotizing enterocolitis, one for pneumonia and one for diarrhea with dehydration .
- The combined mean OOPE on non-hospitalized neonates with IMNCI illnesses was Rs.159.9 and was higher than that incurred on non-IMNCI illnesses Rs.121.6. The overall mean combined expenditure on hospitalized neonates was Rs.4,993

Intervention

Based on the formative research, standard IMNCI guidelines (WHO 2003) and WHO recommendations on care-seeking, a Neonatal Well-Being Card [Navjat Shishu Raksha Card (NSRC) was developed containing the names of hospitals. It included pictures/photographs of neonatal danger signs which were considered to be most comprehendible and appropriate by the mothers/caregivers during FGDs. A "reference module" was also developed containing messages about the concept and delivery of the study intervention and this was explained and distributed to the hospital staff of the participating sites. Intervention included one-to-one counseling of mothers/caretakers within 48 hours of delivery and using the card. During counseling, posters were put up in the rooms of the Pediatricians.

The study enrolled 510 newborns (243 from the RCH Centre and 267 from the District Hospital) from September 2007 to April 2008, and 490 (96.1%) babies were followed-up at 6-8 weeks either at the outpatients' clinic of the respective hospitals (43.3%) or at home (52.8%). The remaining 20 (3.9%) babies were lost-to-follow-up

Results of the intervention

- 50% Newborns had more than one morbidity during the study period
- Qualified medical help sought was 2.12 times more after intervention. This was statistically significant
- For IMNCI illnesses, care seeking was twice as high and there was also an increase in the usage of government facilities
- For the six weeks' immunization, there was 43.3% turnover post- intervention as opposed to 30.2% during the pre-intervention phase
- Only one-to-one counseling was done which was seen to increase care-seeking

Conclusion

- A relatively simple intervention targeted at recognition of neonatal danger signs and promotion of qualified medical care-seeking has significant impact on care-seeking behavior for sick neonates in urban Lucknow.
- BCC interventions have the potential to increase care-seeking from government facilities and lead to lowering of the economic burden on households seeking care for their sick newborns.
- A BCC intervention coupled with the advice on routine immunization and follow-up care has the potential to ensure timely immunization and routine follow-up care for newborns.
- Posters and hoardings can be used for communication purposes

This intervention can be scaled up especially in the background of the JSY programme. However the study could not confirm whether it will lead to increase in qualified care-seeking in the rural areas and also in the private medical sector. KGMC was ready to scale up the study and do further research.

Discussion

Question1: How much of the good messages in the MCH card is internalized.

KGMC: If the service provider gives time to the caregivers it helps. Also the same messages

should be given again and again to reinforce them and not to confuse the caregivers. It is important to have pictorial messages with words in the regional language. IEC material is usually not adequately used. Nowadays the workload has increased and service providers have little time to give messages. Hence videos can be shown with NGOs and development partners helping the Government in this aspect.

Question 2: Use of IEC materials by the paramedical staff

KGMC: The paramedical staff is not trained for using the available material. Hence all training programmes should devote time for this and also provide hand holding.

Question 3: What are the requirements for good IEC? Interpersonal communication (IPC) needs Raaz kya hai (perception in communication), Awaaz kaisi hai (what is the tone of the health provider), Alfaz kaisi hai (whether local language is being used) and Andaaz (the body language of the health provider).

KGMC: There is still a need to focus on IPC. The messages should be simple, short and repetitive.

Question 4: Doctors are overburdened with work. What role can ASHA play?

KGMC: ASHAs can do the communication. It is their responsibility and they are being trained for IPC. It is necessary to see whether their skills have been developed.

Question 5: Role of NGOs and PPP

Dr. Dixit:

- NGOs can help in supporting ASHAs. Trainings have been given but internalization is different for each one of them. IPC is very important and there is no alternative for it.

Dr. Manpreet:

- PPP policy and outsourcing policy should be understood. The policy is there because of a lacuna in the health system. The role of private providers and NGOs should be very clear especially with regard to communication. Outsourcing will be only successful if the Government system is very competent, takes the lead and monitors it properly.
- People living in the urban slums do not have an identity card and hence do not get the benefits. Maybe a saral card would help. They have specific problems.
- It is important to study the outcome of the children who were hospitalized. An evaluation should be done to see what is happening to these children and what their morbidity profile is.
- Missed opportunities should be fully explored. An example was given of a good NRC in urban area in Darbhanga in Bihar. Out of 24 children admitted there, four had TB and were fully treated. Similarly once a woman comes to the health facility, she should be completely examined along with her babies and given the required treatment.

Participants during the Consultation

SESSION II:(contd):	Sharing of Evidence from other Urban Health Programmes Chairpersons: Dr. Aruna Narayan (GoUP) Moderator: Vikas Kishor Desai, Independent Consultant & Expert on Urban Health

2.3 Improving access to MNH through community mobilization and partnerships in urban areas -The Sure Start Maharashtra Experience

Dr. Lysander Menezes, PATH

Dr. Lysander started his presentation by observing that despite the supposed proximity of the urban poor to urban health facilities, their access is severely restricted, the public health system is inappropriate, the outreach and referral system is weak, there is social exclusion and lack of information and assistance at secondary and tertiary hospitals, and there are lack of standards and norms for the urban health system.

The objectives of the Sure Start programme were to significantly increase individual, household and community actions that directly and indirectly improve maternal and newborn health, and to enhance systems and institutional capabilities for sustained improved maternal newborn care and health. The programme was implemented in rural areas of UP and in urban areas of Maharashtra. Maharashtra, the second most populous state in India, has more than 50% population residing in urban areas as there is huge in-migration from all parts of the country. The Sure Start programme was implemented in select localities of seven cities viz. Mumbai, Navi Mumbai, Nagpur, Pune, Malegaon, Nanded and Solapur covering a population of 1.6 million.

The programme strategies included need based BCC, mobilizing community groups, leveraging available resources, developing collaborations with the local Municipal Corporation, professional bodies and developing models. A Common Minimum Programme (CMP) was finalized and areas were defined for Self-Care (behaviour and demand generation) and for community systems and linkages.

A 'need-based' BCC strategy was adopted which included questioning the people to find out their issues of concern and for identifying their problems, then doing a behavior diagnosis after which repeated counseling was done with a hope that this would bring about behavior change.

In addition to the CMP, each city implemented a specific model. Nagpur implemented two models while all the other 6 cities implemented a single model. Mumbai and Malegaon implemented the quality of care model, Navi Mumbai implemented the public-private partnership model, the risk pooling mechanisms were implemented in Nagpur (emergency health fund model and prepaid card model) and Nanded(community based health insurance model); Convergence model was used in Pune and volunteerism model in Solapur.

Quality of Care model, Mumbai

The objectives were to increase the availability, accessibility, appropriateness, and acceptability of public and private health services for pregnant women and newborns, and to reduce maternal and neonatal mortality through appropriate and timely referrals. Interventions included developing protocols for general practitioners and public facilities; facilitate establishment of antenatal and postnatal clinics, and establishment of community resource centers.

The outcomes included establishing Four Community Resource Centres through community participation, establishing Antenatal/Postnatal care clinics at the Urban Health Post (UHP) for providing greater access to the community, and acceptance of the clinical protocols which had been developed and implemented by the municipal health facilities.

Public-Private Partnership (PPP) model, Navi Mumbai

The objectives of this model were to enable PPP for improving and strengthening the quality of MNH services at the facility and outreach levels, and achieve NGO participation in community mobilization and supportive supervision for outreach services. The interventions included outreach services through ANC/PNC clinics, specialist clinics at the UHP, yoga for pregnant women, nutrition counseling with the help of private& professional bodies, establishing 20 community groups called DISHA for community mobilization, and preparing and implementing standard management protocols. This was done through NGOs with PATH providing Technical Assistance. Mobile phones were used for sending messages.

The outcomes of the intervention included establishing 20 community groups which were linked with the Navi Mumbai Municipal Corporation. A total of 26,823 pregnant women were examined in 131 clinics and subsequently 2,728 high-risk cases were referred to specialist clinics in the 20 health posts, which also managed care for 732 newborns.

The Convergence model, Pune

The objectives of this model were to raise awareness of HIV among pregnant women, to motivate them to undergo HIV testing, and to test the feasibility of convergence of HIV/AIDS and maternal newborn health for synergy in impact. The intervention focused on creating awareness regarding HIV testing during pregnancy, establishing linkages with Integrated Counseling and Testing Centers (ICTC) and establishing Monitoring of Maternal and Newborn Status (MOMS) committees. The MOMS committees were community groups that liaised with public health institutions to take up the issues of Quality of Care and rights of the beneficiaries in a proactive way. Committees were formed after extensive community consultations and there was one committee with approximately 10-12 members (70% women) for a population of 10,000.

The outcomes of this model included 52 MOMS committees functioning in the project area which are providing support for mothers, including those who are HIV-positive,and establishing linkages with the public health facilities. All the MOMS committees have formed a federation to support them and to deal with the Municipal Corporation& public health facilities.

Emergency Health Funds (EHF) model, Nagpur

The objective was to develop a sustainable financing mechanism for improvement of health among mothers and newborns by creating an "Emergency Health Fund". The interventions included developing guidelines for EHFs by consultative processes, capacity building of EHF members on record keeping and fund management, periodic monitoring and assessment of EHFs with provision of feedback for improvement, and the formation of a federation of EHFs for sustainability.

Prepaid Cards for MNH care were developed with the objective of providing high-quality MNH services at affordable rates. After carrying out needs assessment of the community, a package for pre-paid card was developed and this was followed by a Social Marketing campaign.

The outcomes included establishment and operationalization of 97 EHFs in a 150,000 slum population. Till June 2011, 1,160 families had benefited from the EHFs out of which 127 families used EHF money for delivery and treatment of newborns. The federation of EHFs is providing financial and managerial support to EHFs. A total of 800 families have purchased the prepaid card.

Quality of Care model, Malegaon

The objectives of this model were to ensure better-quality services in public health facilities, to build the capacities of the Municipal Corporation staff for high-quality MNH services and community mobilization, and to develop mechanisms for facilitating continuous dialogue between the community and service providers by institutionalizing client satisfaction norms. The interventions included developing Client Satisfaction norms jointly by the Malegaon Municipal Corporation, the community and the lead partner, developing a community based referral system and quality of care platform, and carrying out exit interviews of clients by the community groups.

The outcomes included regular meetings about the quality of care in two health posts in partnership with Malegaon Municipal Corporation in which a total of 90 community members participated. Furthermore, a meaningful platform for accountability of public health services was created in the form of periodic meetings between the providers and the community. Care-seeking behaviour in Malegaon also improved significantly, perhaps as a result of the community based referral system. An assessment was carried out for this model and it showed that the majority of women were aware of community groups; more than half of them felt that the services in health posts had improved, and nearly half felt that the behavior of UHP staff had improved. But the biggest challenge was shortage of health manpower and sustaining the interventions.

The Volunteerism model, Solapur

The objective of this model was to develop and test a strategy of using volunteers to mobilize the multilingual communities of Solapur to increase uptake of MNH care. The interventions included involvement of the self-help group (SHG) members who conducted surveillance of pregnant mothers, adopted ANC mothers, transmitted messages and monitored 10 parameters of ante-and postnatal care, and included students for group meetings and BCC campaign.

The outcomes included development of a network of 170 SHGs with knowledge on MNH care in Solapur city. A total of 12,000 pregnant women were adopted during the project period and 800 Female National Service Scheme (NSS) students were trained in BCC for MNH. This volunteerism model was accepted by Solapur Municipal Corporation and financial provision has been provided by them.

The Community based Health Insurance (CBHI) model, Nanded

The objective of this model was to introduce CBHI model for MNH care within a target slum population of Nanded city. The intervention consisted of a Needs Assessment for design of the CBHI programme, formation of a service providers' network and implementation of the community based health insurance scheme known as Apni Sehat.

The outcomes included reaching out to 30,000 people residing predominantly in the Muslim pockets of Nanded and thus benefitting 664 families and 161 mothers and newborns. Institutional deliveries

increased to 90% in 2011, compared to 60-70% in 2008. Antenatal care check-ups also increased substantially. However the private hospitals started charging over the agreed cost and the premium was costly.

Overall impact of Maharashtra models

- Two Municipal Corporations replicated best practices of Sure Start
- Budget allocation in State RCH PIP for Mahila Arogya Samiti
- Community groups and service providers are sharing a common platform to discuss issues related to service delivery

The change in practices is reflected in the data in the table:

Indicators	Baseline 2008	End line 2011
Early registration	41%	54%
Institutional Delivery	78%	88%
Proportion of women getting 3 or more antenatal check ups	70%	83%
Percentage women receiving postnatal check up	38%	57%

Learnings:

Supply can meet demand with public-private collaboration – An integrated package of MNH health services needs to be provided along with awareness in the community so that demand is created. Timely quality medical care should be available and which is affordable.

In the end Dr. Menezes described an Ideal Operation model for MNH with different components and focus (as given below)

Focus	Solution	Operation model
Community Awareness	IPC, community campaigns, Information Communication Technology (ICT) applications	Public and private collaborative projects
Willingness in Community	Behavior change	Public and private collaborative projects
Quality	Standard Quality of Care protocols	Protocol setting by state, monitoring by private audit agencies
Affordability	Demand and supply side financing	Private finance/insurance bodies
Comprehensive health access	Integration of MNH services	Private and public health service coalitions

At the end of the presentation Dr. Desai suggested that the different approaches as outlined above could be used.

2.4 Eleven City experience of Urban Health Initiativein Uttar Pradesh

Dr. Geeta Pillai, Urban Health Initiative, USAID

Dr. Geeta spoke about the Urban Health Initiative in UP, a project supported by the Bill and Melinda Gates Foundation as a part of its five country initiative. The project has been implemented for the past two years and focuses on Family Planning. The first year was to formalize the interventions.

Recent data has reflected that 40% of women had unintended pregnancies and of these 22% are in UP. In India only few states would be able to achieve the MDG4 &5 goals and most states will not be able to achieve their targets. The urban poor are significantly worse off than the rural population. In these areas, private sector is an important player since most deliveries take place in private hospitals and nursing homes. The poor have one child more while the rich meet the stipulated family size. The unmet need for contraception among the poor is 16% especially of intrauterine devices (IUDs) and injectables.

The mid-term informal assessment of the initiative shows that some difference is being made. The increase in the contraceptive prevalence rate (CPR) is visible in Agra. Earlier people mainly used traditional methods along with condoms, but now there has been increase in the male and female sterilization rates, the intra uterine contraceptive device (IUCD) acceptors rate, and the injectable acceptors rate. However, it is significant to note that there is a high drop-out as well and hence it is important to train the health workers to manage the drop-outs or be able to convince the clients to take up another method.

For IUCD insertion, 40 to 90% providers are private providers and are FOGSI members. It is important to reach people and also the providers. The Government of UP is thinking of encouraging Postpartum IUCD insertion as this will help in reducing both maternal and neonatal mortality. Women get injectable contraceptives from private facilities and public facilities, but here again there is a high drop-

Experts during the session

out rate. There is a need to counsel those likely to drop out so as to motivate them to continue using these injections and at the same time be aware of the side effects.

With regard to Oral Contraceptive Pills (OCP) and Condoms, 90% of people get these from the private sector through medicine shops and other stores which sell them. Social marketing is being tried out by putting OCPs and Condoms at Paan shops etc. There is also a need to involve the informal sector providers. Postnatal and post-abortion family planning shows less progress. Women are told to come back but they do not come back and hence the services need to be provided at the time of the abortion.

Some pertinent strategies suggested for urban areas are:

- For Outreach services, the USHA model should be adopted
- Job aids need to be developed and distributed
- Media marketing of services and supplies should be undertaken
- Mass media like TV and radio spots should be widely used for conveying messages
- Traffic islands could be used as platforms for delivering messages
- Religious leaders should be involved in the dialogue and communication events

Discussion:

Dr. Desai: Increasing the Couple Protection Rate (CPR)impacts the total fertility rate (TFR) which will have an effect on the IMR. Once USHAs are in place, the focus should be on improving the CPR.

2.5 Inequalities among the unequal - Inequalities in maternal care and newborn outcomes: one year surveillance of birth in vulnerable slum communities in Mumbai

Dr. Wasundhara Joshi, Director, SNEHA

Dr. Wasundhara spoke about the large urban inequalities in India with a substantial urban rich advantage. Even among the urban slums, all are not equal. Under the city initiative, a one-year surveillance of births in vulnerable slum communities in Mumbai was carried out with an objective of describing maternal care uptake in vulnerable slum communities, and to understand the differential effects of degrees of poverty on the service utilization. Birth surveillance was undertaken in 48 slum areas in six urban wards with a total population of 280,000, and it covered 5,238women during the period 2005-06.A vulnerability score card was developed based on the criteria of insubstantial housing, un metered electricity, informal water supply, no toilet facilities, hazardous location and rental accommodation. This scorecard was easy to fill and helped in predicting vulnerable communities.

The communities were then divided into four quartiles based on their socio-economic status and the differences between these groups were assessed. Data showed that the mothers were mostly in the age group of 20 to 29 years. 51% had their first pregnancy below 18 years of age, 69% were literate and 55% lived in a nuclear family. There were a number of cases with early marriages and early pregnancies. On comparing the different quartiles, the following observations were made:

		Least Poor	Poorest
1.	Literacy	more than 80%	50%
2.	Age at first pregnancy < 20 yrs.	40%	60%
4.	ANC checkup in public facility	30%	nearly 60%
5.	Number of ANC visits (three or more)	95%	80%
6.	Home delivery	Mostly institutional	25%

In addition, the results showed that

- There were 18% Caesarean sections in the private sector compared to 14% in the public sector. In some private facilities the rate could be more than 50%.
- Awareness about a health post in a slum area was low with many people unaware that there is a health post in their slum area. Moreover farther the health post was, less was the chance of them knowing about it. Also due to the travel cost they preferred going to the nearest private healthcare provider.
- The reasons attributed for home deliveries were customs and traditions 27%, quick labour and delivery 12%, nobody to accompany 9%, and afraid of hospitals 5%. In 70% of home deliveries, a traditional birth attendant (TBA) (Dai) was the birth attendant. Dr. Joshi raised a pertinent question regarding how to involve these TBAs since the Government is presently focusing on institutional deliveries. In M East and F North Wards there were 24% home deliveries while the Low Birth Weight infants ranged from 19% to 24% in the four centile groups.

On comparing the mortality pattern between the four socio-economic quartiles, it was found that the stillbirth rate per 1,000 live births was 18.3% in the poorest quartile and 22.4% in the least poor quartile. The NMR per 1,000 live births was 24% in the poorest quartile and 19% in the least poor Quartile.
Thus the study implicated that

- Within poor communities, there are socio-economic differentials in health- care uptake and outcomes
- Although healthcare uptake is relatively high, home births without skilled attendance was quite high in the poorest quartile (27%)
- Use of the largely unregulated private sector is high and increases systematically with socio-economic status
- More money implies "modernity" plus choice, but is the choice (of private unregulated sector) for the better?

Various reasons were identified for women not accessing the public health facilities. These included: waiting for a long time in a queue for getting medical attention; inappropriate behaviour of the hospital staff (scolding, abusing, shouting or slapping); being turned away and told to return later saying there is still time in delivery; refusal of delivery in the hospital as facilities were not available; and transfer to other hospitals. These factors got compounded for the poorest quartile of the women. Hence while

providing services for the urban poor; different approaches need to be tried out depending on the type of slum and socio-economic differentials. She shared the story of a newborn baby who was referred to six facilities before it was admitted and ultimately died.

Dr. Wasundhara concluded her talk with a quotation from Dr. Margaret Chan, Director- General, WHO - "Cities are the future of our world. We must act now to ensure that they become healthy places for all".

Discussion

- Dr. Desai opined that studies in different cities will yield similar results and hence it was important to find ways for addressing these issues.
- Dr. Vani stated that women don't go for institutional deliveries despite JSY due to a variety of reasons such as bad behavior of the hospital staff, fear of surgery, unfriendly atmosphere, lack of privacy and personal rapport with doctor, and absence of sanitation facilities. There is an urgent need to improve the labor rooms and the behavior of the staff.
- Dr. Desai responded that labor rooms are being strengthened and family friendly hospitals are being developed under NRHM but still there are lots of gaps.
- Dr. Shradha Dwivedi highlighted the difficulties faced by the public health facilities such as overburdening and bottlenecks such as inadequate workforce and financial procedures. She asked the gathering to find ways and work out how the private sector can help the Government sector.
- Other issues such as unequal distribution of human resources in health, doctor's absenteeism, lack of governance and accountability in the public sector, and disconnect between the medical colleges and district hospitals were also highlighted.

SESSION III: Group Work Part I

The objectives of this group work activity were to identify issues related to Acceptability, Affordability, Accessibility and Quality of Newborn Care among the urban poor population, and to explore possible solutions with special focus on potential role of private service providers. The participants were divided into four groups and each group was given a topic for discussion and developing a set of recommendations which were then presented in front of all the participants for wider consensus. The group-wise recommendations are as follow:

Group I : Acceptability

Recommendations:

Demand side

- Institutional strengthening for encouraging community participation through convergence
- Strengthening local governance structures and their role clarification
- Introduction of community-based health worker USHA
- Focusing research in areas of evidence-based BCC and IPC

Supply side

- Enabling policies
- Resource mobilization through private/corporate sector involvement
- Establish quality assurance mechanism at each level
- System strengthening

Facilitator : *Dr. Sanjay Pandey, UNICEF*
Rapporteur : *Ms. Richa Sharma*

Group 2 : Affordability

Recommendations:

- Defining Health Financing method
- Identifying acceptable model of health financing to reduce out of pocket expenditure
- Developing appropriate systems and policies to support such model

Facilitator : *Dr. Ajay Gambhir, NNF*
Rapporteur : *Dr. Sanjiv Kumar*

Group 3 : Accessibility

Recommendations:

- Define areas of work (what is urban or suburban or slum or per-slum area)
- Define scope of work (existing national programme or new initiative)
- Mapping of resources and rational allocation
- Facility operationalization (infrastructure, HR, SOPs, Guidelines, Capacity building)
- Community participation, BCC and IPC
- Accountability framework
- Convergence for addressing social determinants and providing health care

Facilitator : *Dr. Deoki Nandan, Santosh Univ.*
Rapporteur : *Dr. Kumkum Srivastava*

Group 4 : Quality

Recommendations:

- Establishing and strengthening Regulatory cum Recommendatory mechanism
- Developing a decentralized process
- Developing norms, guidelines, accrediting systems
- Capacity building of institutions (both public & private)
- Operationalization of quality processes
- Accreditation process
- Supportive supervision at each level
- Reporting from field and facility

Facilitator : *Dr. Amit Bhanot, PSI*
Rapporteur : *Ms. Nikita Arora*

DAY 2 (29 August 2012)

The day started with Prof. Shashi Vani recapitulating the proceedings of Day 1. She succinctly shared the salient points from each presentation and the following discussions, and also highlighted certain issues which require further deliberation and consideration. This was followed by the next session.

SESSION IV: **Innovation and State Urban Health Experience from Gujarat**

Chairpersons: Dr. Manazir Ali (Aligarh Muslim University, UP)

Moderator: Dr.C.P. Mishra (Banaras Hindu University, UP)

4.1 Kangaroo Mother Carefor LBW infants in socio-economically deprived sections of urban slums

Dr. Shashi N. Vani, Professor Emeritus of Pediatrics, P S Medical College, Karamsad, Gujarat

Dr. Vani spoke about the importance of Kangaroo Mother Care (KMC) especially among the urban poor. Ninety-nine percent of the global neonatal deaths occur in developing countries, with India contributing the highest proportion of more than 25%.Of the total global burden, it is estimated that India has 20% of births (26 millions), 30% of neonatal deaths (1.2 million), 40% of low birth weight infants (8 million), 40% of still births and25% of maternal deaths. Every two minutes one newborn dies in India and the majority of them die at home (tribal, rural or urban slum areas). It has been shown that in high mortality settings, simple, low cost interventions have a greater potential to reduce NMR than the highly technical and costly interventions like the ventilators, surfactants etc.

Dr. Vani outlined the objectives of her presentation on KMC as to increase awareness regarding its multiple benefits, and to universalize proper practice of KMC including home based care of low birth weight (LBW) infants in socio-economically deprived sections of poor urban slums and hospital settings, at different levels of care. She briefly discussed the different postnatal interventions and their effectiveness in reducing neonatal mortality at 90% coverage, as described in the Lancet Neonatal Survival Series of 2005.

KMC is not just a "Poor man's Incubator"and not just "Skin to skin contact", but it is humanization of care of LBW infants and sick and other newborns. The basic components of KMC include "STSC and plus "which consist of:

a. Holding the baby naked, directly on mother's bare chest with STSC in almost vertical position, for as long as possible during the day (Kangaroo Position)
b. To give exclusive breast feeding as much as possible, and with supplements wherever indicated (Kangaroo Feeding)
c. To have planned early discharge and regular follow-up including neuro-developmental assessment for a definite period(Kangaroo Follow-up)

KMC can be used widely – for STSC soon after birth (BKMC), for stabilization of LBW infants including pre-term and full-term IUGR babies, to sick newborns/unstable babies (SKMC), to term babies (TKMC) and during transport of sick newborns.

A number of good quality studies have shown that there is a significant weight gain in babies given KMC due to production of more breast milk. Recent evidence also shows better brain growth and neurological development with KMC, less chance of motor and cognitive delay and also less chance of nosocomial infections. The benefits of KMC for mothers include feeling of greater involvement in the care of her pre-term baby, reduced incidence of postpartum depression, faster recovery of mother, and greater confidence about baby care after discharge from the hospital. The benefits of KMC for the family include less duration of hospitalization, reduced cost of care, more satisfaction, involvement of the whole family in baby care, and better care of other family members including siblings. At the country level, benefits include reduced health expenditure due to decrease in infrastructure costs, reduced IMR, and less morbidity and mortality of babies.

Challenges in proper implementation of KMC:

1. In the hospital settings include health personnel's lack of awareness, lack of conviction, apathy and lack of confidence in implementing KMC, fear of family losing income, inadequate infrastructure like space, tools, inadequately trained staff for supervision, and poor cooperation from patients since there is no glamour attached to the practice of KMC as it does not appear to be an intensive intervention.
2. At home include lack of awareness, proper guidance and supervision, shortage of time, inadequate support from family members, and apathy and fear of holding a very tiny baby.

Enabling factors for acceptance of KMC include appreciation of the importance of KMC in all settings (hospital or home), provision of adequate facilities in hospital, counseling of family members regarding benefits of KMC and motivating them for all possible support to mother. Equally important is to convince the healthcare providers since they need to advice, guide and supervise KMC at hospital or at home. Another important factor for KMC promotion at the level of mothers is systematic training.

KMC needs to be promoted at the national level by including it along with breast feeding in the National Health Policy as has been done in many countries. Other steps include orientation of health workers, mothers and the community about the importance of KMC, transfer of medically stable babies to KMC wards followed by supervised KMC at home, and ensuring ambulatory follow-upcare till baby weight reaches 2,500 grams.

Dr. Vani ended her talk by citing from studies "Approximately 2.5 million newborn deaths can be averted by low-cost technological interventions of which breast feeding and KMC have a major share and together they have a compounding effect on the survival of the newborn, especially the most vulnerable low birth weight infants which include the pre-term and full term IUGR babies".

Discussion

- The number of hours (duration) of KMC is important. The family needs to be convinced. In the hills, babies are usually kept in a bag for KMC and it is important to cover their head, hands and feet. Health workers also need to be convinced about their beneficial effects and should monitor the baby. The LBW babies can be discharged early even when they attain weight of 1.6 kg although the usual recommendation is to discharge them at 1.8 kg.

- Globally there is lot of evidence that KMC reduces mortality, but KMC has not been implemented at scale in public facilities and in the community.
- In several projects, e.g. in Jhagadia in Gujarat, a number of innovations have been made such as a KMC bag. Initially the mothers were shy but now they have accepted KMC especially after the family members were involved and messages were reinforced through mothers' meetings. It has been seen that the families stitched more bags on their own and even used a bag for term babies. There have been no accidents till now due to KMC. Now even fathers and fathers-in-law have started participating as a result of sustained efforts.
- During training sessions the use of routine terms should be promoted.
- Translational research is needed. This is a challenge and all medical colleges should be involved.

Experts from Gujarat – Dr.Vikas K Desai and Dr. Shashi N Vani

4.2 Gujarat Urban Health Alliance experiences

Dr. Vikas Kishor Desai, Independent Consultant, Former Director (RCH) & Add. Director (FW), Govt. of Gujarat

Dr. Desai started her presentation by sharing facts about the urbanization in Gujarat which is the third most urbanized State in the country with approximately 15% population below the poverty line (BPL) population and 18% urban slum population.

Urbanization and migration was a big challenge in the state and hence a planning exercise was conducted for the health systems in urban areas in Gujarat, which led to the development of an Urban Health System plan and the Gujarat Urban Health Project (UHP). The urban health system plan included administration structure plan, RCH service plan, infrastructure plan and monitoring plan, and formation of an Urban Health Society. The objective of the Gujarat Urban Health Project was to develop and strengthen the primary healthcare delivery system in the urban areas in Gujarat, focusing on the health needs of urban poor and other vulnerable groups. Its strategic approaches included:

- Promoting, supporting and institutionalizing the involvement and management capacity development of the Urban Local Bodies
- Developing and strengthening management and support mechanisms at districts, regions and state levels
- A uniform Urban Primary Health Centre (UPHC) system for all urban areas of Gujarat

- Promoting, supporting and institutionalizing public-private partnership
- Promoting, supporting and institutionalizing community involvement and partnership

Initially the project started providing services in eight municipal corporations covering 42% of the state's urban population, but now it is operational in small cities also. There were two exceptions where there were no corporations but high proportion of urban population – Ahmedabad and Surat with both having more than 70% urban population.

Governance structures were established at both the State and the Corporation levels.

1. At the State level, a Director (Urban Health) was appointed with support staff consisting of an Administrative Officer, M&E Assistant and a Financial Assistant. Other professional support staff (for planning, coordination monitoring & finance) was appointed similar to the structure of the Project Management Support Unit at the State level under NRHM.
2. At the corporation level, Urban Health Societies were registered and Corporation Project Management Units (CPMU) was established with support staff (Zonal Public Health Managers, M& E Assistant and Finance Assistant). Efforts were made to provide RCH services at all levels – home, outreach and facility. Real-time Institution Management Systems (RIMS) software was introduced for monitoring Routine Immunization and the Integrated Disease Surveillance Project (IDSP) made functional.

Recruitment and placement of outreach workers was done as per the population norm recommendations of the National Urban Health Mission. The Outreach workers included Sanitation inspector, Malaria workers, Family planning workers and ANMs. USHAs were appointed as Link workers and AWWs were given additional assignments (in Surat). Self Help Groups (SHGs) were formed known as Mahila Arogya Samitis. Monitoring posed a major challenge. A mix of data sources were used which included active surveillance data, UPHC data, Municipal Corporations and Government Hospital data, State surveillance unit data on private practitioners/hospitals, and Multiple Indicator Cluster Survey (MICS) data from urban slums.

The infrastructure for Urban Health Centers was developed by upgrading all existing units in the Municipal Corporations and developing new UPHCs as per the mapping exercise. Urban Health Sub-centerswere developed for very remote slum clusters. The UHC facilities and Human Resources (HR) were setup as per the NUHM draft guidelines. The RCH programme in Urban Gujarat consists of home based care through ANMs, AWWs, and LHWs. Village Health and Nutrition Days (MAMTA Divas) were organized during which immunization sessions were held. Processes were established for UHCs development and their strengthening, and the various national and state schemes (JSY, JSSK, RSBY, sexually transmitted diseases (STD) care, Prevention of Parent to Child Transmission (PPTCT), Chiranjivi, Balsakha and eMAMTA) were introduced.

The idea of PPP in MCH came from state's previous experience with other disease control programmes. In Ahmedabad the NGOs provide health care services, while in Surat the services are provided by the Municipality. In Surat, for vector borne disease, data and other information is given by more than 200 practitioners through SMS which is then included in the software. The Vector Borne

Disease Programme (VBDP) was thus an opportunity for developing PPP. The process of partnering with the private sector was also learnt under the Malaria control programme.

Chiranjeevi and Balsakhas schemes were adopted due to an urgent need to increase institutional delivery rate for there duction of MMR and NMR. The PPP models were established for addressing the problem of acute shortage of specialists (especially gynecologists) in rural health services. A policy dialogue was established with the State Government, Indian Institute of Management, Ahmedabad, SEWA Rural and GTZ, and a series of consultations were conducted with FOGSI members at the state level as well as in the districts.

The Chiranjeevi scheme was the first PPP model to roll out to provide free delivery facility to BPL women and APL tribal women. A voucher system was established through policy dialogue with the private providers and the SHG organization SEWA Rural at Jhagadia. After a number of negotiations and advocacy points, a formula was evolved for recognition of centers, payments, reports and monitoring systems. Any qualified gynecologist with specific facilities (as spelt out in policy) could register for the scheme. The remuneration package consisted of Rs.179,500 for 100 deliveries and an additional Rs.68,000 for transportation to government facility (Rs.200 transport cost per one mother). An advance of Rs.25,000 was given to the private provider and the remaining amount was paid on submission of receipts and reports. It was mandatory for the clinics to display sign board for the services available and mentioning that no additional charge has to be paid by the woman/mother or her family. During the past 5 years, deliveries under Chiranjeevi scheme constituted 25 to 30% of the total delivery load of the state. The scheme was monitored regularly through drop-out registers, number of women served and deaths, and enquiry into extra charge levied by the doctor with the help of grievance redressal cell., The rates have now been revised to Rs.280,000 for 100 deliveries in private facilities and Rs.80,000 for 100 deliveries in government facilities.

During the monitoring it was observed that there was reduction in the maternal mortality rate compared to the estimated rate, but neonatal mortality remained unchanged. This led to the introduction of a similar initiative for newborn care (Balsakhal scheme) at the level of CHC, district hospitals, and institutions partnering under Chiranjeevi. Under this scheme, Pediatricians are supposed to attend to all newborns at the place of birth for two days, and provide early neonatal care, immunization, and feeding advice. If a baby becomes sick, it would be transferred and treated in the Pediatrician's NICU, but if the baby requires higher level of care, it would be transferred to a Medical college hospital. The Gynecologist will receive Rs.30,000 and the Pediatrician will receive Rs.1,30,000 for every 100 babies treated. The transport charges would be reimbursed for the transfer of babies from one facility to another by the Pediatrician.

At present there are 493 Chiranjeevi doctors (Obstetricians) and 217 Balsakha doctors in the state. Under the Balsakha scheme PHCs, CHCs and SCs have also been handed over to NGOs along with budgets. The State Government is also trying to develop its own HR team.

The second phase of Balsakha scheme has also been implemented (Balsakha II). It is applicable to all babies not covered under scheme I, that is, babies born to BPL families at home, at Sub-centre or at PHC. The babies are examined as per IMNCI protocols and those identified as being in the Red zone (danger zone) are referred to private Pediatricians partnering under this scheme. The Pediatrician

receives Rs.145,000 for every 100 babies treated, and transport charges shall be given to the Pediatrician for transfer of babies from one facility to another. The scheme has now been extended to cover infants till 1 year of age under the Extended Balsakha scheme.

It was heartening to note that the Gujarat state branch of the Indian Academy of Pediatrics conducted training of hospital staff while the Government provided support with the standardized protocols. Since nearly70% deliveries occur in the private sector, quality of care in these facilities is an important aspect which the government is now focusing. . In order to further improve the quality, baby friendly center sare being developed, but the progress is slow. Dr. Desai then outlined the ingredients for a successful PPP – feedback, avoidance of making too many promises to both parties, use of standard operating procedures, establishing community intervention methodologies, indemnity, grievance redressal mechanism and a clear time frame for transition and withdrawal.

The Chiranjeevi and Balsakha programme sled to improved practices in the intervention group in the home born as well as in the facility born babies. In Surat the home deliveries decreased from 48.6% in 1996 to 27.9 % in 2010, and tetanus toxoid immunization increased from 64.5 % in 1996 to 93.7% in 2010. Percentage of fully immunized children increased from 34.6 % in 1996 to 60.5% in 2010 while the non-immunized children decreased from 23.1% in 1996 to 0.8% in 2010. Early breast feeding rates increased from 11.5% in 1996 to 37.1% in 2010 and the complementary feeding increased from 10.1 % in 1996 to 46.1 % in 2010

Dr. Desai ended her talk by focusing on the seven essential components for an effective PPP-Policy, Plan, Process, People, Protocol, Performance audit, Patience and Perseverance.

Discussion

1. There were numerous problems in the beginning especially delay in payment due to which some doctors withdrew from the programme. Moreover some doctors had pending funds of more than seven lakhs. But now it is operating well because of the advance payment and timely payment of the remaining money. .
2. In the early phase, there were other problems also such as doctors conducting only normal deliveries and not Caesarean Sections. Hence the payments were delayed. Now it has been stabilized.
3. It was suggested that Vector borne disease control programme can be an entry point in urban health. Moreover professional associations like the IAP and FOGSI should be involved. The strengths of both the systems should be examined and combined for PPP.
4. In the 7 Ps of PPP, Participatory should be added.

SESSION V: Group Work Part 2

The objective of this group work activity was to brainstorm planning activities for partnership with private service providers and identify resources for four domains – development of comprehensive lead programmes, improving demand and promoting household practices through community participation, enhancing competence of slum-based TBAs for specific activities, and partnership with private sector for improved service delivery and advocacy. The recommendations suggested by the four groups are as follow:

Group 1 : Development of comprehensive lead programmes

Recommendations:

- Mapping of Stakeholders for policy development and field implementation
- Identify areas of operationalization (e.g. capacity building, resource generation and mapping, M & E)
- Advocacy for more political support and improvement in governance
- Developing Accountability framework with community participation
- Strengthening existing systems and working together with ICDS

Facilitator : *Dr. Rajesh Khanna, NIHFW*
Rapporteur : *Ms. Richa Sharma*

Group 2 : Improving demand, promoting household practices & outreach services through community participation

Recommendations:

- Identify community stakeholders willing to support newborn care initiative (e.g. community leaders, local practitioners, SHGs, State & District Urban Development Authorities)
- Assessment of community demand and care-seeking behavior
- Development of evidence-based contextualized communication strategies
- Use of innovative IT platforms for health communication (like mHealth)
- Use of different platforms for health communication (e.g. melas, ICDS functionaries, public awareness lectures)
- Community-based health care financing mechanisms

Facilitator : *Dr. Amit Bhanot, PSI*
Rapporteur : *Dr. Sanjiv Kumar*

Group 3 : Enhancing competence of slum based TBAs for improved Maternal Newborn Care

Recommendations:

- Mapping of TBAs according to their work and potential future role (for ANC or IPC or PNC)
- Capacity building/training as per their expected role
- Linking them with the health system (ANMs, health posts, hospitals)
- Supporting them in the field
- Incentives for appropriate practices
- Linkages with community/other stakeholders

Facilitator : Mr. George Philips (Intra Health)
Rapporteur : Mr. Praveen Kumar

Group 4 : Planning for partnerships and identifying resources

Recommendations:

- Mapping of partners (private, corporate, NGOs, FBOs) and resources
- Defining roles for each partner
- Advocacy for developing evidence-informed policies for operationalizing Public-Private Partnerships
- Establishing norms for quality mechanisms

Facilitator : Mr. Atul Kapoor, PSI
Rapporteur : Ms. Nikita Arora

SESSION VI:	WAY FORWARD AND VALEDICTORY
	Panel members: 1) Mr. Mukesh Kumar Meshram, MD-NRHM, GoUP 2) Mr. Amod Kumar, IT Advisor to the Hon'ble Chief Minister of UP 3) Dr. Hari Om Dixit, G M Community Process, GoUP 4) Dr. Sanjay Pandey, Health Specialist, UNICEF, UP Facilitator: Dr. Rajiv Tandon, Senior Advisor-MNCHN, Save the Children

6.1 Summary of the Consultation

Dr Rajiv Tandon Senior Advisor-MNCHN, Save the Children

Dr. Rajiv Tandon thanked Mr. Mukesh Kumar Meshram (MD-NRHM, GoUP) and Mr. Amod Kumar (IT Advisor to the Hon'ble Chief Minister of UP) for taking out their precious time to attend the National Consultation and briefed them about the proceedings. He informed that the Consultation was organized to discuss ways of improving newborn care for the urban poor, and the potential of including private providers since most of health care in these areas is being provided by these providers. Altogether the consultation was attended by 110 participants from 85 organizations which included the government, donors, medical colleges, NGOs, academicians, and professional and training associations/organizations from the states of Gujarat, UP, Maharashtra and Delhi.

The eminent experts included Prof. Vinod Paul from AIIMS who has been involved in the development of many Five Year plans in the past at the national level. While pointing out that the urban poor population is increasing rapidly, he suggested seven solutions taking care of both the demand and supply side issues. The National Urban Health Mission discussions are happening at the national level, and it is expected to be launched soon. He said that we need to "Walk the Talk".

Dr Tandon remarked that though there are many healthcare models for the urban poor in the country (either Government or NGO led), none of these models or any activity for newborn care, nutrition or maternal health show any clarity on policy and programmatic front. The definitions of urban poor, non-slum urban poor, or squatters are not clear. There are issues of migration, seasonality, water and sanitation. It is also clear that the first health care contact by more than 50% of urban poor is with the informal private providers since they are available, affordable and accessible. The question that arises then is as to how do we plan to involve them. One way to draw the informal private providers into the planned health care structure is to give them a role, maybe in BCC, or in motivating people or for providing referrals. Consultations with Professional organizations will be required for this.

The other experts included Dr Wasundhara from SNEHA who had talked about the work carried out in a research mode with community participation and linkages to the system. Appreciative enquiry had also been introduced. However the study identified variation in health care uptake and outcomes even within the urban poor population based on their socio-economic differentials, and this suggests that there cannot be one strategy. Prof. Shally Awasthi had conducted an ICMR research for behavior change strategy in Lucknow, UP. The processes were shared and every step had evidence which can be used.

The Sure Start Programme had tested different intervention models in different cities of Maharashtra, and generated some evidence. While Dr Geetha Pillai talked about the intervention in 11 cities of UP which had lots of learning and innovative approaches, Dr Dixit presented the CCSM model in UP, its challenges for scaling-up, and its successful model for supportive supervision. Prof. Shashi Vani led the newborn health agenda with her presentation on KMC especially in resource scare settings. In the end, Dr Vikas Desai talked about the systemic reforms undertaken by the Gujarat government to tackle urban health at the State and at the Corporation level. There are many lessons and innovative approaches to be learned from the Chiranjeevi and Balsakhas schemes. A visit to Gujarat would be useful to study their urban health system.

During the consultation, two Group exercises were organized.

- The first group work activity was planned to identify issues related to Acceptability, Affordability, Accessibility and Quality of Newborn Care among the urban poor population, and to explore possible solutions with special focus on potential role of private service providers
- The second group work focused on four themes – development of comprehensive lead programmes through close partnership with stakeholders, ways to improve demand by promoting household practices, enhancing competence of health workers at all levels with improved linkages with health facilities, and partnership with the private sector and academia for enhancing service delivery and for advocating for greater attention to the urban poor newborn.

In the end Dr Tandon said many recommendations have been suggested which are doable and these will be an integral part of the Book of Proceedings. There will be clear policies and programmes which can be implemented at the State and National level. He requested the Government of UP to champion urban health especially for the urban poor newborn, and be the pioneer for an Urban Health Mission.

6.2 Views of Government of Uttar Pradesh

Mr. Amod Kumar, IT Advisor to the Hon'ble Chief Minister of UP

Mr. Amod Kumar spoke about National Urban Health Mission or National Health Mission which is soon to be launched. He also said that the private sector has been involved in rural health under the RSBY programme, but it has a greater role to play in the urban areas than the rural areas. In the UP Health Systems project, one key strategy is PPP and there is a need to concentrate on this because quality in the private sector is an important issue for providing services in the urban area.

He advised caution regarding the involvement of informal private providers because a recent judgment passed by the High Court had directed the State government to take action against the informal providers, which has led to some activities against them. Since the High court is regularly monitoring this, the GoUP cannot do much till legal recourse is taken and/or the Supreme Court gives some directives to reverse the order. There is a need to involve them because their services can be used for giving health messages, BCC and for referral services. He agreed that it was an important issue which needs to be carefully looked into.

RSBY is underutilized in UP because of the very casual attitude towards the poor. It is essential that the package is advertised in all rural and urban poor areas so that its utilization increases. In UP a Saubhagyati Yojana was also initiated for health insurance but it has been a failure. Hence there is a need to concentrate on RSBY and its implementation.

6.3 Remarks by Mission Director NRHM, Government of Uttar Pradesh

Mr. Mukesh Kumar Meshram, MD-NRHM, GoUP

Mr. Meshram thanked Dr Tandon for the experiences that had been shared. He said that UP is a very big state witht remendous scope and challenges in the health sector and the State Government is quite open for best practices and tried and tested examples. State specific models can be developed which can then be successfully implemented. Recently the World Bank supported UP Health Systems Development Project (UPHSDP) has been launched with sufficient funds available for existing health system improvement through gap analysis, survey and capacity building. Infrastructure funding is from NRHM. The norms have been established and30% of the total allocation has to be put for infrastructure development. To make it a workable system, sensitization and training for manpower is required. A model needs to be developed so that not only the poor, but also the well-to-do sections of the society visit the Public Health system. It is important to identify the gaps and address them. As part of the quality drive, 40 hospitals are in the process of being prepared for accreditation by the National Accreditation Board for Hospitals (NABH).

Valedictory function (sitting from left to right – Dr. Sanjay Pandey, Dr.Hari Om Dixit, Sh. Amod Kumar, Sh. Mukesh Kumar Meshram, Dr. Rajiv Tandon)

In the state a Health Partners Forum has been formed which meets quarterly with the agenda of sharing global best practices and those of other States, and based on that a list of doable activities are planned and organized. District specific plans are made with inputs from the Health Partners Forum. Each district plan requires modification as per the instructions from GoI depending upon district-specific issues – in some districts it is malnutrition, some districts have tribal groups, some districts are fluoride affected and some districts are arsenic affected.

The State Institute of Family Planning Systems Agency is winding down on 31st March 2013 and a transition plan will be made. 'Merry Gold' and 'Merry Silver' hospital accreditation has started and NRHM will take this over. The tehsil and block level private hospitals will be identified and partnerships under PPP will be developed. For urban areas vouchers through PPP can be initiated. These have to be planned and included in the PIP.

The urban health posts are in the process of being modified and 100 new posts have been sanctioned. Since people are not aware of these facilities, the Government is making and distributing a Family Health card for each family which would list all the details – the facilities, which doctor and what services they will get. In addition Private Service Providers have been involved in the implementation of Mobile Medical Units (MMU) and the plan is to operationalize 150 MMUs in the high focus districts in the current year.

The urbanization trend will result in the urban population of 50% in the coming years. Migration will occur to the slums which are without civic amenities and these are big vulnerable populations. The challenge is to address them and make them part of our programmes so that the indicators improve. Hence this is the right time and these consultations will help. The recommendations and suggestions will be incorporated in NRHM plans where there are provisions for the urban poor and vulnerable groups.

The Municipal Corporation boundaries have to be redefined since the haphazard development has occurred which has become home to the urban poor. These peri-urban areas are being covered through urban posts. However there is a need to plan efficiently and the biggest challenge is the limited staff.The Health Partners are expected to provide support in preparing plans based on the recommendations of this Consultation

6.4 Vote of Thanks

Dr. Sanjay Pandey, Health Specialist, UNICEF-UP

Dr. Pandey thanked the MD NRHM and IT Advisor to Hon'ble CM of UP for attending the Consultation and listening to the proceedings summary. He requested them to take this initiative forward and expressed UNICEF's willingness to support the State Govt and other partners. He also expressed his appreciation for the experts from other states, senior state health officials of the GoUP, academia from medical colleges, programme staff and donor partners for their positive contribution during these 2 days. In the end he thanked Dr. Rajiv Tandon and his team from Save the Children for working together with UNICEF in organizing the consultation.

ANNEXURES

ANNEXURE I. INVITATION LETTER

SPMU/CH/18-3-II/2012-13/936

Mukesh Kumar Meshram
IAS
Mission Director

National Rural Health Mission
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Dated- 31/07/2012

Dear .....,

Dear sir/madam,

Invitation to National Consultation on Potential Role of Private Sector Providers in Delivering Essential Newborn Care, Lucknow, August 28 – 29, 2012

It is a well known fact that India's share of neonatal deaths in the world is a significant 30%. Neonatal mortality contributes to about two-thirds of all infant deaths, and about half of under-5 deaths in the country. There is a growing recognition that in order to reduce the under-5 and infant mortality rates in the country, a significant decline in neonatal mortality rate is required – especially reduction of deaths within the first one week of life. With one-third of India's urban population residing in slums newborn care is sub-optimal among India's urban poor leaving neonates born in urban poor settings at even greater risk. Save the Children (SavingNewborn Lives) and UNICEF in partnership with the Ministry of Health and Family Welfare, Government of Uttar Pradesh invite you to a two day consultation on the role private providers could play in the provision of essential newborn care within urban poor settings.

The challenges in addressing needs of the newborns in urban poor settings exist at both community as well as program level. The proposed consultation to be organized in Lucknow will highlight the challenges and suggest a way forward in light of the existing opportunities and lessons from successful experiences. The objective of the consultation is to discuss the potential role of the private sector providers in delivering essential newborn care especially in the under-served urban and peri-urban settings in India.

The private sector providers could bring strengths to address health care seeking behaviours, low cost and affordable health solutions and ensure access by community. Evidence indicates that, in many parts of India, the private sector provides a large volume of health services but with little or no regulation. Collaboration with the private providers with adequate skills can be engaged for franchising models to deliver NBC services, but needs discussion on scope and objectives of partnership, policy and legal frameworks, capacity to monitor such partnerships and other issues.

Improving newborn care needs innovative thinking to ensure that the current opportunities are not wasted – and ensure that India can continue to grow and prosper with proper care to newborn children. We expect participation from a wide range of stakeholders (Government – UP and National, corporate sector, NGOs, donors, academia, media and others). Your inputs will be invaluable and we look forward to your participation in order to make the Consultation a success. Please block your diary on the above mentioned dates. The venue and agenda for this 2 day meeting will be shared with you shortly.

Dr. Rajiv Tandon

Senior Advisor,
Newborn Child Health and Nutrition
Save the Children

Ms. Adele Khudr

State Representative,
UNICEF, Lucknow

Mr. Mukesh Kumar Meshram

Mission Director,
National Rural Health Mission
Ministry of Health and Family Welfare,
Government of Uttar Pradesh

ANNEXURE 2. CONCEPT NOTE

Concept Note on the National Consultation on The Potential Role of Private Sector Providers in Delivering Essential Newborn Care in under-serviced Urban and Peri-Urban settings

Lucknow – August 2012

The Problem:

India's share of neonatal deaths in the world is around 30% of the global neonatal deaths. Of the 26 million babies born every year in India, about 936,000 babies die before the age of one month. According to the SRS 2010 report, neonatal mortality contributes to about two-thirds of all infant deaths (NMR 34/1000 live births, IMR 50/1000 live births) and about half of under-5 deaths in the country (U-5MR 64/1000, SRS 2009). Though IMR has shown a steady decline over the last few years (from 58/1000 in 2004 to 50/1000 in 2009), the decline in NMR has been disproportionately slow (from 37/1000 in 2004 to 34/1000 in 2009).

There is a growing recognition that in order to reduce the under-5 and infant mortality rates in the country, a significant decline in neonatal mortality rate is required – especially reduction of deaths within the first one week of life. Under the Janani Suraksha Yojna scheme of the National Rural Health Mission (NRHM), there has been a significant increase in institutional deliveries and influx of mothers and newborns in the facilities. In addition the Integrated Management of Neonatal and Childhood Illness (IMNCI) and the Home Based Newborn Care (HBNC) programs have been operationalized. All these programs have resulted in an increasing number of sick newborns presenting to district hospitals and other referral hospitals. However, essential new born care and care of the sick new born have been found to be lacking within the continuum care which is from the house hold where still many newborns are born and in some of the health care facilities.

There is significant evidence that past programs and approaches are not achieving the desired objectives and need refinement. Lack of demonstrated political will to assume responsibility and accountability for services as well as absence of interdepartmental coordination within several urban bodies such as department of public health, urban development, medical education, municipal corporation and urban local bodies has further made the matters worse. The ultimate responsibility of providing health services in urban areas is not clear, unlike rural areas where the district administration is responsible for service provision; ambiguity regarding this distinctly prevails in urban areas

Improving newborn care needs new ideas and new partnerships to ensure that the current opportunities are not wasted – and ensure that India can continue to grow and prosper with proper care to newborn children.

Assumption:

The Proposed Consultation:

One-third of India's urban population resides in slums and squatters, their vulnerability being characterized by poverty and powerlessness. Newborn care is sub-optimal among India's urban poor, yet scarcely documented. Neonates born in urban poor settings are at high risk of death owing to multitudinous factors. Challenges in addressing needs of the newborns in urban poor settings exist at community as well as program level and need to be addressed simultaneously. The proposed consultation to be organized in Lucknow will highlight the challenges and suggests a way forward in light of the existing opportunities and lessons from successful experiences and also identify possible role of private providers in improving newborn care.

The objective of the consultation is to discuss the potential role of the private sector providers in delivering essential newborn care especially in the under-served urban and peri-urban settings in India.

The following emerge as imperatives for improving newborn care among the urban poor in India:

i) Development of comprehensive lead programs through close partnership among academic agencies like National Neonatology Forum, NGOs, socially committed private doctors, hospitals and city governments;
ii) Improving demand, promoting household practices, service outreach through trained slum-based health volunteers and women group and encouraging slum-level health funds as a community risk pooling measure;
iii) Enhancing competence of slum-based TBAs to improve home delivery practices and encourage hospital deliveries by linking them to affordable facilities;
iv) Investment in building human resource capacity at all levels for providing improved newborn healthcare;
v) Partnership with the private sector (private/charitable health facilities and non-government organizations) and academia for enhancing service delivery and for advocating for greater attention to the urban poor newborn;
vi) Making the invisible visible and reaching the unreached and more vulnerable clusters.

The private sector providers could bring strengths to address health care seeking behaviours, low cost and affordable health solutions and ensure access by community. Evidence indicates that, in many parts of India, the private sector provides a large volume of health services but with little or no regulation. Collaboration with the private providers with adequate skills can be engaged for franchising models to deliver NBC services, household behavior change, improved and healthy practices etc. These include the motives of the private sector providers, scope and objectives of partnership, policy and legal frameworks, benefits of such partnerships, technical and managerial capacity of governments and private agencies to manage and monitor such partnerships, incentives for the private sector providers, stakeholders perspectives towards partnership, focusing on quality and innovations and explicit benefits to the poor through such partnerships. While there has been a continued assumption on private sector not being regulated and checked for its quality, it is important that regulation of both the

private and public sector be given priority attention by way of establishing an accreditation system where both are regulated, developed and treated on equal footing. Building capacities of the private sector in efficient provision of services can also be looked into.

The proposed consultation is designed to start the conversation about mutual interests and possible potentials that would benefit the private sector providers as well as the public health sectors.

Ministry of Health and Family Welfare Government of UP, UNICEF Lucknow office and Save the Children India (Saving Newborn Lives) will jointly organize this consultation in Lucknow.

Time line: the consultation will be held in Lucknow on April 10-11,2012

Process:

- UNICEF , other core UP partners and Save the Children with work further to finalize the contours of the consultation.
- Wide range of stakeholders will participate (Government – UP and National, corporate sector, NGOs, donors, academia, media etc).
- Hold an open and participatory forum to explore opportunities to work for improving newborn care in the urban poor environments. Possibly use open space technology as the meeting methodology to allow generation of ideas, building consensus and establishing priorities.
- Disseminate the consultation's findings and recommendations widely.

Key Agenda:

1. Situation of NBC in urban and peri-urban setting
2. Sharing evidence and experiences on engaging private sector providers in delivering newborn care (within Uttar Pradesh and from other states)
3. Way forward and recommendations

Expected outcomes:

1. Sensitization of partners and policy and program implementers on the role of private sector providers in delivering essential newborn care services.
2. Agenda setting and coalition building for partnership, policy and legal frameworks
3. Role rationalization of informal private sector providers

ANNEXURE 3. AGENDA

National Consultation on "Potential Role of Private Sector Providers in Delivering Essential Newborn Care in under serviced urban and peri-urban settings"

Date : 28-29 August 2012
Venue: Conference Room, Hotel Lineage, Gomti Nagar, Lucknow – 226010.

AGENDA

DAY : 1		
Registration	**10:00 AM to 10:30 AM**	
Inauguration followed by Introduction to Newborn health care services in urban and peri-urban settings	**10:30 AM to 01:00 PM**	a. Welcome note by Dr. Rajiv Tandon, Senior Advisor-MNCHN, Save the Children (Saving Newborn Lives-SNL) LAMP LIGHTING CEREMONY b. Child Health & Immunization in India: Dr. Manpreet Singh, Consultant (Child Health), MoHFW, GoI c. Community Based Child Health – Reaching the unreached in the urban India: Dr. Gaurav Arya, Health Specialist, UNICEF d. BMGF plans for UP: Dr. Devendra Khandait, PO, State Programs, BMGF e. Challenges in Urban Health in UP: Prof. Deoki Nandan, Chancellor Santosh University & Former Director NIHFW f. Best practices for addressing neonatal mortality in urban areas: Prof Vinod Paul, HOD, Deptt. of Paediatrics, AIIMS g. Child Health Programme in UP: Dr. Hari Om Dixit, G M Community processes, GoUP
Lunch Break	**01:00 PM to 01:45 PM**	
Sharing of evidence from other urban health programmes and Discussion	**01:30 PM to 02:30 PM**	Chairpersons: Dr. Manpreet Singh, MoHFW, Dr. Hari Om Dixit, GoUP Moderator: Dr. Devendra Khandait, BMGF 1. The city initiatives for newborn health – Improving survival and health of new born from slum

		communities: Dr. Wasundhara Joshi, Director, SNEHA 2. Care seeking behavior for sick newborn among the urban poor in Lucknow: Prof. Shally Awasthi, Dept of Pediatrics, KGMC, Lucknow
Sharing of evidence from other urban health programmes (continued)	**02:30 PM to 04:00 PM**	Chairperson: Dr. Aruna Narayan Moderator: Dr. Vikas Kishor Desai 1. Improving access to MNH through community mobilization and partnerships in urban areas - The Sure Start Maharashtra Experience: Dr. Lysander Menezes, PATH 2. 11 City experience of UHI: Dr. Geetha Pillai, UHI 3. Inequalities in maternity care and newborn outcomes: one year surveillance of birth in vulnerable slum communities in Mumbai: Dr. Wasundhara Joshi, Director, SNEHA
Tea/ Coffee Break	**01:00 PM to 01:45 PM**	
Group Work 1: Issues for Newborn Care among urban poor and possible solutions including potential role of private service providers	**02:30 PM to 04:00 PM**	GROUP FACILITATORS: • Group 1 on Acceptability: Dr. Sanjay Pandey, UNICEF • Group 2 on Affordability: Dr. Ajay Gambhir, NNF • Group 3 on Accessibility: Dr. Deoki Nandan, Santosh University and Ex-Director, NIHFW • Group 4 on Quality: Dr. Amit Bhanot, PSI
DAY : 2	**Starts at 09:00 AM**	
Recap of day 1	**09:AM to 09:15 AM**	Dr. Shashi N. Vani
Innovation and State Urban Health experience from Gujarat	**09:15 AM to 10:00 AM**	Chair: Dr. Manazir Ali, AMU Moderator: Dr. C. P. Mishra, BHU 1. Kangaroo Mother Care for LBW babies in socio-economically deprived sections of urban slums: Dr. Shashi N Vani, Dept. of Pediatrics, P N Medical College, Ahmedabad 2. Gujarat Urban Health Alliance experiences: Dr. Vikas Kishor Desai, Former Director (RCH) & Add. Director (FW), Govt. of Gujarat

Group Work 2: Proposed plans for partnership with private service providers and identifying resources	**10:00 AM to 11:15 AM**	GROUP FACILITATORS: • Dr. Rajesh Khanna, NIHFW - Development of comprehensive lead programs through close partnership among academic agencies like NNF, NGOs, socially committed private doctors, hospitals and city governments • Dr. Amit Bhanot, PSI - Improving demand, promoting household practices, service outreach through trained slum-based health volunteers and women group and encouraging slum-level health funds as a community risk pooling measure. • Mr. George Philip, IntraHealth Inc.- Enhancing competence of slum-based TBAs to improve home delivery practices and encourage hospital deliveries by linking them to affordable facilities & investment in building human resource capacity at all levels for providing improved newborn healthcare • Atul Kapoor, PSI - Partnership with the private sector (private/charitable health facilities and non-government organizations) and academia for enhancing service delivery and for advocating for greater attention to the urban poor newborn
Tea/ Coffee Break	**11:15 AM to 11:30 AM**	
Group Work presentations	**11:30 AM to 01:00 PM**	By Group facilitators
Way forward and Valedictory	**01:00 PM to 02:00 PM**	• Mr. Mukesh Kumar Meshram, MD-NRHM, GoUP • Mr. Hari Om Dixit, G M Community Process, GoUP • Mr. Amod Kumar, Advisor-IT to the Hon'ble Chief Minister of UP • Dr. Sanjay Pandey, Health Specialist, UNICEF, UP Facilitator: Dr. Rajiv Tandon (Save the Children/SNL)
LUNCH	**02:00 PM to 03:00 PM**	By Group facilitators

ANNEXURE 4. LIST OF PARTICIPANTS

National Consultation on "Potential Role of Private Sector Providers in delivering NBC in Urban and Peri-urban settings"
28-29 August 2012, Hotel Lineage, Gomti Nagar, Lucknow, Uttar Pradesh

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ANNEXURE 5. RECOMMENDATIONS SUBMITTED TO GoUP

Summary Policy Recommendations

The Potential Role of Private Sector Providers in Delivering Essential Newborn Care in under serviced urban and peri-urban setting
Based on National Consultation held in Lucknow on August 29, 2012

Background

India's share of neonatal deaths in the world is around 30% of the global neonatal deaths. There is a growing recognition that in order to reduce the under-5 and infant mortality rates in the country, a significant decline in neonatal mortality rate is required – especially reduction of deaths within the first one week of life. One-third of India's urban population resides in slums and squatters, their vulnerability being characterized by poverty and powerlessness. Newborn care is sub-optimal among India's urban poor. Improving newborn care needs to focus on the continuum of care approach with its link to nutrition and WASH. New ideas and new partnerships are required to address the migrant, equity and gender issues. Although there are successes stories and which show what we can address the challenges of newborn health with better partnership with the informal and unregulated private sector providers.

The private sector providers could bring strengths to address health care seeking behaviours, low cost and affordable health solutions and ensure access by community. Evidence indicates that, in many parts of India, the private sector provides a large volume of health services but with little or no regulation. Collaboration with the private providers with adequate skills can be engaged for franchising models to deliver Newborn health services, household behavior change, improved and healthy practices etc. These include the scope and objectives of partnership, policy and legal frameworks, benefits of such partnerships, technical and managerial capacity of governments and private agencies to manage and monitor such partnerships, incentives for the private sector providers, stakeholder's perspectives towards partnership, focusing on quality and innovations and explicit benefits to the poor through such partnerships. Besides that, there is a need to generate evidence on applied and operational issues through research.

Policy Recommendations

Development of a UP Urban Health policy and Operational guidelines by March 2013

The key focused areas include:

- Structures for Governance
- Convergent action
- Infrastructure
- HRH including USHAs
- Demand generation – Community mobilization and BCC
- Partnerships including with the Private sector
- Regulatory mechanisms
- Having good data for decision making
- A referral system

- Financing mechanisms
- Innovations and Research
- Budget provisions

Proposed Immediate next steps

1. Formation of a UP state multi-stakeholder Task Force for policy formulation and development of operational guidelines
2. Setting up of Governance structures
   - Registration of Societies at the State and Corporation levels
   - Appointment of a State Urban Health Director with support staff
   - Setting up of Programme Management Support Units at the State and Corporation levels (on the lines of NRHM) with appointment of personnel
3. Mapping of facilities and HR in the Public and private domains
4. Developing the norms and guidelines
5. Developing PIPs at the State, Corporation and municipality levels following the RMNCH continuum of care approach with a clear goal for newborn care
6. Budget allocation through NUHM and NRHM
7. Infrastructure upgradation and HR recruitment and skill development
8. Creating a centre of excellence for Urban Health Research and Innovations

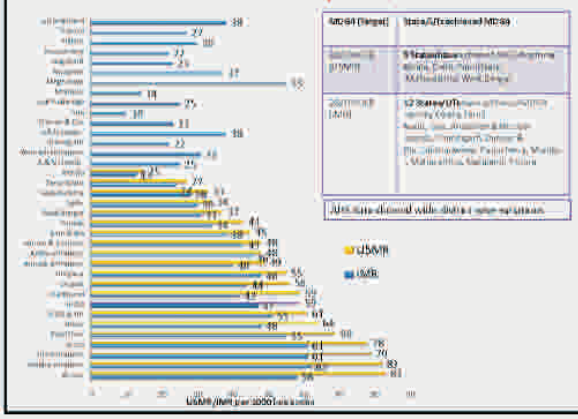
PRESENTATIONS

NATIONAL RURAL HEALTH MISSION

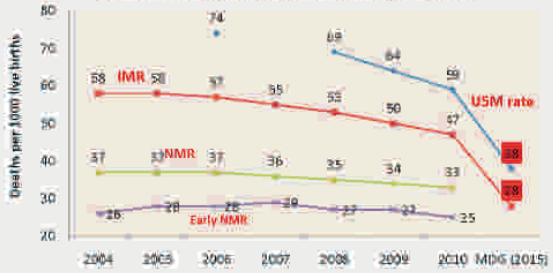
An Overview of Child Health Program including immunization in India

Dr. Manpreet Khurmi
Consultant – Newborn & Child Health
Ministry of Health & Family Welfare
Govt. of India

Status of Under Five Mortality and IMR, SRS 2010

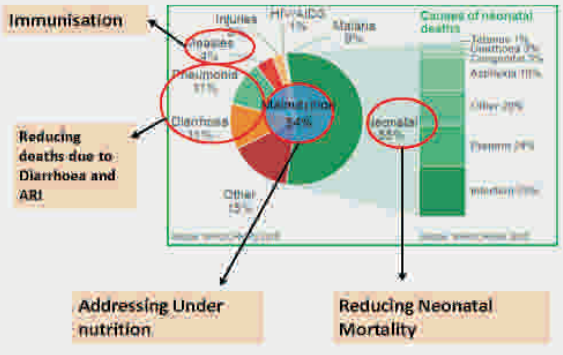


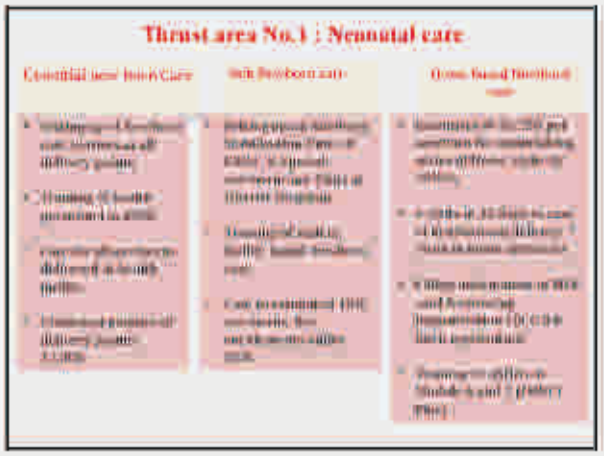
Situation of Child Health in India (SRS 2010)



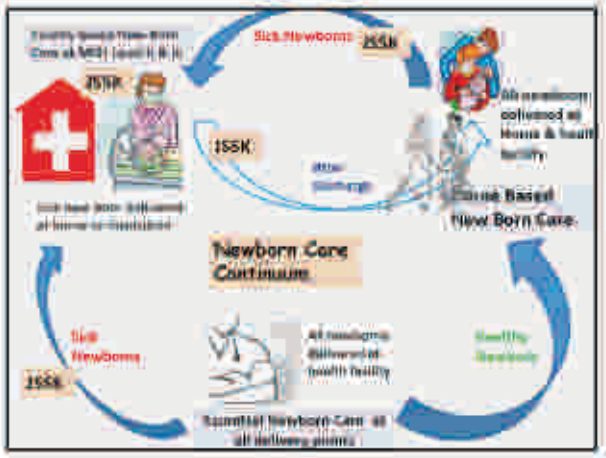
- Consistent decline in U5MR and IMR
- Slow decline in NMR
- Significant gender variation seen
- Significant urban-rural differential

Thrust Areas for Reducing Under 5 Mortality in India

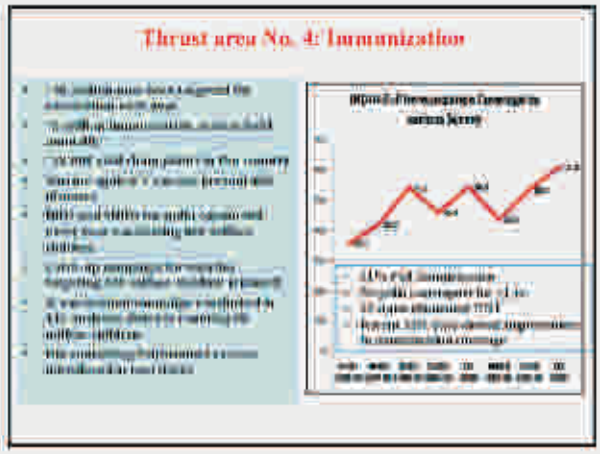



Thrust area No.1 : Neonatal care

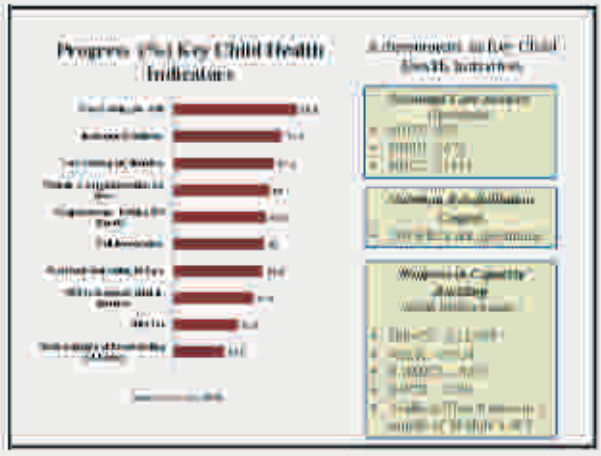

Thrust area No.2 : Malnutrition


Sick Newborns
Home Based
New Born Care
Newborn Care
Continuum


Thrust area No.3 : Diarrhoea and ARI


Thrust area No. 4: Immunization


Thank You


Progress (%) Key Child Health Indicators

COMMUNITY BASED CHILD HEALTH REACHING THE UNREACHED... IN URBAN INDIA

Dr. Gaurav Arya, MBBS, MPH
Health Specialist, UNICEF

The Year 2012... Snapshots – The highs

- The 13th President of Republic of India took oath
- India won 6 medals at 2012 London Olympics for the first time in history
- India won the Under-19 World Cup
- India successfully launched the Prithvi missile




The Year 2012... Snapshots – The lows

- Floods in Assam render thousands homeless
- Indian Hockey team finishes last in the pool in London Olympics
- Inflation continues unabated
- 11 Trains incidents claim more than 100 lives




Where are the health issues? Who says...

- That close to 49000 infants have died in India in 2012
- That approximately 32000 neonates died in 2012
- That 10500 children (under-5) died due to pneumonia in 2012
- That 9000 children (under-5) died due to diarrhoea in 2012
- That about 60,000 women have died during pregnancy/ childbirth in India in 2012
- That most of these lives could have been saved by simple community based public health interventions

The "India shining paradox"..

India registered an impressive economic growth rate of 7.5 - 8.5 per cent between 2000 and 2010*

- Yet about 37 per cent of the population live below the official poverty line
- Only 20 % of people have access to reliable essential healthcare

50% of India's current population is 0 to 25 years old**

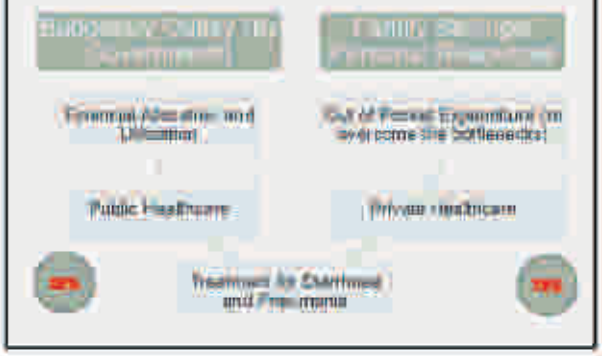
Low Public Health Expenditure

India's public spending on health is among the lowest in the World

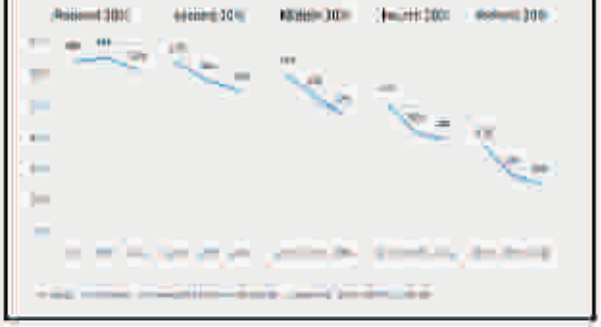
India	1.2	4.2

- Over 2.2 % of population is pushed into poverty every year due to medical expenses
- Medicines account for 72% of private expenditure on health (out of pocket payments)

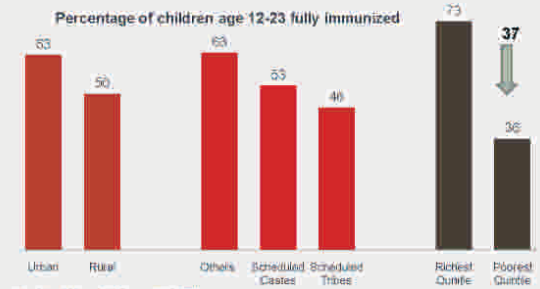
Healthcare Financing



Level of under-nutrition in children of the poorest households has stagnated

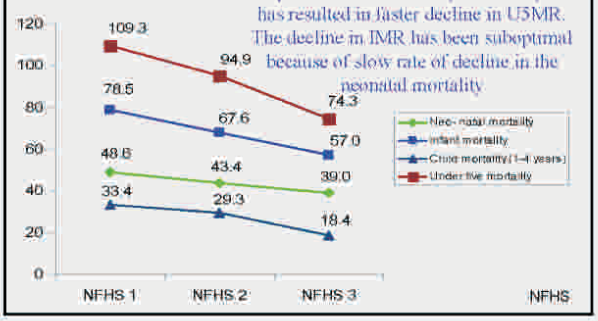


There are glaring disparities in Immunization coverage

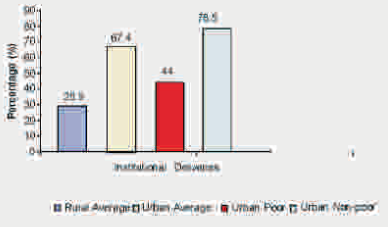


Reduction in neo-natal mortality, IMR and U5MR is stagnating

Sharp fall in child mortality rate (1–4 years) has resulted in faster decline in U5MR. The decline in IMR has been suboptimal because of slow rate of decline in the neonatal mortality



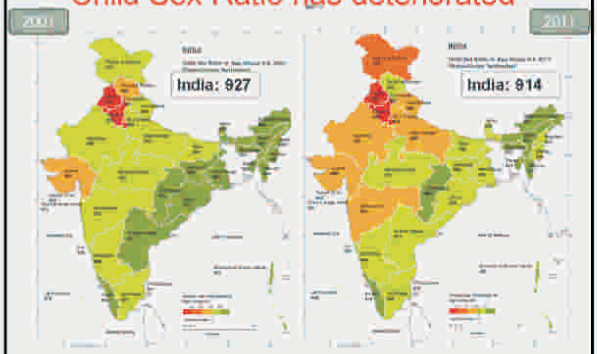
Poor Access to Maternity Services

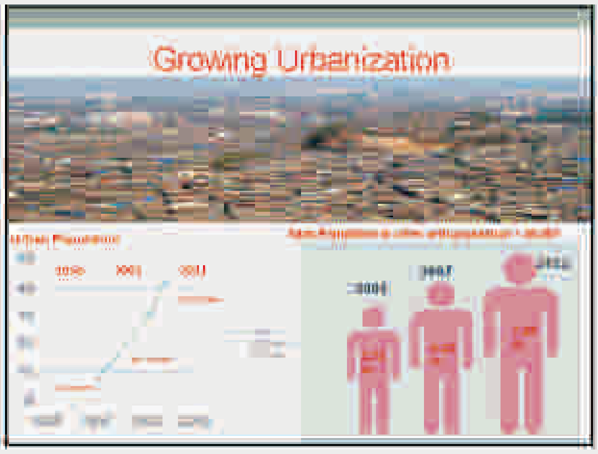


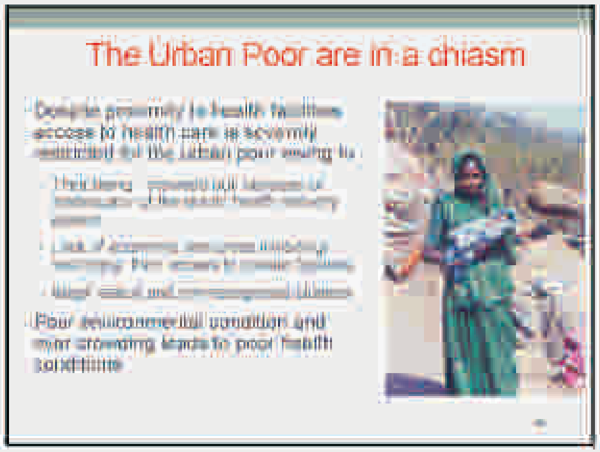
Source: Re-analysis of NFHS-3(2005-06) by Wealth index

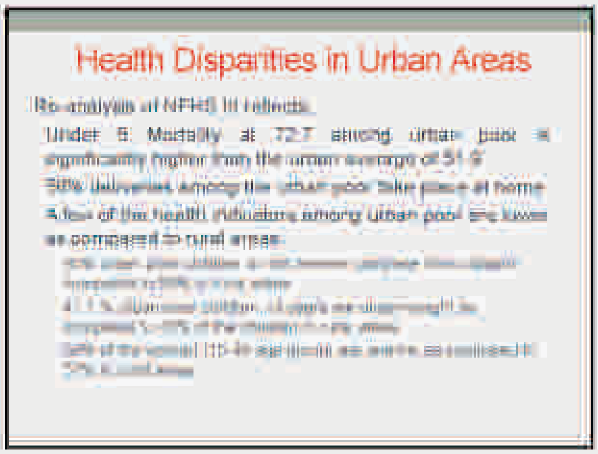
Institutional Deliveries - All India 38.6%

Child Sex Ratio has deteriorated




Growing Urbanization
Urban Population


The Urban Poor are in a chiasm
access to health care is severely
Poor environmental condition and
over crowding leads to poor health
conditions


Health Disparities in Urban Areas
Re-analysis of NFHS III reveals
Under 5 Mortality at 72.7 among urban poor is
56% deliveries among the urban poor take place at home
as compared to rural areas


Improving Healthcare in India
Focus on investing (reinvesting GDP) in public health – address the paradoxical disconnect between economic growth & health indicators
Public sector investment
Private sector investment
Focus on reaching the unreached through efficient and effective public health interventions in public and private domains – aim to reduce the inequities
Focus on neglected public health challenges e.g. Diarrhoea, Pneumonia, Malaria, TB
Focus on emerging public health challenges in urban and rural areas (specific to need)

Strengthening Health Systems

- Macro reforms
  - Investment for short, medium and long term
  - Partnerships – Public-Private, Public-Public and Private-Private
  - Reaching the bottom of the pyramid
- Micro reforms
  - Needs assessment in the community
  - Capacity development of health providers
  - Rational deployment
  - Performance based incentives
  - Utilizing the existing resources (financial and human) efficiently

Potential Health Partners

- Government and its agencies
- Civil Society (including PRIs, SHGs, CBOs etc)
- Corporates
- Media
- Medical Colleges
- Development agencies/ Development partners
- Individual healthcare providers
- Last but definitely not the least: Community

Way forward..

- Synchronizing different health initiatives
- Developing common platforms for discussion and advocacy
- Advocating through common messages
- Identifying gap areas in community healthcare - holistically
- Providing niche and generic support
- Working together with all stakeholders
- Cross sharing of learnings
- Walking the talk..

The '10 commandments'

1. Concentrate effort on diseases with the highest disease burden
2. Tackle the most relevant problems to include the community
3. Develop, strengthen and sustain a system of community health workers to ensure care close to where people live, and to improve the linkages between the population and local health facilities
4. Maintain and improve the syndromic approach and guidelines. The guidelines that form the basis of syndromic diagnosis and treatment must consider not only new diagnostic techniques and treatments that raise the positive predictive value of symptoms
5. Ensure regular updates and adaptation of guidelines to reflect local epidemiology and programmatic progress
6. Strengthen health systems and supervision to provide for a motivated and trained work force

The 10 commandments*…

6. A steady and reliable supply of drugs and diagnostics, financial access and transport for patients and quality care at secondary level
7. Explore the use of innovations such as mobile phones and text messaging to conduct supervision and data collection and even behavior change
8. Invest in methods to efficiently train more people in community based approaches, including use of alternate and innovative methods of in-service training, including computer-based training or distance learning
9. Enhance the spirit of partnership, including involving the private sector to improve the quality and accessibility of services and harmonize donor efforts to maximize the use of resources and improve effectiveness.
10. Maintain a strong approach to evaluation

*inspired from: Integrated management of childhood illness: what have we learned and how can it be improved? Chopra et al. BMJ 2012

I collected my figures with a purpose in mind, with the idea that they could be used to argue for change. Of what use are statistics if we do not know what to make of them? What we wanted at that time was not so much an accumulation of facts, as to teach the men who are to govern the country the use of statistical facts (Florence Nightingale)[1]

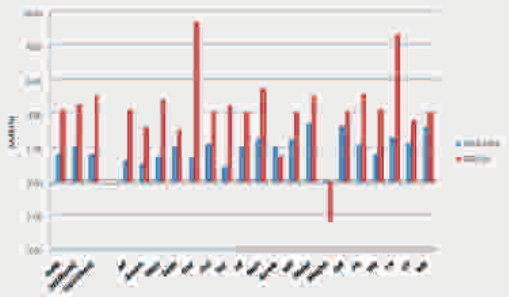
1 Quoted in 'Measuring Up to the Measurement Problem' Christopher Scott, London School of Economics PARIS 21

Best practices for addressing neonatal mortality in urban areas

Vinod Paul

Professor & Head, Department of Pediatrics,
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI
Chair, Technical Resource Group on Child Health, MoHFW
Member, High Level Expert Group on Universal Healthcare Coverage,
Planning Commission, Government of India

Figure 2: Comparison of average annual rate reduction (AARR) of IMR between pre-NRHM (1990-2004) and post-NRHM (2005-2010)



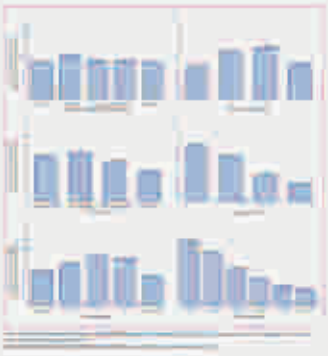
City	IMR 2008-10
Kolkata	19
Mumbai	20
Chennai	21
Delhi	32

We need to do the right things..

Seven best practices for addressing neonatal mortality in urban areas

Apologies to Stephen Covey, the author of the best-seller "Seven Habits of Highly Effective People"

JSY



Supply side

1. Deliveries in facilities

Absolute change in births in facilities: 2002-03 to 2007-09

UNICEF Coverage Evaluation Survey 2009

Institutional deliveries 73%

Supply side

Deliveries in facilities *providing high quality of care*

JSY Impact

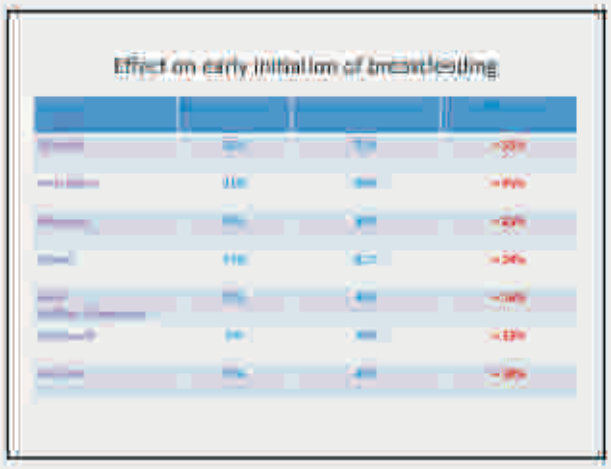
Reduction among JSY beneficiaries
-MMR by 2 points
-PNMR by 4 points

Did not have power to estimate MMR reduction

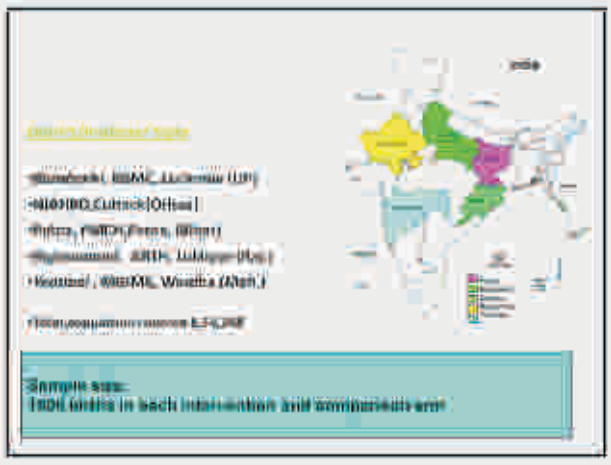
Lim 2010

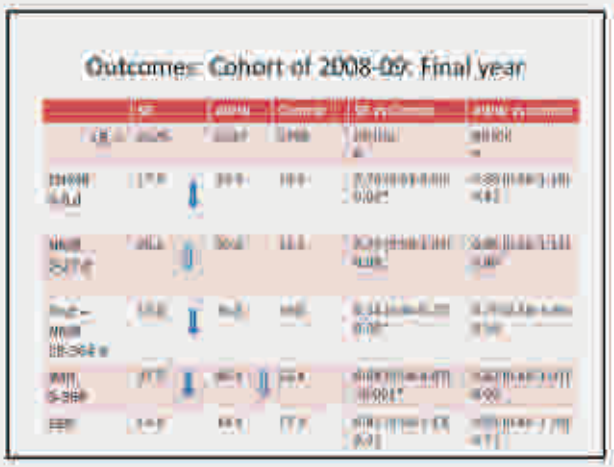
Supply side

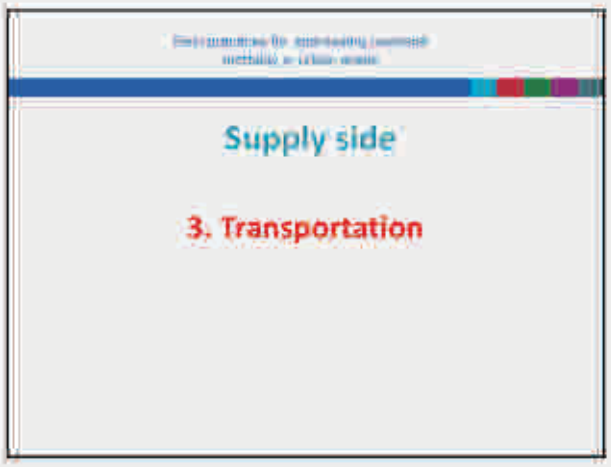
2. Home-based postnatal contacts

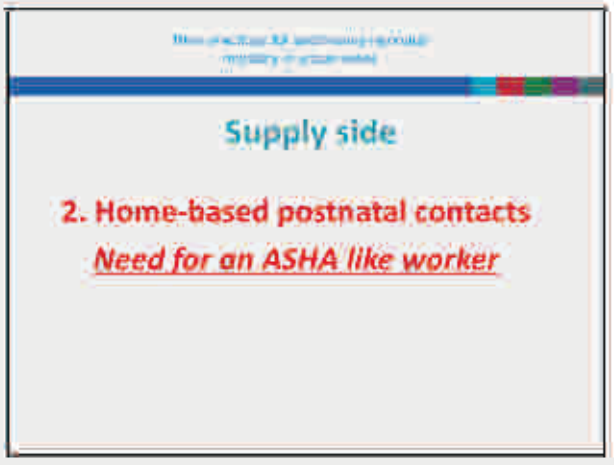

Effect on early initiation of breastfeeding


20% reduction in NMR




Outcome: Cohort of 2008-09: Final year


Supply side
3. Transportation


Supply side
2. Home-based postnatal contacts
Need for an ASHA like worker

Supply side

3. Transportation

for the mother and the sick babies

Chiranjeevi scheme

Demand side

4. Financing

a. Voucher schemes

Demand side

4. Financing

b. Cash transfer (JSY)

JSY

Beneficiaries	0.74 million	11.09 million

Demand side best practice

4. Financing

a. Voucher schemes

b. Cash transfer (JSY)

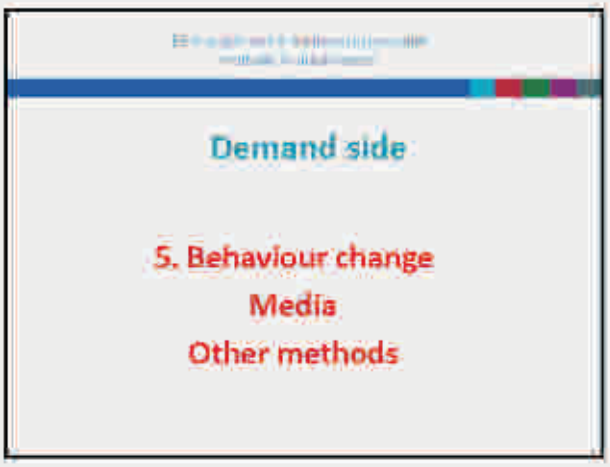
c. Insurance

Uptake of JSY

Insurance: need for a better model

- Often does not cover pregnancy / newborn care
- Fragment health care
- Do not provide full coverage of needed services
- High transaction fees and
- Fail to cover the most needy


Demand side
4. Financing
No user fees
Cash-less access
No intermediary
Universal


Demand side
5. Behaviour change
Media
Other methods


Demand side
5. Behaviour change


Demand side
6. Community mobilization

Agra experience

Demand-Supply side

7. mHealth / eHealth

Demand side

6. Community mobilization

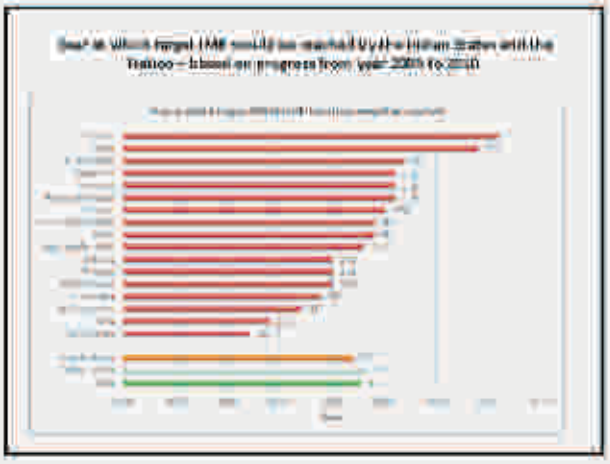
mHealth / eHealth

- Heath education / counseling
- Consultation
  - Care seeking
  - Clinical decision-making
  - Follow up
- Program monitoring

Beginning of a revolution

PPP

Quality facilities	Yes	Yes
Home contacts / ASHA like worker		May
Transportation	Yes	Yes
Financing		
Behavior change communication	Yes	Yes
Community mobilization		Yes
Outreach / eHealth	Yes	Yes

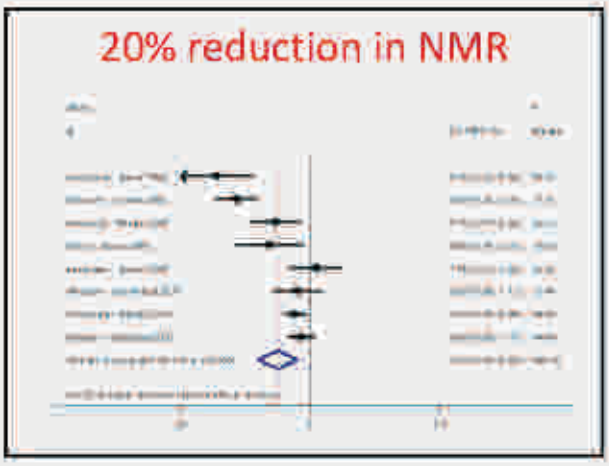


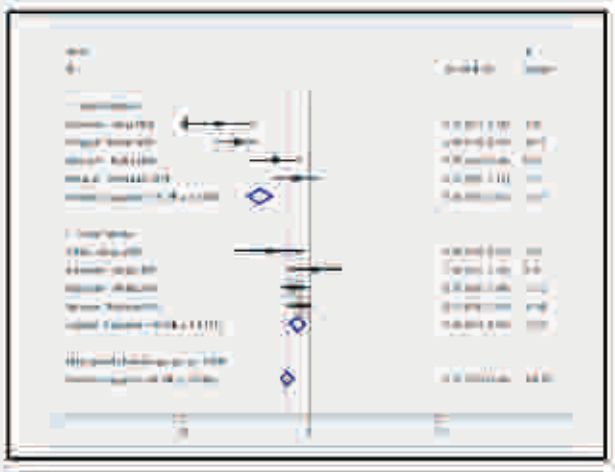
We need to create future ..

"If we don't create the future ..

"If we don't create the future, *the present extends itself"*

- Toni Morrison (Song of Solomon)



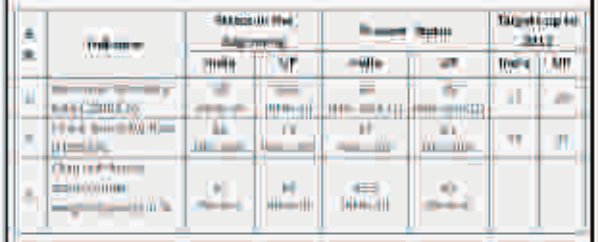


Child Health Programme Uttar Pradesh

Comprehensive Child Survival Programme

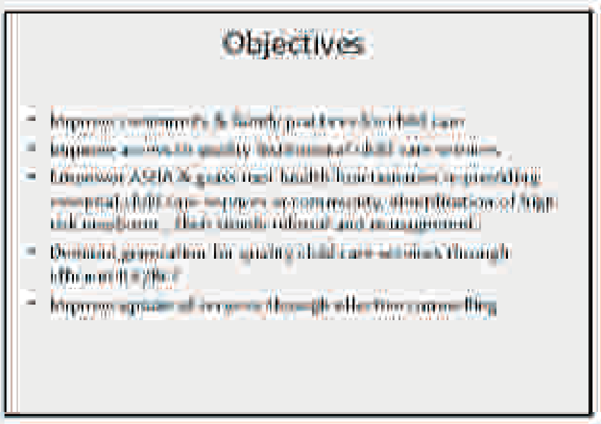
- Comprehensive Child Survival Programme initiated in UP in October 2007 with main objectives to , reduce infant and neonatal mortality rate

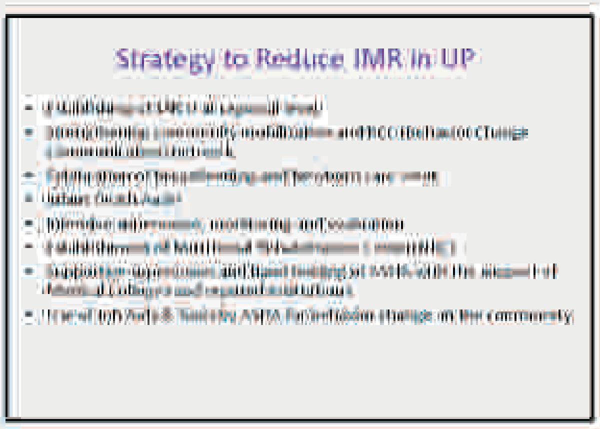
NRHM Key Goals & Achievements

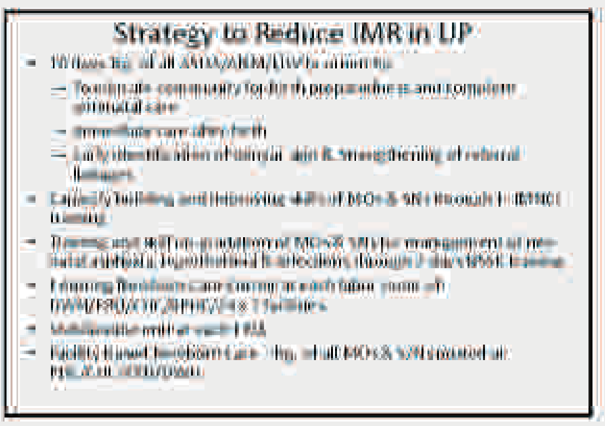


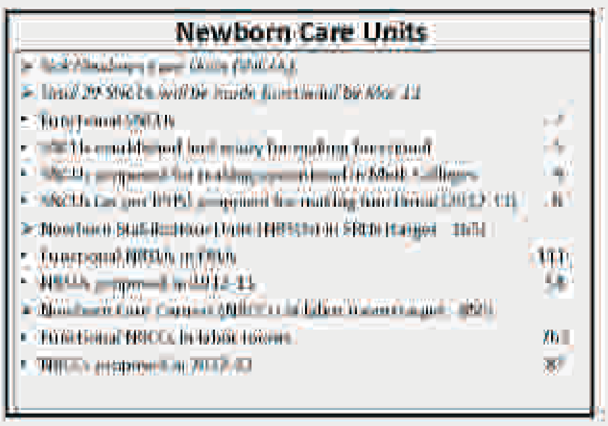
Goals

- To reduce the Infant Mortality Rate from 67 per 1000 live births (SRS 2008) to less than 30 per 1000 live births by the year 2012 in intervention areas.
- To reduce the neonatal mortality rate in the pilot area by 30 percent from the existing level

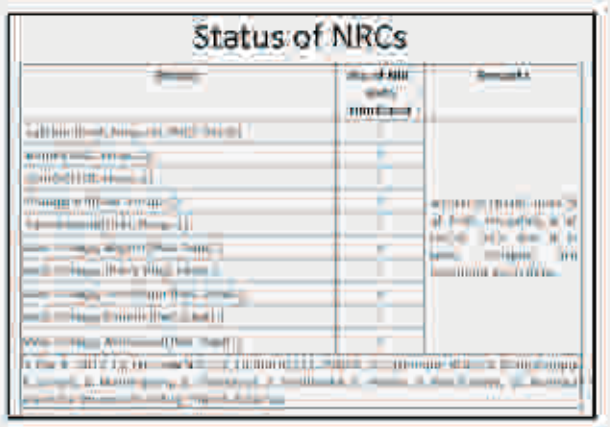

Objectives


Strategy to Reduce IMR in UP

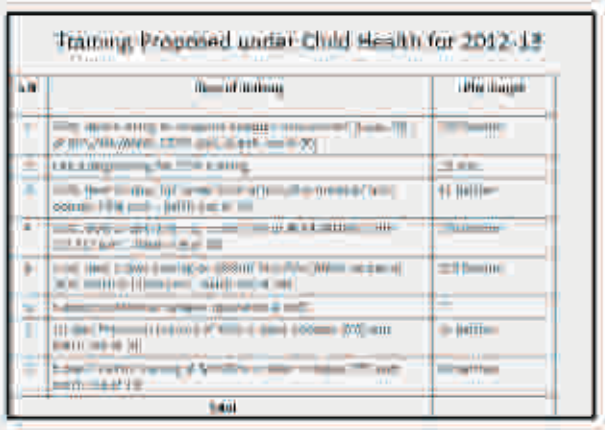

Strategy to Reduce IMR in UP


Newborn Care Units

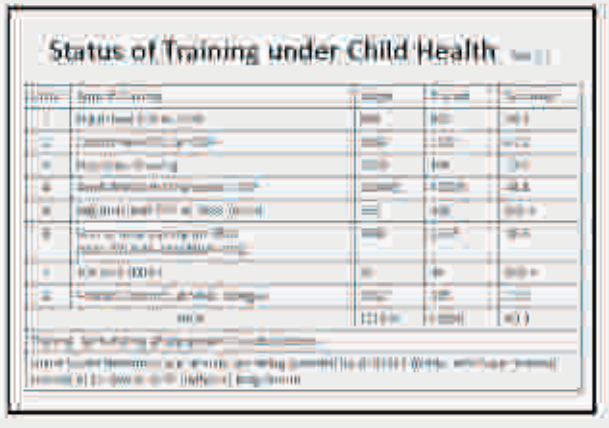
Status of NRCs



Training Proposed under Child Health for 2012-13



Status of Training under Child Health



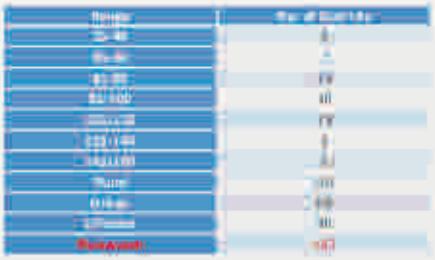
Thanks

Top 100 IMR districts – State wise

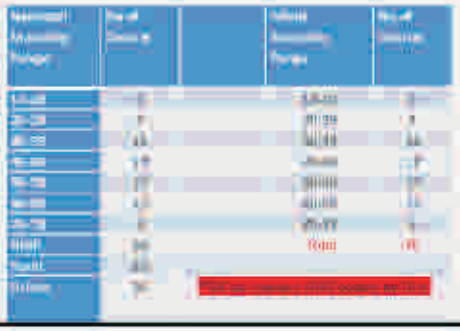
State	No. of Districts
•Assam	4
•Bihar	1
•MP	11
•Orissa	4
•Rajasthan	4
•UP	47

Out of the top 100 districts in the country with highest IMR 83 falls in UP. The highest being in district Shrawasti U.P NNMR -73 and IMR is 103

U5 Mortality



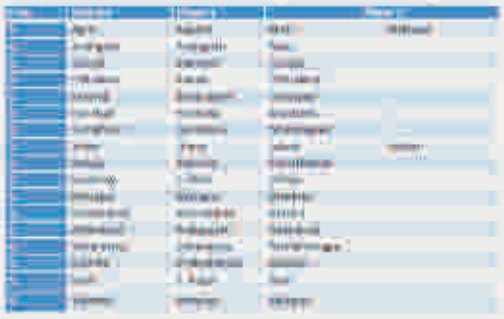
Neonatal and Infant Mortality Scenario in UP



CCSP Phases in UP

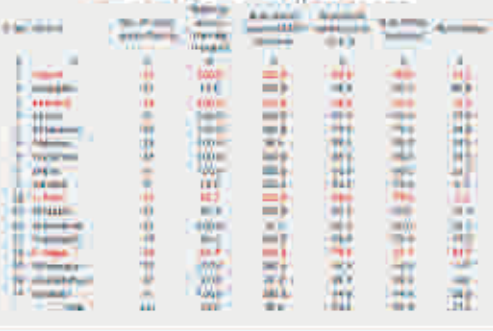
- Pilot Phase in Lalitpur district, started in 2005
- Phase 1 : 27 districts (One from each division)
- Phase 2 : 19 districts
- Phase 3 : 36 districts

CCSP Districts (1+2 Phase)



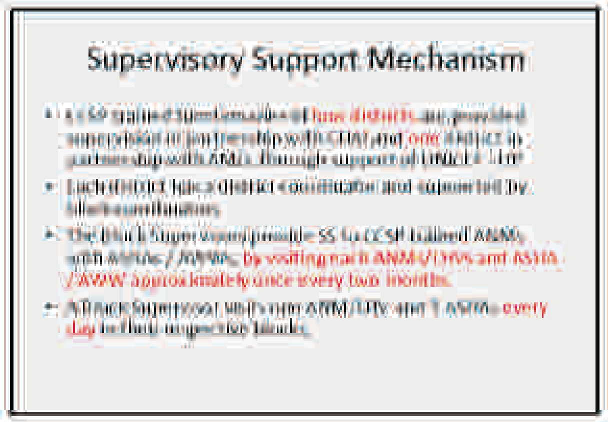
% of Newborns Visited (July-Sept.2011)

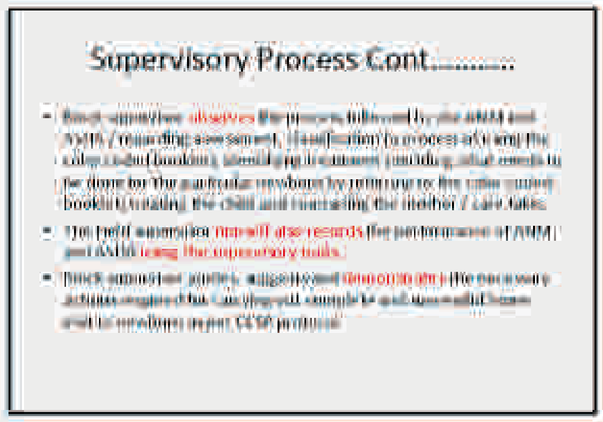
CCSP Status –Sept. 2011

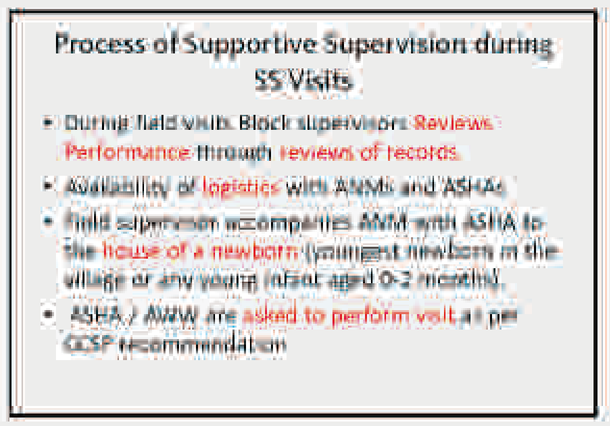


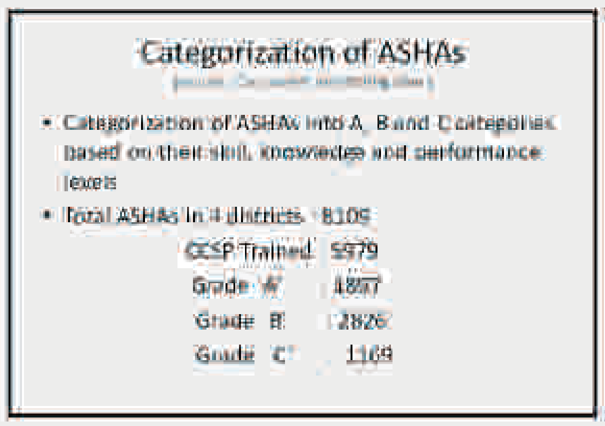
Objectives of Supportive Supervision under CCSP Program

- To support the Government supervisory systems to perform the role of supportive supervision under CCSP through capacity development of LHVs and ANMs
- To empower and support Community Workers (ASHAs / AWWs) by building their capacity in implementing CCSP through line supervisors (ANMs) by providing handholding support to ANMs and ASHAs.

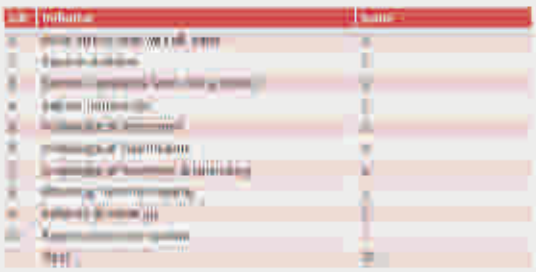

Supervisory Support Mechanism


Supervisory Process Cont..........

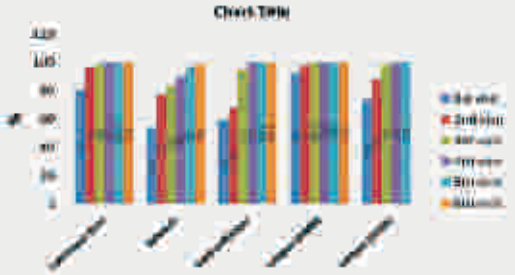

Process of Supportive Supervision during SS Visits
During field visits Block supervisors Reviews Performance through reviews of records.
Availability of logistics with ANMs and ASHAs
the house of a newborn
ASHA / AWW are asked to perform visit as per CCSP recommendation


Categorization of ASHAs
Categorization of ASHAs into A, B and C categories based on their skill, knowledge and performance levels
Total ASHAs in 4 districts 8109
CCSP Trained 5979
Grade 'A' 1887
Grade 'B' 2826
Grade 'C' 1169

Categorization of ASHAs



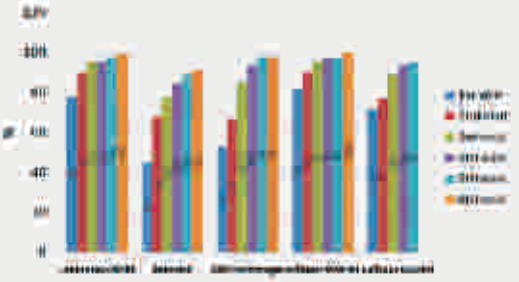
Improvement in Assessment of PSBI by ASHAs

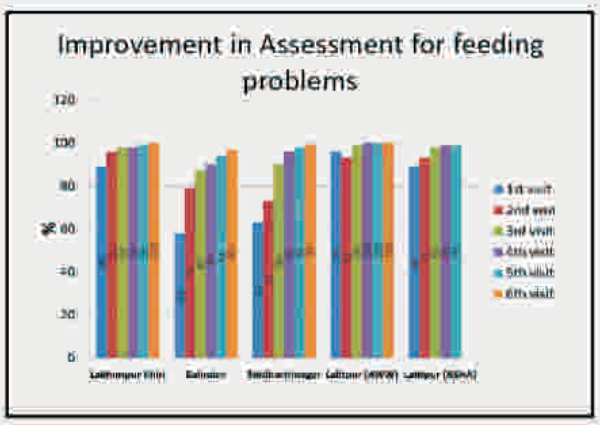


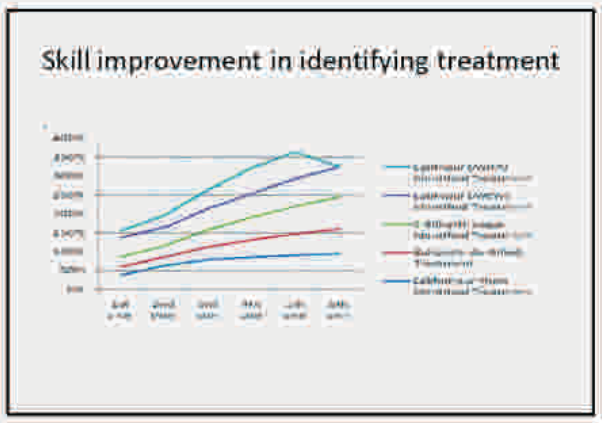
Interpretation of Scores for Categorization

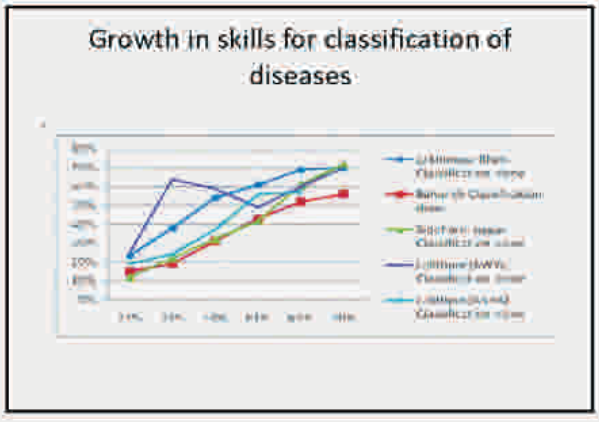
- A category : Score 9 or 10
- B category : Score 7 or 8
- C category : Score less than or equal to 6

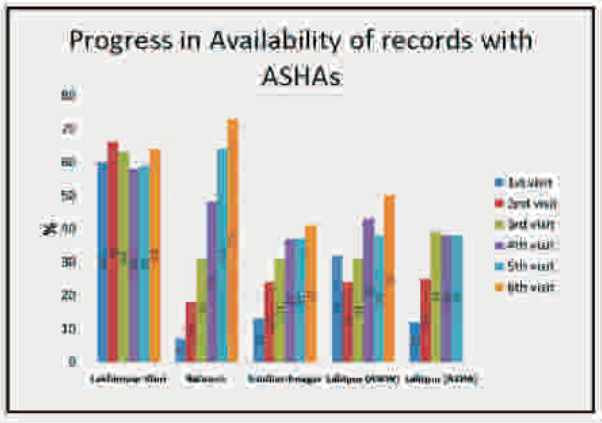
Improvement in Assessment of young infants for Diarrhea



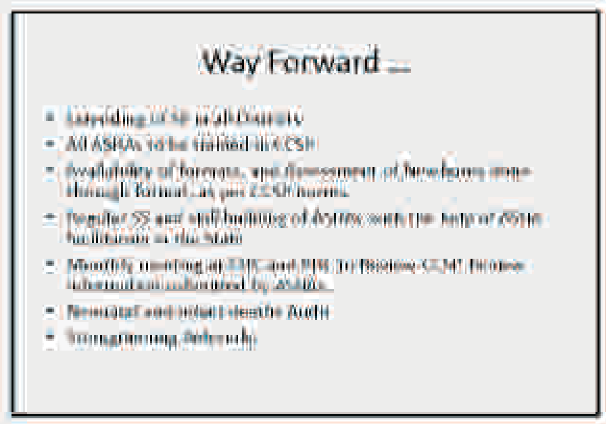

Improvement in Assessment for feeding problems
120
100
80
60
40
20
0
1st visit
2nd visit
3rd visit
4th visit
5th visit
6th visit

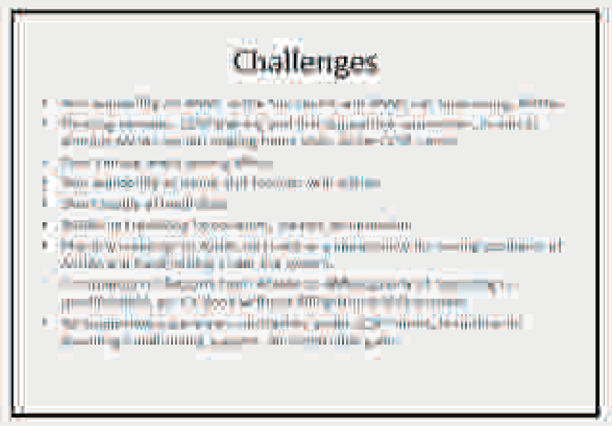

Skill improvement in identifying treatment

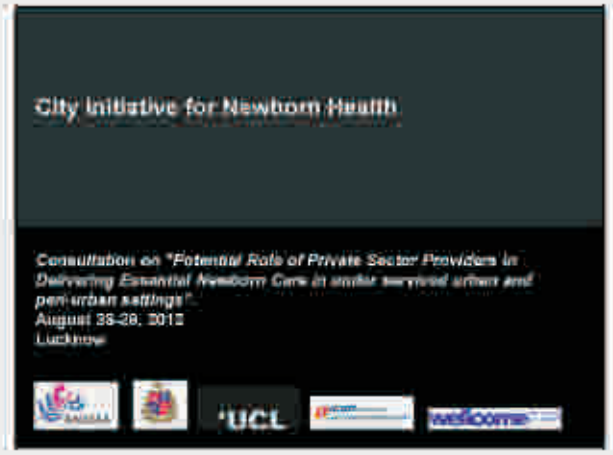

Growth in skills for classification of diseases


Progress in Availability of records with ASHAs
1st visit
2nd visit
3rd visit
4th visit
5th visit
6th visit


Achievements of Supportive supervision


Way Forward ...


Challenges


City Initiative for Newborn Health
Consultation on "Potential Role of Private Sector Providers in Delivering Essential Newborn Care in slums/ semi-rural/ urban and peri-urban settings"
August 38-28, 2012
Lucknow
UCL

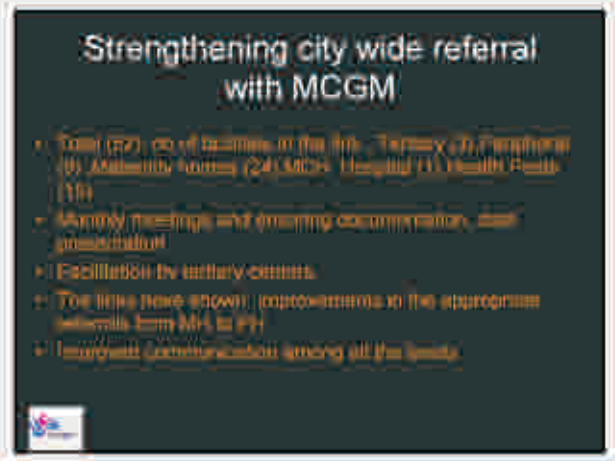

The birth of City Initiative for Newborn Health: CINH

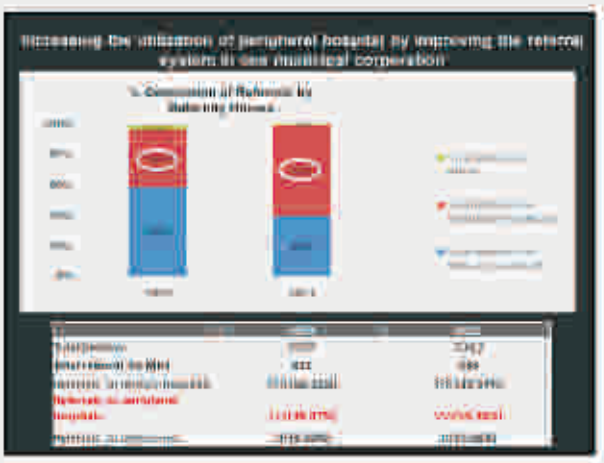

55%

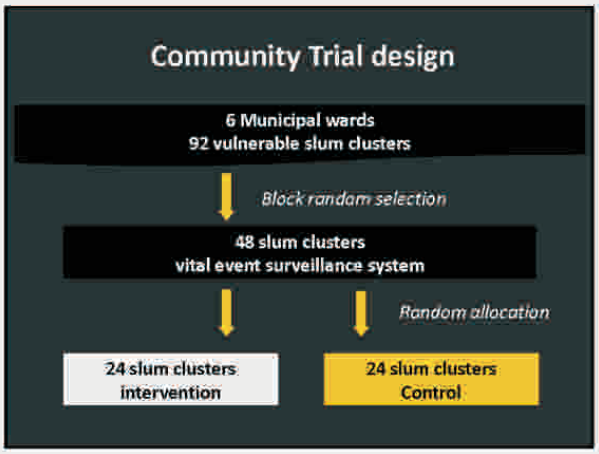

The Model

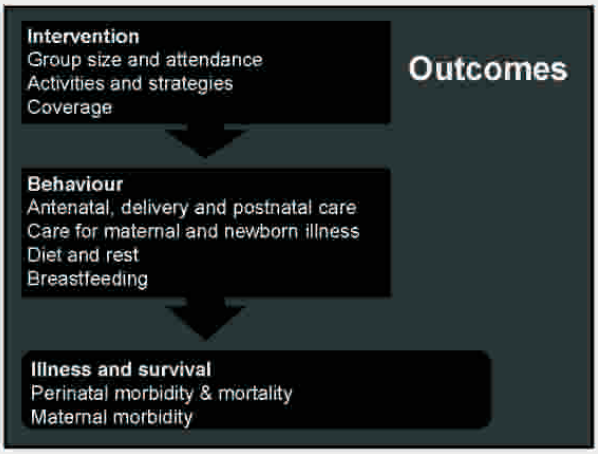

Strengthening Systems By
nurturing partnerships
Strategy

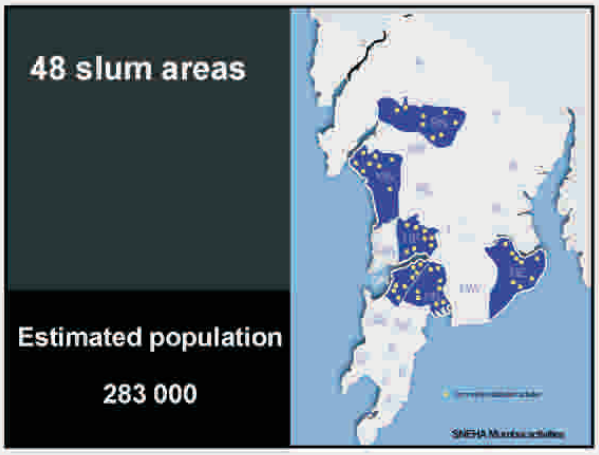

Change

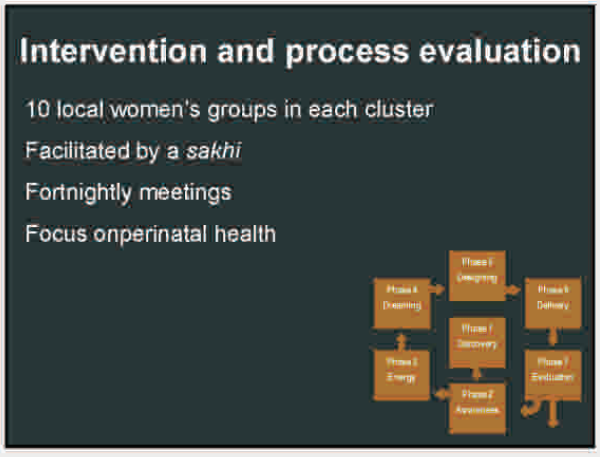

Strengthening city wide referral
with MCGM




Community Trial design
6 Municipal wards
92 vulnerable slum clusters
Block random selection
48 slum clusters
vital event surveillance system
Random allocation
24 slum clusters
intervention
24 slum clusters
Control


Intervention
Group size and attendance
Activities and strategies
Coverage
Outcomes
Behaviour
Antenatal, delivery and postnatal care
Care for maternal and newborn illness
Diet and rest
Breastfeeding
Illness and survival
Perinatal morbidity & mortality
Maternal morbidity


48 slum areas
Estimated population
283 000


Intervention and process evaluation
10 local women's groups in each cluster
Facilitated by a sakhi
Fortnightly meetings
Focus onperinatal health

"... we had never pondered so much about our lives and events. We liked to revisit our experiences and understand the emotions felt during pregnancy and delivery"

235 group members helped 1372 others
one woman reached out to 6 other women

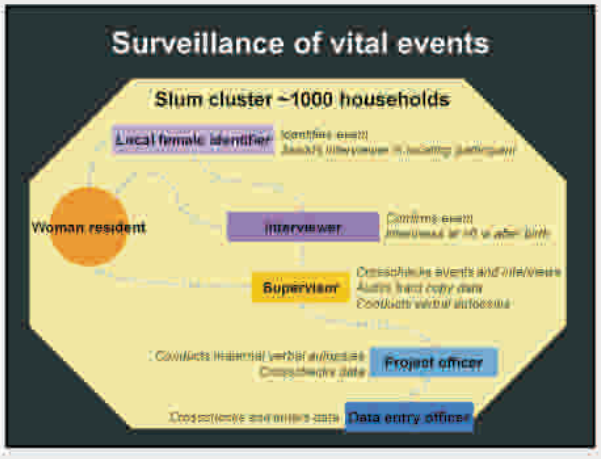
Gave information and advice

Provided financial support

Advised women to consult doctor or hospital

Accompanied women to hospital

Gave premarital advice



What have we learned?

Uptake of health care is high and rising

Mortality rates are falling

The urban paradox

closeness and distance

- Groups were not large
- Limited connections
- Limited diffusion

Many projects evaluate their success like this...

What have we learned?

Group members stumbled at dreaming and strategizing

Low opinion of potential to leverage change

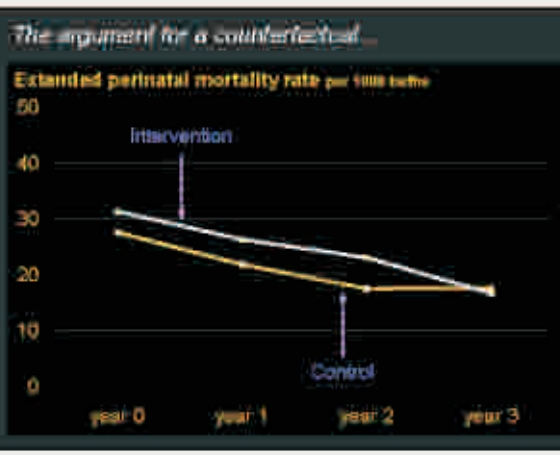
Concerns about investment to enact strategies

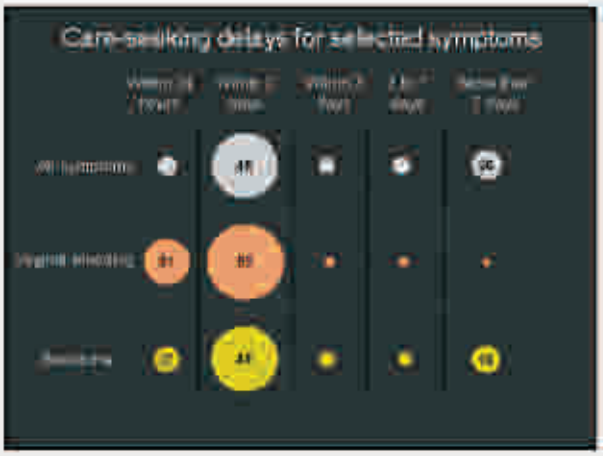
Many small, unorganized actions

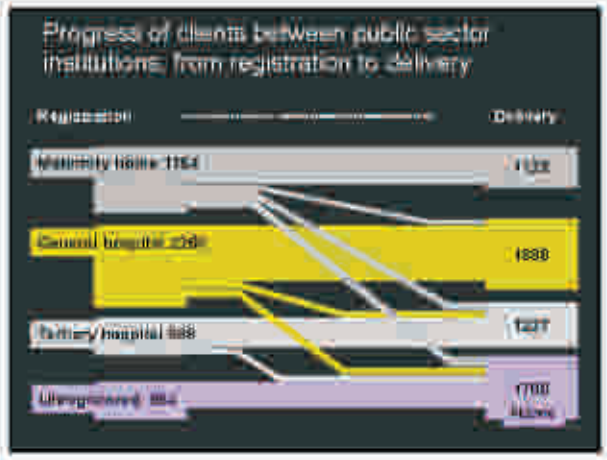
They liked learning things

They had many concerns

The argument for a counterfactual...







Implications

- High care-seeking rates are encouraging, but they don't tell us about quality or health outcomes
- Clients often remain in the same sector and with the same provider
- Private health care is preferred
- Care-seeking patterns for serious symptoms reflect a broader trend of care-seeking


...because
every
woman and
child counts.
SNEHA Society for
Nutrition Education and
Health Action
www.snehamumbai.org

Behaviour change for care-seeking for sick newborns- An ICMR Funded Project Results: Implications for neonatal health programming among urban poor

Prof. Vinay Kapoor, MD, DNB & Dr. Neeraj K Srivastava, PhD
Department of Pediatrics, KGMU, Lucknow

Causes of Neonatal Mortality

- **Direct Causes:**

  Dying diseases are leading direct causes of neonatal deaths.

- **Underlying Causes:**

  Improper newborn care/feeding practices, low hygiene, Low knowledge of danger signs, sub-optimal care-seeking, inadequate access to maternal & neonatal health services, etc

- **Social Causes:**

  Poverty, low education and life skills of parents, gender discrimination, quality & quantity of health resources available for maternal and neonatal health, etc

BACKGROUND

The Global Neonatal Health Problem

Magnitude:

- Among all global deaths, 1/3 rd occur within the first few years of life
- Among 10 million child deaths, 4 million occur in neonatal period
- Most neonatal deaths (98%) occur in developing countries.
- Highest numbers of neonatal deaths occur in South Asia
- [illegible] in the leading countries

Neonatal Health Problem in India & U. P

- The NMR in India is 39/1000 live births while in UP is 47.6 per 1000 live births (NFHS-3)
- NMR among urban poor in UP (50/1000 live births) is similar to rural counterparts (49.4/1000 live births).
- UP alone contributes to 8% of global neonatal mortality and 26.1% to India's neonatal mortality.
- More than half (52%) of the neonatal deaths occur due to infections (UNICEF 2002).

United Nations Millennium Development Goal-4

- MDG-4 stipulates a reduction of two-thirds in under-five deaths i.e. from 95 per 1000 live births in 1990 to 32 per 1000 by the year 2015
- Among 68 priority countries, only 16 are on track to meet MDG-4
- In South Asia, Bangladesh and Nepal are on track to meet the MDG-4 while India and Pakistan have shown limited progress
- In India, average annual rate of reduction in child mortality from 1990 to 2006 has been 2.6% while that needed to meet MDG-4 from 2007-2015 is 7.6%
- Neonatal Mortality accounts for more than half of the child mortality and more than 70% of infant mortality in India

Importance for studying care-seeking behavior for sick neonates

- To inform policy, it is important to study how households use care and how the health system deliver care
- Reviews by WHO and other research groups indicate considerable research gaps with reference to the care-seeking component of the family/community care, especially for neonatal illnesses
- Care-seeking for sick newborns is an area for which very few interventions have either been proposed or implemented
- Care-seeking for sick newborns in developing countries is a priority research area

Integrated Management of Neonatal & Childhood Illnesses (IMNCI) Strategy

Stages in the process of care-seeking (WHO Model)

- Recognition of illness
- Labeling of illness
- Resorting to Care

RATIONALE FOR CURRENT STUDY

- There was scarce quantitative data in Uttar Pradesh on the socio-[illegible] factors which affect newborn survival.
- [illegible] evidence for the impact of interventions to promote newborn care-seeking among urban poor was very limited in general and for Uttar Pradesh in particular.
- Post natal health education trials for improving recognition & labelling of newborn danger signs and care-seeking among institutionally delivered mothers have not been reported in Uttar Pradesh.

OBJECTIVES

- **Primary Objective:**
  To design a BCC intervention package and assess its impact on qualified medical care-seeking for sick neonates among the study group
- **Secondary Objective:**
  To assess the factors associated with care-seeking behavior for neonatal illnesses among the study group

STUDY HYPOTHESIS

We hypothesized that a Behavior Change Communication (BCC) intervention package delivered to urban poor mothers within 48 hours of institutional delivery could improve qualified medical care-seeking for sick neonates in urban Lucknow, Uttar Pradesh.

STUDY SETTING

[illegible]

2. District hospital in Lucknow

STUDY DESIGN: Before and After Intervention study

1. Formative Research
2. Before Intervention Phase
3. Design and pretest of the intervention
4. After intervention Phase

SAMPLE SIZE

1020 neonates were enrolled (510 in before intervention phase and 510 in after intervention phase.

Ethical Considerations

- The study was conducted after obtaining Institutional Ethical Clearance from King George's Medical University and permission from relevant district authorities.
- The study is registered at www.clinicaltrials.gov with identifier NCT 00832143.

Selection Criteria

- **Inclusion criteria:**
  - Neonates were screened within 48 hrs of delivery on all working days (excluding Sundays and holidays) and enrolled after taking written parental informed consent.
- **Exclusion criteria:**
  - Those who required any resuscitation at birth or
  - Presented with any clinically detectable serious congenital malformation or
  - Were hospitalized for any morbidity immediately after birth or
  - Were not the residents of Lucknow or
  - Were likely to move out of the city in next one month.

Study Definitions

- **Neonatal Illnesses**

a. IMNCI Illnesses: Diarrhea with dehydration, Persistent diarrhea, Pneumonia, Septicemia, Meningitis, Isolated Fever, Pathological Jaundice, Ear discharge, Multiple Pustules, Umbilical Sepsis

b. Non IMNCI Illnesses: Diarrhea, Upper Respiratory tract infection, Jaundice, Dermatitis, Conjunctivitis, Others

- **Low Birth Weight** (< 2500 grams)
- **Preterm** (On the basis of LMP of the mother & Ballard Score)

Study Definitions (Cont.)

- Types of Medical Providers
  a. Government Providers (GPs)
  b. Non-Government Qualified Consultants (NGCs)
  c. Non-Government Dispensers (NGDs)
- Traditional/Spiritual Healers
- Any Medical Care: GPs, NGCs or NGDs
- Qualified Medical Care: GPs & NGCs

Study Outcomes

1: Care-seeking behavior

- Primary outcome measure was [illegible]
- Sub-analysis of the effect of intervention on:
  a. Qualified medical care for illness [illegible]
  b. Care-seeking from Government providers
  c. any medical care (GPs, NGCs or NGDs) for sick neonates

2: Factors associated with care-seeking behavior

- Cultural factors (local views/beliefs relating to use of traditional/spiritual care and/or use of local remedies)
- Socio-demographic factors (gender of mother, type of family, household income, etc.) and underlying factors (such as prior antenatal care, etc.) associated with "qualified medical care" as well as "any medical care" for sick neonates among the mothers of pre-intervention phase

PHOTOGRAPHS OF NEONATES TAKEN AT THE TIME OF RECRUITMENT/FOLLOW-UP

Focused Group Discussions

Five FGDs conducted at study [illegible] at PHC1 Center (n=1) and at a district hospital (n=1)

FGDs were conducted to:

- Study the perceptions of caregivers regarding various sources (medical care/traditional care/spiritual care) for different neonatal illnesses.
- Study perceived effectiveness of various remedies (medical care/traditional care/spiritual care) for different neonatal illnesses.
- Study the perception of mothers regarding medical care received from different types of medical providers including quality [illegible]
- Identify the sources for information (available and preferred) for child health among the study community

FGD Results

- *Home Remedies, Self-Medication and Traditional Care*
  - Acute Respiratory Infection (ARI)
  - Digestive problems
  - Eye/Ear problem
  - Jaundice
  - Fever
  - Skin troubles
- "Sukha rog" and perceived "[illegible]"
- Neonatal illnesses due to "supernatural" ("Upri") causes
- Perceptions regarding care at public hospitals
  Availability of drugs at the spot, types of interactions, quality of care
- Sources for health information
- Counseling through the health provider was considered most important to promote neonatal health

*[illegible] Symptom-specific care-seeking behavior for sick neonates among urban poor in Lucknow, northern India. Journal of Perinatology [illegible]

RESULTS
Before-Intervention Phase

- 510 newborns were enrolled (154 from RCH Center and 356 from District Hospital) from March 2007-August 2007
- 481 (94.4%) were followed-up at 6-8 weeks, at the outpatients' clinic of the respective hospitals (30.2%) or at home (64.2%)
- 5.6% were lost-to-follow-up

Factors associated with any medical & Qualified care-seeking

- Study site
- Father's education
- Household income
- Residence
- Number of antenatal care visits
- None of the newborn variables were found to be associated

Out-of-Pocket Expenditures

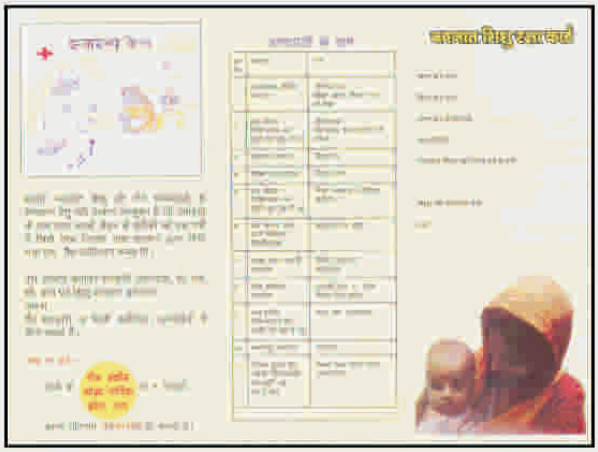
Factors associated with qualified medical care-seeking

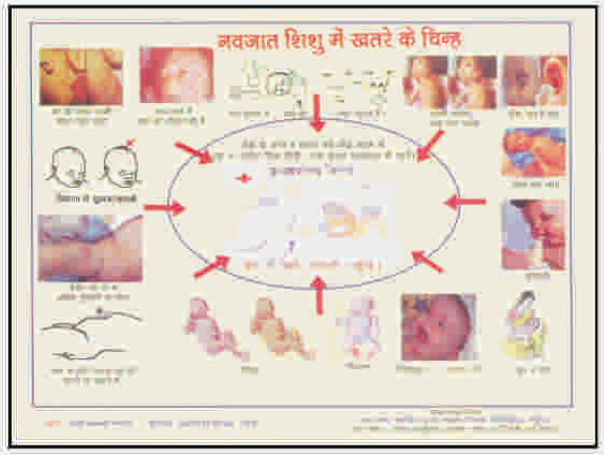
- Study Site
- Maternal Education
- Father's Education
- Mothers' Parity
- Number of ANC visits
- Household Income

Out-of-Pocket Expenditures (Cont.)

STUDY INTERVENTION

- Based on our formative research (Awasthi et al 2008), standard IMNCI guidelines (WHO 2003) and World Health Organization (WHO) recommendations on care-seeking (WHO 1999), we developed a Neonatal Well-Being Card [*Navjat Shishu Raksha Card (NSRC)*].
- We used the pictures/photographs of neonatal danger signs which were considered to be most comprehendible/appropriate by the mothers/caregivers during FGDs.
- We also developed, explained and distributed a "reference module" containing messages about concept and delivery of study intervention to the hospital staff of the participating sites.





IEC STRATEGY

(1) 'NAVJAT SHISHU RAKSHA' CARD (NSRC)
(2) ONE-TO-ONE COUNSELING

SUPPORTING CHANNEL

(1) POSTERS
(in the Pediatrician's room, at the place of registration, in the wards etc.)

(2) Counseling and distribution of NSRC by HOSPITAL STAFF

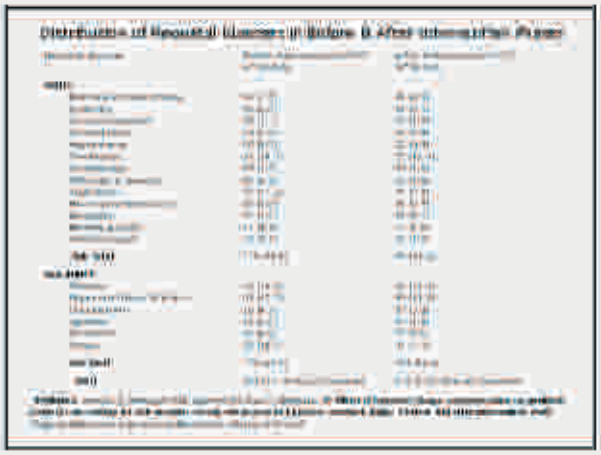
SENSITIZATION WORKSHOP

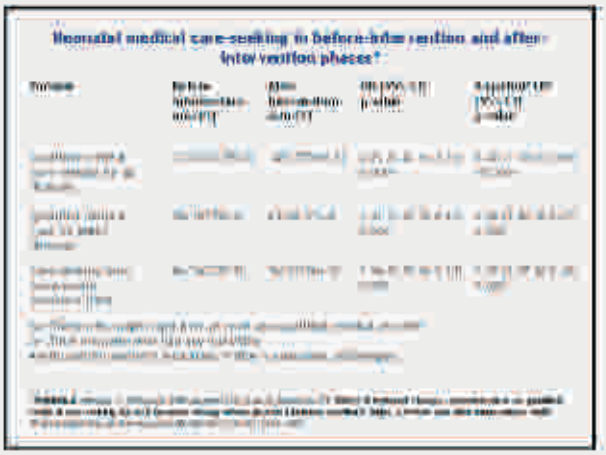
RESULTS

After-Intervention Phase

- 510 newborns enrolled (243 from the RCH Center and 267 from the District Hospital) from September 2007- April 2008
- 490 (96.1%) were followed-up at 6-8 weeks, at the outpatients' clinic of the respective hospitals (43.3%) or at home (52.8%)
- 20 (3.9%) were lost-to-follow-up

Baseline characteristics (Cont.)

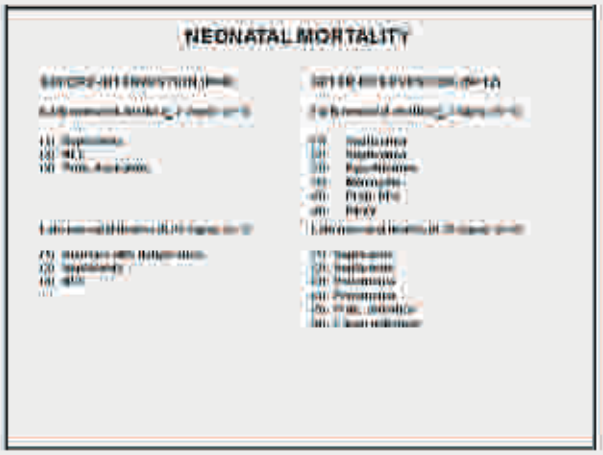


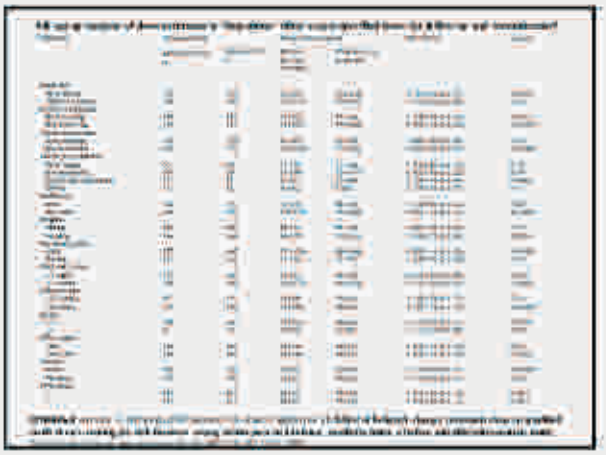


Care-seeking Behavior (Before & After)

- Care was sought from at least one medical provider (GPs, NGOs or HGDs) for 88.5% (192/217) sick neonates after intervention as compared to 80.1% (196/245) sick neonates before intervention (OR=1.80; 95% CI= 1.06 to 3.05; p=0.02).
- Mean number of medical providers consulted was 1.1 (±0.30) (n=196) and 1.03 (± 0.17) (n=192) in the before and after intervention phases, respectively.

NEONATAL MORTALITY





RESULTS
Intervention Assessment

- 91.8% mothers accessed HBC at follow-up at 6-8 weeks

Mothers' turnout at outpatients' clinic on pre-specified dates:

CONCLUSIONS

Effect of BCC intervention:

- A relatively simple intervention targeted at recognition of neonatal danger signs and promotion of qualified medical care-seeking had significant impact on care-seeking behavior for sick neonates in Urban Lucknow
- BCC intervention has the potential to increase care-seeking from government facilities and if promoted these will lead to lowering the economic burden on households seeking care for their sick newborns.
- BCC intervention coupled with the advice on routine immunization and follow up care has the potential to ensure timely immunization and routine follow up care for newborns.

CONCLUSIONS (Cont.)

Care-seeking behavior:

RECOMMENDATIONS (Cont.)

- Our findings suggest that it is possible to increase qualified medical care seeking for sick newborns through socio-culturally contextualized BCC intervention in urban Lucknow.
- With rising proportion of institutional deliveries, this BCC intervention needs to be considered for scaling up in urban Lucknow.
- It needs to be further investigated whether this BCC intervention increases medical care seeking in other settings (such as rural and other urban areas).

RECOMMENDATIONS

PUBLICATIONS

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]

Improving access to MNH through community mobilization and partnerships in urban areas

Sure Start Maharashtra Experience

Lysander Menezes

PATH

Sure Start: Objectives

- To significantly increase individual, household and community actions that directly and indirectly improve maternal and newborn health
- To enhance systems and institutional capabilities for sustained improved maternal newborn care and health

PATH

Urban poor - Issues

- Despite supposed proximity of the urban poor to urban health facilities their access is severely restricted
- Inadequacy of public health system
- Ineffective outreach and weak referral system
- Social exclusion and lack of information and assistance at secondary and tertiary hospitals
- Lack of standards and norms for urban health system

PATH

Sure Start - Maharashtra

- Second most populous state in India
- More than 50% population in urban areas
- Huge in-migration from all parts of India
- Sure Start was implemented in select localities of 7 cities of Maharashtra (Mumbai, Navi Mumbai, Nagpur, Pune, Malegaon, Nanded, Solapur) in 1.6 million population covered

PATH

Strategies adopted

- Need Based BCC
- Mobilizing community groups
- Leveraging available resources
- Collaborations with Local Municipal Corporation and professional bodies
- Model approach

ASK

↓

Identify problems

↓

Behavior Diagnosis

↓

Counsel for possible solutions

↓

Behavior change

NEED BASED BCC

Common Minimum Programme

[illegible]	[illegible]
[illegible]	[illegible]
Nutrition	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Model specific interventions

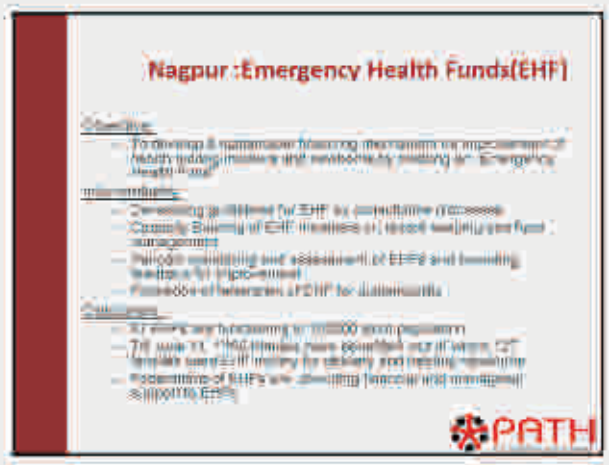
City	Model
Mumbai	Quality of Care
Navi Mumbai	Public Private Partnership
Pune	Convergence
Nagpur	Emergency Health Fund, Prepaid card
Malegaon	Quality of care
Solapur	Volunteerism
Nanded	Community Based health insurance

Mumbai – Quality of care

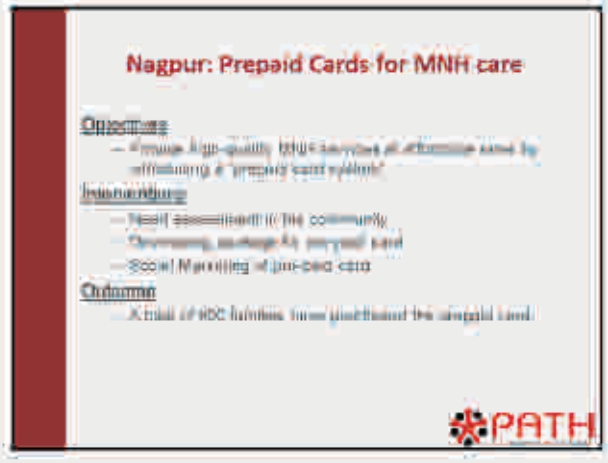
Pune - Convergence

Navi Mumbai- Public Private Partnership

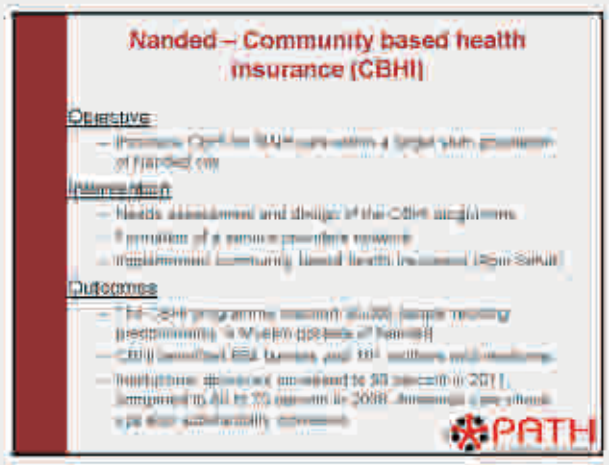
Monitoring of Maternal and Newborn Status (MoMS) Committees in Pune

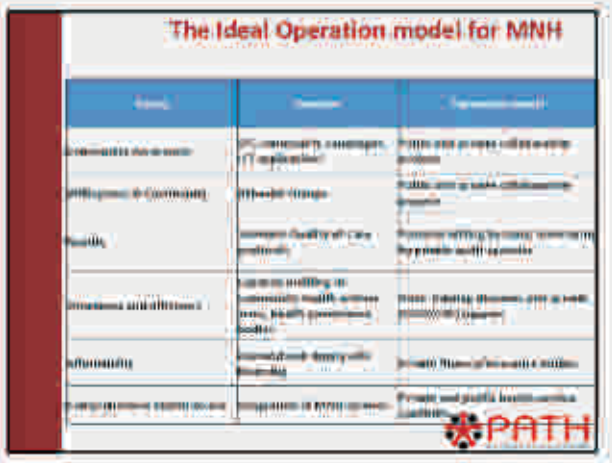

Nagpur :Emergency Health Funds(EHF)
PATH


Malegaon – Quality of care
PATH

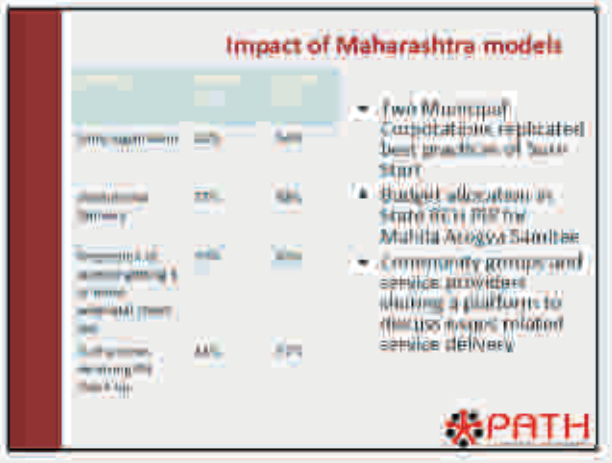

Nagpur: Prepaid Cards for MNH care
Outcomes
Interventions
Outcomes
PATH

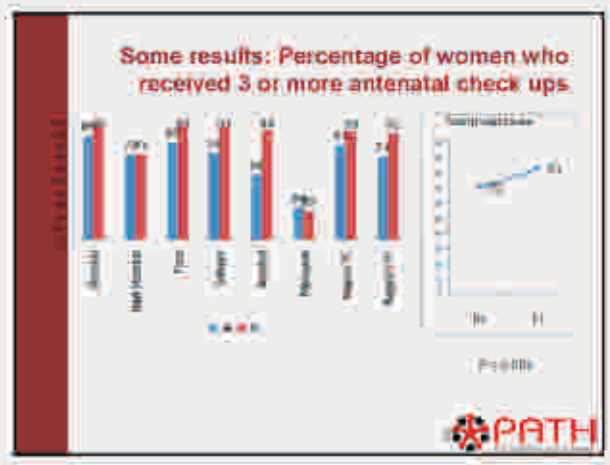

Solapur :Voluntarism
PATH

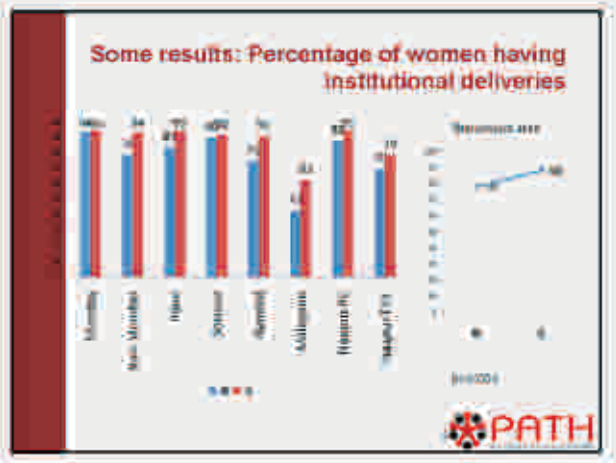

Nanded – Community based health insurance (CBHI)
Objective
Intervention
Outcomes
PATH

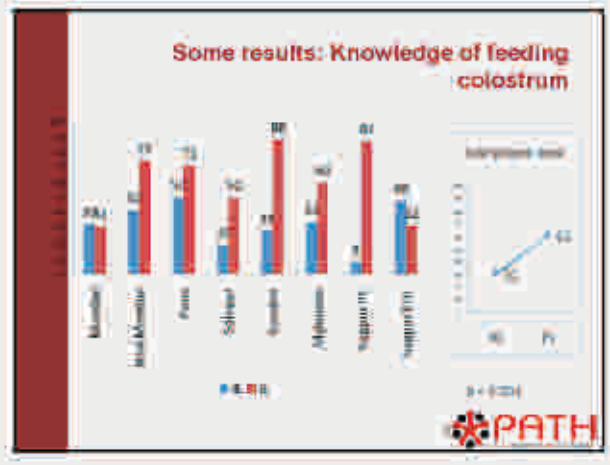

The Ideal Operation model for MNH
PATH

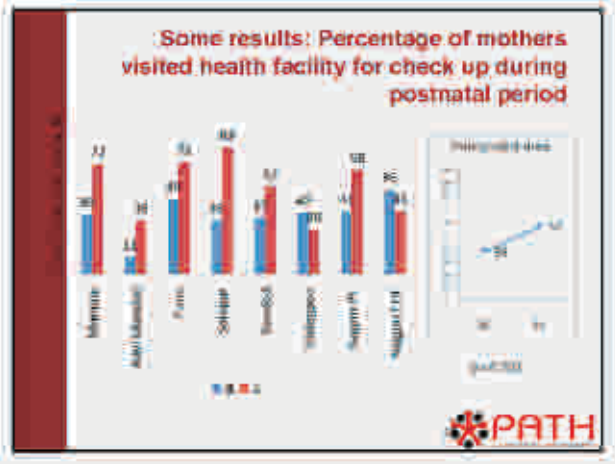

Supply meets demand with public private collaboration
PATH


Impact of Maharashtra models
PATH


Some results: Percentage of women who received 3 or more antenatal check ups
PATH


Some results: Percentage of women having institutional deliveries
PATH


Some results: Knowledge of feeding colostrum
PATH


Some results: Percentage of mothers visited health facility for check up during postnatal period
PATH

Inequalities among the unequal

Pattern in India

- Large Urban Inequalities
- Substantial Urban Rich advantage
- Rural areas have large inequalities
- Rural poor disadvantaged comparable to urban poor

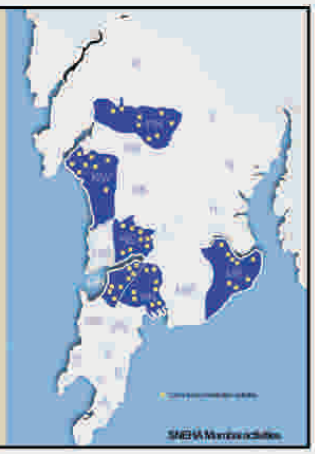
Inequalities in maternity care and newborn outcomes in Mumbai slums

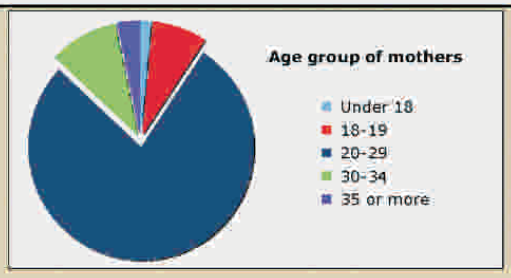
Objectives

- To describe maternity care uptake in vulnerable slum communities
- To understand the differential effects of degrees of poverty on service uptake

Data Source

- Birth surveillance
- 6 urban wards
- 48 slum areas
- Population 280,000
- 5238 Women
- Period 2005-06





51% had their first pregnancy under 18 yrs

69% literate

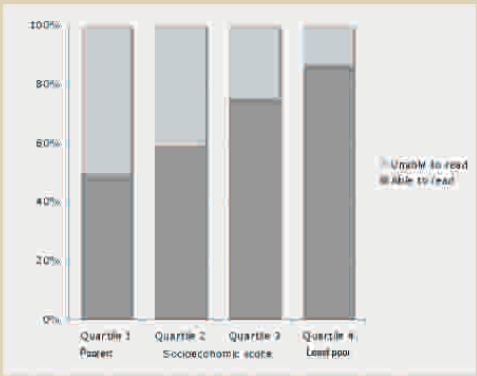
55% live in a nuclear family

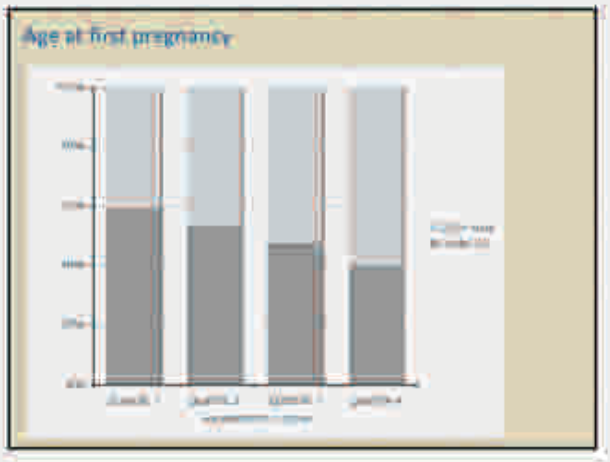
Vulnerability Scorecard

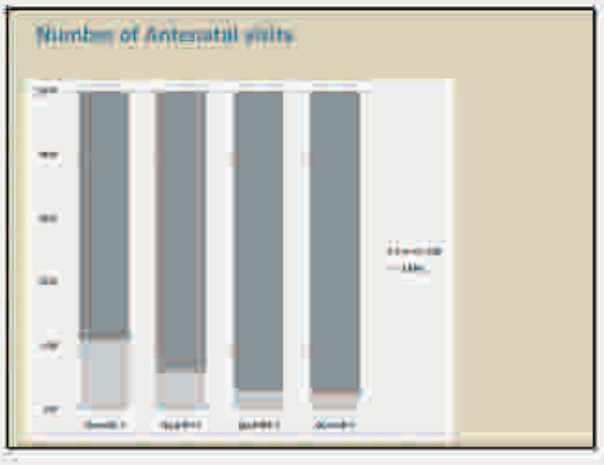
	Factor	0	1	2	Score
1	Insubstantial housing	Hardly any (<5%)	Some (5-49%)	Most (50-100%)	
2	Unmetered electricity	Hardly any	Some	Most	
3	Informal water supply	Hardly any	Some	Most	
4	No toilet facilities	Hardly any	Some	Most	
5	Hazardous location	No	Yes		
6	Rental accommodation	Less than half	More than half		
	Total score, out of 10				

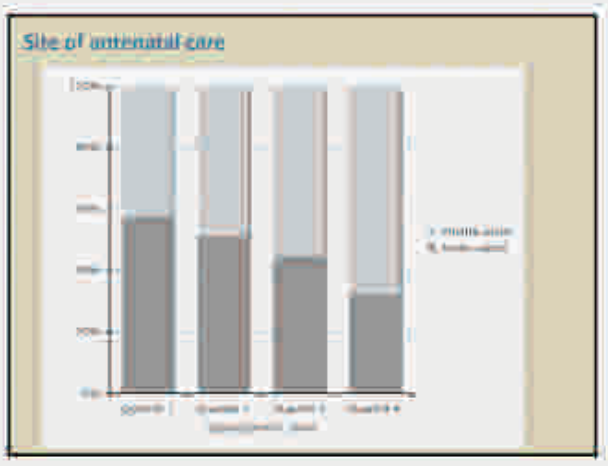
Osrin D, Das S, Bapat U, Alcock G, Joshi W, Shah-More N. A rapid assessment scorecard to identify informal settlements as higher maternal and child health risk in Mumbai. *International Journal of Urban Health*. (SUH, 2012.

Literacy

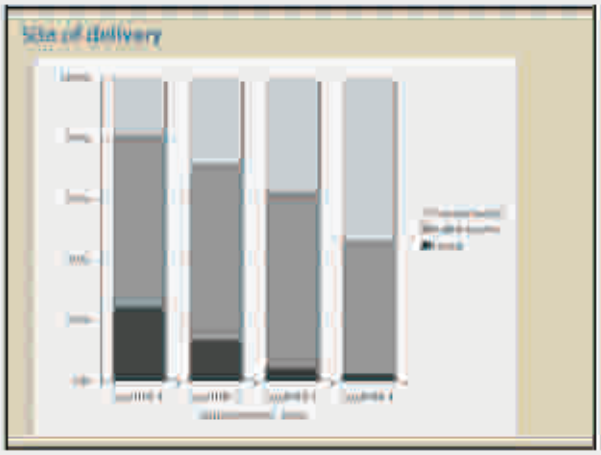



Age at first pregnancy


Number of Antenatal visits


Site of antenatal care


Where to go for what and when?



Cesarean section

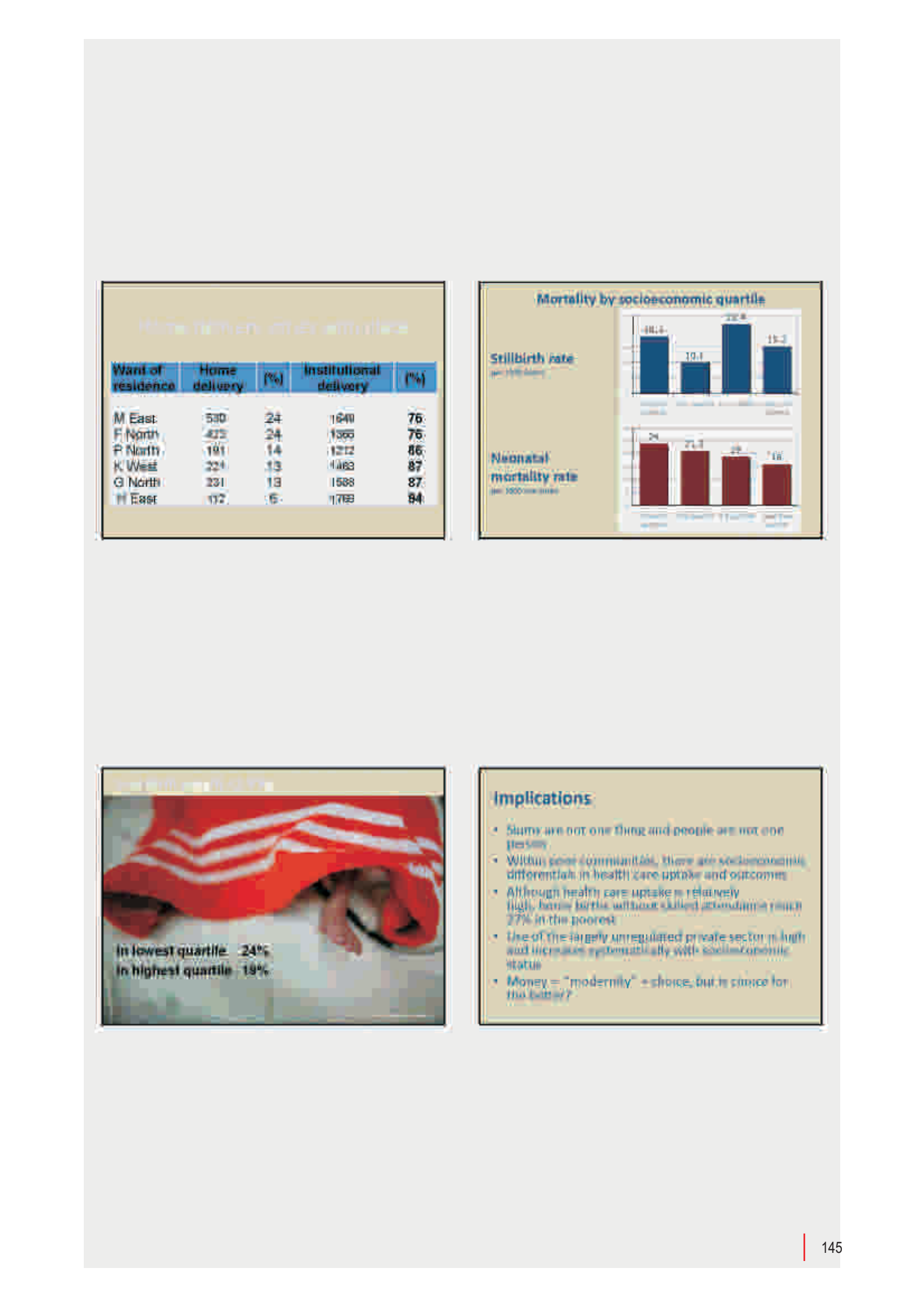
In lowest socioeconomic quintile	11%
In highest socioeconomic quintile	19%
In public facilities	14%
In private facilities	18%

Ward of residence	Home delivery	(%)	Institutional delivery	(%)
M East	530	24	1649	76
F North	422	24	1366	76
P North	191	14	1212	86
K West	224	13	1483	87
G North	231	13	1588	87
H East	112	6	1768	94

Mortality by socioeconomic quartile

Stillbirth rate

Neonatal mortality rate



Implications

- Slums are not one thing and people are not one person
- Within poor communities, there are socioeconomic differentials in health care uptake and outcomes
- Although health care uptake is relatively high, home births without skilled attendance reach 27% in the poorest
- Use of the largely unregulated private sector is high and increases systematically with socioeconomic status
- Money = "modernity" + choice, but is choice for the better?

Reasons

- Women had to wait a long time in a queue for getting medical attention
- Hospital staff scolded, abused, shouted at or slapped the woman
- Turned away and told to return later saying there is still time in delivery
- Refused delivery at hospital as facilities were not available and were transferred to other hospitals

Cities are the future of our world. We must act now to ensure that they become healthy places for all.
Margaret Chan, Director-General, WHO

A Happy Ending

- Rohana Begum, 28 Yrs.

Fever, Cold & Cough since 3 days.

- Urgent USG Scan – Live Pregnancy with Big Retroplacental Clot
- Clinical Diagnosis at 6.30pm
- Transfer to Institute at 7.30 to 8.00 pm
- LSCS 8.30 to 9.15 pm
- Total duration 2hr 45min

Greetings from Gujarat, India

Kangaroo Mother Care

- To increase proper awareness / spreading the multiple benefits of KMC
- To universalize proper practice of KMC in country and world including
  - Home based care of LBW in socio economically deprived sections of poor urban slums
  - and also in hospital settings at different levels of care

Consultation on
Potential Role of Private Sector Providers
in
Delivering Essential Newborn Care
in
Under serviced Urban and Peri urban Settings

Kangaroo Mother Care

Shalini N Vani
Ahmedabad

Kangaroo Mother Care(KMC)

Kangaroo Care (KC)
Kangaroo Method of Care
Skin to Skin Contact (STSC)

BACKGROUND

- 99% of neonatal deaths occur in developing countries.
- India contributes to 1 million neonatal deaths(25% of the global burden)
- Majority of maternal and neonatal deaths (more than 50%) occur at home, beyond the reach of health services

In settings of high mortalities,
Simple, low cost interventions have a greater potential to reduce NMR
than the high tech and costly interventions like ventilators, surfactants etc

Newborn Health Challenge

- India faces the biggest newborn health challenge of any country in the world.
- Other most global burden , it is estimated that India has
  - 40% of births (25 lakhs)
  - 30% of neonatal deaths (12 lakhs)
  - 40% of low birth weight babies (10 lakhs)
  - 46% of all births
  - 22% of maternal deaths
  - Every 7 minutes one newborn dies in India
  - Majority die at homes (Rural Urban divide)

Postnatal effective interventions

- At 90% coverage ,estimated potential to reduce neonatal mortality
- (The Lancet Neonatal Survival Series)

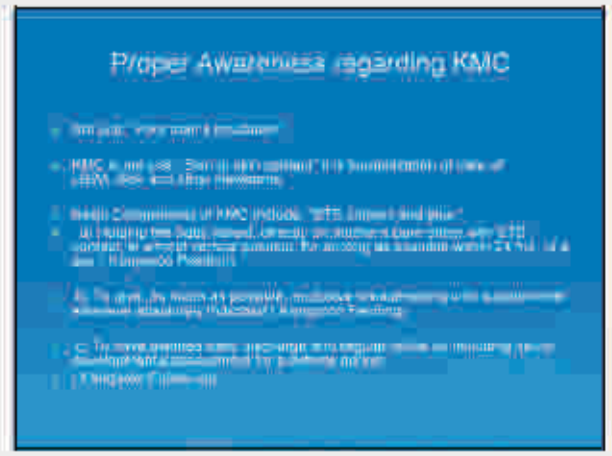
- Neonatal resuscitation – 6-42%
- Breast feeding ——— 65-87%
- Prevention & management of hypothermia – 18-42%
- KMC (care of LBW in health facilities)
- Avoidance of infections – 31% (7-35%)
- Community based pneumonia care - 27% (18-35%)

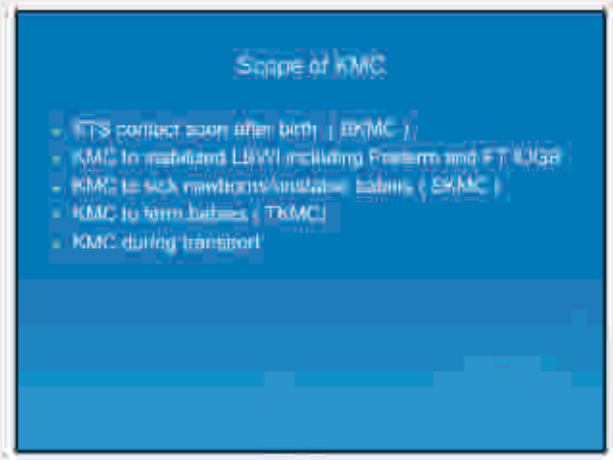
Kangaroo Mother Care

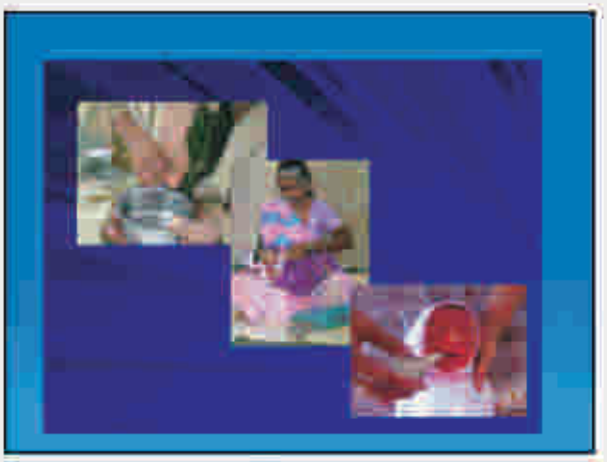
Introduction of Concept of KMC

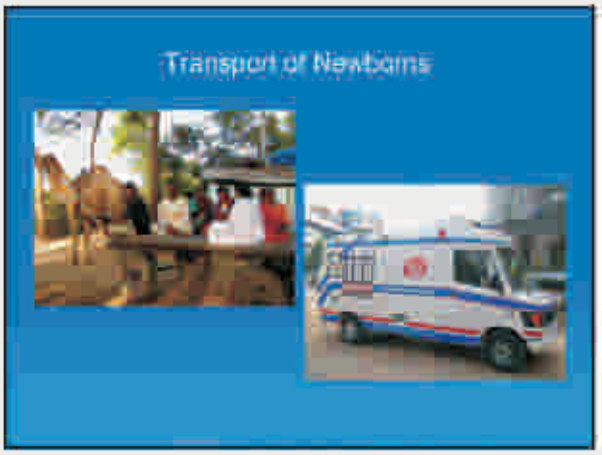
- Edgar Ray Sanabria and Hector Martinez
- Initiated KMC at Bogota, Colombia (1979)
- Institute Materno Infantil at San Juan de Dios Hospital

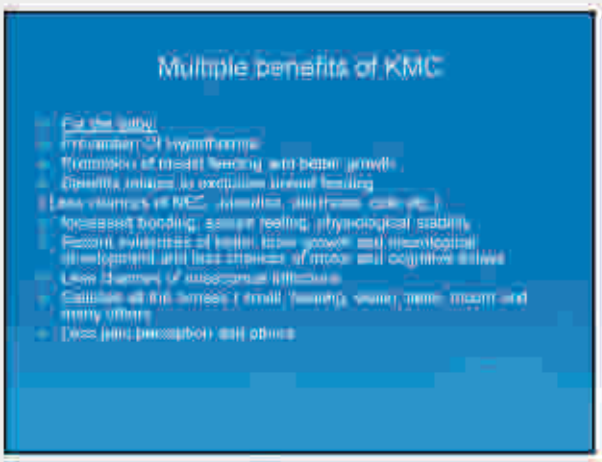
- 11000 deliveries per year
- NICU overcrowded, understaffed, under equipped, cross infection ,death
- For LBW lack of incubators, personnel, and separation of mother and infant leading to high morbidity and mortality
- KMC introduced successfully. Excellent results

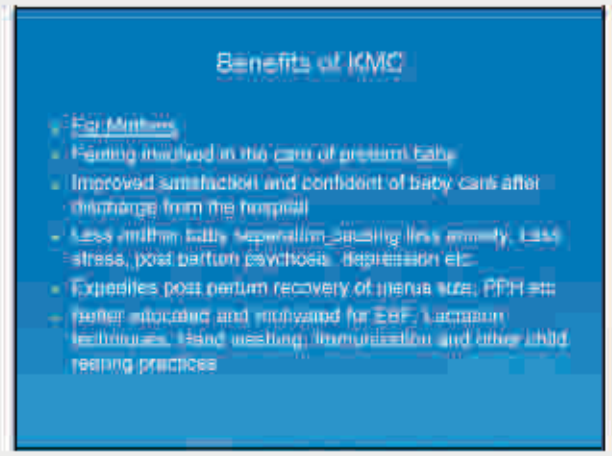

Proper Awareness regarding KMC

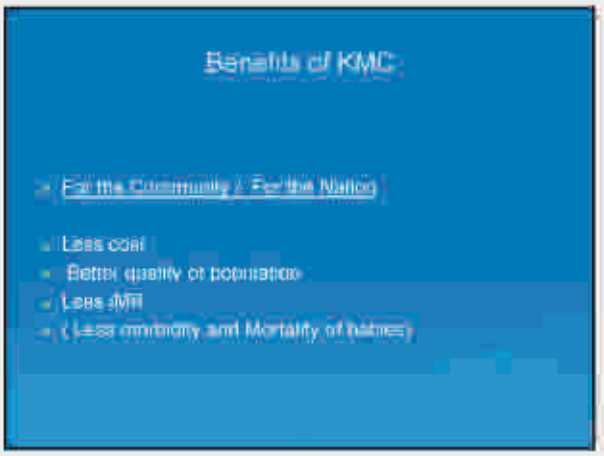

Scope of KMC
KMC to stabilized LBWI including Preterm and FT SGA
KMC to sick newborns/unstable babies (SKMC)
KMC to term babies (TKMC)
KMC during transport

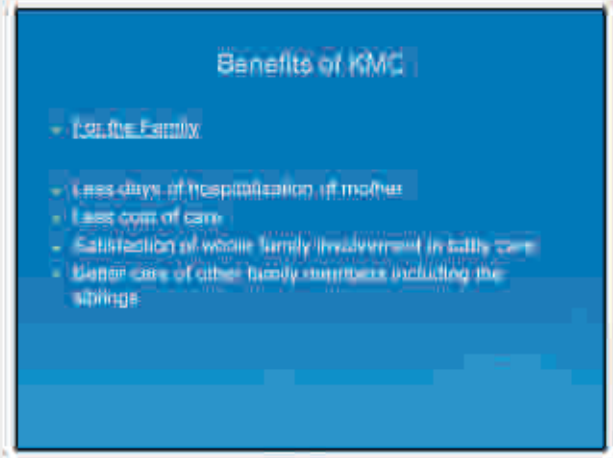


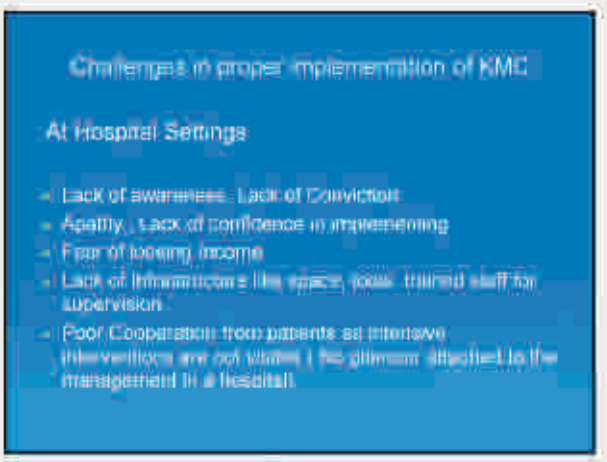

Transport of Newborns


Multiple benefits of KMC


Benefits of KMC
For Mothers
Feeling involved in the care of preterm baby
Improved satisfaction and confident of baby care after discharge from the hospital
Less mother baby separation leading less anxiety, Less stress, post partum psychosis, depression etc
Expedites post partum recovery of uterus size, PPH etc
better education and motivated for EBF, Lactation techniques, Head washing, Immunization and other child rearing practices


Benefits of KMC
For the Community / For the Nation
Less cost
Better quality of population
Less MM
(Less morbidity and Mortality of babies)


Benefits of KMC
For the Family
Less days of hospitalization of mother
Less cost of care
Satisfaction of whole family involvement in baby care
Better care of other family members including the siblings


Challenges in proper implementation of KMC
At Hospital Settings
Lack of awareness , Lack of Conviction
Apathy , Lack of confidence in implementing
Fear of losing income
Lack of Infrastructure like space, less trained staff for supervision
Poor Cooperation from parents as intensive interventions are not visible (No glamour attached to the management in a hospital)

Challenges for KMC at Home

- Lack of Awareness
- Lack of Proper Guidance and Supervision
- Lack of Time
- Lack of Support from family members
- Apathy
- Fear of holding a very tiny baby and others

Promotion of KMC

- Systematic training and periodic evaluation promotes significant practice of KMC not just looks attractive although any follow up
- Continuous small group education using KMC charts available showing the pulses of KC in NICU and take remedial measures
- In NICU give almost the same attention as any other intensive care
- NICU practice will convince others to follow up at home and also

- Appreciate the importance of KMC in all settings (Hospital or Home)
- Provide adequate facilities in hospital
- Counsel family members for the benefits of KMC and motivate them for all possible support to mother
- Health Care Providers must be convinced and motivated to advise, guide and supervise KMC at Hospital or Home

Promotion of KMC at National Level

- KMC along with Breast feeding to be included in National Health Policy as has been done in many countries
- Step 1 Orientation of Health workers and mothers and community for importance of KMC
- Step 2 Transfer medically stable babies to KMC wards /supervised KMC at home
- Step 3 Ambulatory Follow up Care of baby wt. less than 2500 grams

- Approximately 2.5 million newborn deaths can be averted by low tech interventions of which Breast feeding and KMC have a major share and together they have a compounding effect on the quality of survival of the newborns especially the most vulnerable low birth weight infant including the preterm and full term IUGR babies

Gujarat Urban Health Alliance Experiences

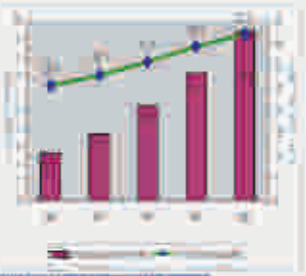
Dr. Vihar K. Desai

Development of Urban Health system

- Urban health system plan
- Urban health administration structure plan (State, Regional, ISG, Zonal in corporation)
- Urban health HR service plan (RCHO, CHC, Zonal PH managers, FO, VI & E asst., USHAA/LWs)
- UHCs, SCs, UHC & Maternity Norms
- Urban health monitoring Plan
- Urban health society formed
- City health mutual MoU

Gujarat 3rd most urbanised state in the nation

Category	[illegible]
Municipal corporations	8
Cities (100,000-2,00,000 Pop.)	24
City (50,000-100,000)	33
City (<50,000)	226
Total	243



Estimated 50% urban population by 2026

Gujarat Urban health Project

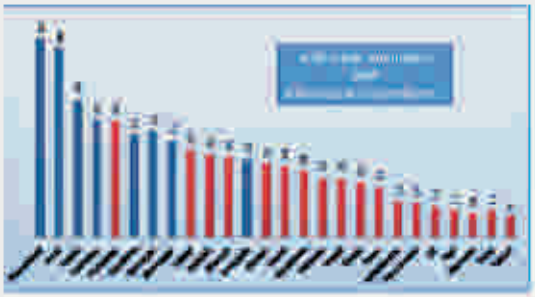
Objective

- To develop and strengthen primary health care delivery system in the urban areas to address the rising urban health needs of urban poor and other vulnerable groups

The strategic approaches include

- Promoting, supporting and institutionalizing assessment and Management Capacity Development of the urban local bodies
- Developing and strengthening management and support mechanisms at district, region and state levels
- Creating Urban Primary Health Centre (UPHC) system for all urban areas of targeted
- Promoting, supporting and institutionalizing Public Private partnership
- Promoting, supporting and institutionalizing Community mechanisms and Networks

District wise % urban population in Gujarat



Urban health management –Municipal Corporation

- Municipal corporation
1. Urban health societies registered
2. CPMU with
   CPC, Zonal PH managers, M & E asst & Finance asst
3. RCH home- outreach –PUHC
4. RIMS introduced
5. IDSP functional

Urban health management –State

- State health
1. Director urban health
2. Administrative Officer
3. M&E asst
4. Financial assistant
- NRHM
1. Professionals (planning, co ordination monitoring & finance) working with SPMU

Outreach services

Outreach workers

- U / Mahila workers
- FHW
- ANMs

UPHC

- LHV
- AWW additional assignment (rural)

Mahila Arogya committee

- SHG

Health Program Monitoring

Mix data source

- Active surveillance (slum)
- UPHC data
- Municiple corporation & Government hospital data
- SSU – Private practitioners/hospitals
- MICS in Urban slums

RCH program in Urban Gujarat

- Home based care – ANMs, AWWs, LWs
- VHND (MAMTA Divas) including immunisation by health and ICDS
- UHCs development / strengthening
- Chiranjivi & Balsakha
- JSY & JSK
- RSBY
- STD care & PPTCT
- E MAMTA

UHCs

- Municipal corporations
  - All existing units upgraded to UHCs
  - New UPHCs developed as per mapping
  - UHSC for very remote slum cluster
  - UHC facilities as per NUHM draft guidelines
  - UHC HR as per NUHM guidelines
- Municipalities
  - new UHCs
  - UHSCs
  - UHC facilities as per NUHM draft guidelines
  - UHC HR as per NUHM guidelines

Public Private Partnership Projects (Medical Care service)

(Urban & Rural)

- Chiranjivi yojana- institutional delivery
- Balsakha Yojana- Newborn- Infants
- PHCs/ CHCs/UHCs Institutions
- FP centres

(Urban)

- UHCs Institutions - Ahmedabad
- ICDS- Ahmedabad
- VBD - Surat

Partners

Inter sector:

- Private doctors
- Trust run institutions
- Corporate sectors
- NGOs
- Academic institutions (Medical/ Nursing/ANMs)

Intra sector:

- ICDS
- Education
- Civil supply
- Academic institutions (Medical/ Nursing/ANMs)

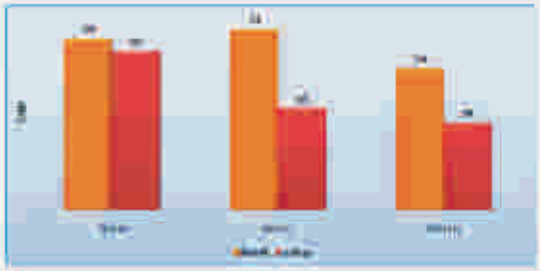
Chiranjivi and Balsakha

- Urgency to increase institutional delivery rate towards reduction of MMR and NMR
- Acute shortage of Gynecologists, so could be all resource against private Gynecologists practicing in small towns
- Policy Dialogue – Government, IMA, FOGSI Rural, CTF
- Issues of consultations with FOGSI members at HQ as well as districts
- To day

493 GY doctors (Obstetricians)

217 Balsakha doctors

Trend of IMR in Urban and Rural Gujarat

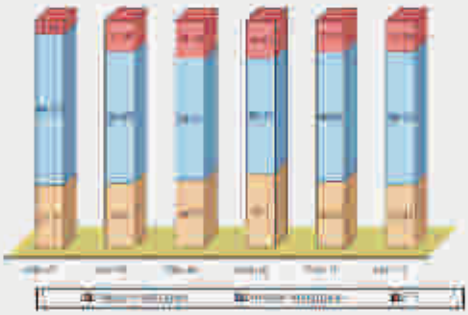


Between NFHS2 and NFHS III
3 Pts decline in Rural and 45% decline in Urban

Chiranjivi

- BPL category and APL tribles
- Qualified Gynecologist with facilities spelt out can register with CDHO
- Package for 100 deliveries (1) Rs.1,79,500/- (2) Rs.88,000/- (Rs.200 transport cost to mother)
- Rs. 25,000 advance and rest on submission of receipts and reports
- Sign board to be displayed for services available and with a mention of no additional charges to be paid

Break up of Institutional Deliveries with CY deliveries



Balsakha I

Chiranjeevi Yojna and CHC and District Hospitals where services of pediatricians are not available

- Will attend all newborns at the place of birth for 2 days , early neonatal care , immunizations , feeding advice.
- Sick Baby will be transferred and treated in his / her NICU
- If baby requires higher level NICU care , the baby will be transferred to medical college hospitals
- Gynecologist will receive Rs 30,000 and pediatrician will receive Rs 1,30,000 for 100 babies treated
- Transfer charges shall be given for transfer of babies from one facility to another by the pediatrician as above and will be reimbursed

Ongoing monitoring and assessment for action

- Dropout registered doctors
- Number of women served, deaths reported
  Significant reduction in maternal deaths against estimated but low impact on new born deaths
  → Balsakha
- Extra charge by doctors- Inquiry and return of paid money
- Over a period representation for revision of rates. For 100 deliveries (1) Rs.2,80,000/- (2) Rs.90,000/-
- Arrangement for Balsakha doctor

Balsakha II

- This will be applicable to all babies born to BPL families born at other places than those mentioned in part 1, i.e. born at home, subcentre or a PHC
- The babies are examined as per IMNCI protocols and those who are identified as sick sure are referred to the private pediatricians partnering under this scheme
- The pediatrician will receive Rs 1,45,000 for 100 babies treated
- Transfer charges shall be given for transfer of babies from one facility to another by the pediatrician as above and will be reimbursed

Extended Balsakha Yojana

- Age group of beneficiaries 2nd month of age to 12 months
- Package of Extended Balsakha Yojana scheme for 100 infants: ₹ 25,000

Total package of infant examined & treated= Rs.1,25,000/-

1. The neonatal mortality rate was significantly lower in the IMNCI clusters in the subgroup born at home but not in the subgroup born in a health facility
2. Infant mortality and neonatal mortality beyond the first 24 hours were also significantly lower in the IMNCI clusters than in the control clusters among home births but not among facility births

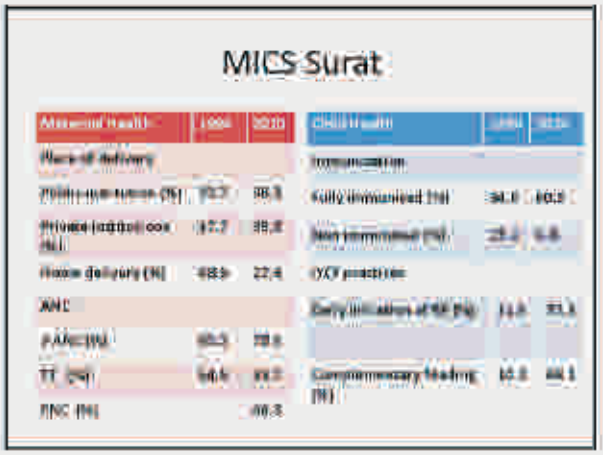
Sharing of Experience PPP

Building up PPP

Success of PPP

- Practices were improved in the intervention group in home born as well as facility born babies,
- The magnitude was higher in the home born subgroup

MICS Surat



Maternal health	2006	2010
Place of delivery		
Institutional births (%)	70.7	88.3
Private institutional births (%)	37.7	38.8
Home delivery (%)	48.9	22.4
ANC		
ANC (%)	85.5	88.6
TT (%)	94.4	97.0
FNC (%)		46.8

Child health	2006	2010
Immunization		
Fully immunized (%)	54.0	60.0
Non immunized (%)	28.4	5.8
CCF practices		
Early initiation of BF (%)	14.4	31.1
Complementary feeding (%)	10.0	44.1

PPP = P7

- Policy
- Plan
- Process
- People
- Protocol
- Performance audit
- Patience = Perseverance