# SNEHA
## City Initiative for Newborn Health, ASK Partnership

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***Abstract:*** *This paper summarizes one NGO's experience in building partnerships with the public sector health system with the outcomes achieved sustainability issues involved and lessons learnt presented through of three case-studies. It also focuses on approaches which can lead to building public and private partnership models.*

A common definition of public-private partnership (PPP) is that it involves a contractual agreement between the public and the private sectors, whereby the private operator provides services that have traditionally been executed or financed by a public institution. The ultimate goal of PPP is to obtain more 'value for money' than traditional public procurement options would deliver. Some of the ways in which this might be achieved are reduced life-cycle costs, more efficient allocation of risk, faster implementation, improved service quality and additional revenue (Andre & Lorna 2006).

Public-private partnership (PPP) is prevalent in almost all sectors in India (Bhat, 1999). It has become a common approach to health care problems worldwide. Many PPP were created during the late1990s, but most of them were focused on specific diseases such as HIV/AIDS and malaria. Due to the well-documented deficiencies of public sector health systems, the poor in India are forced to seek services from private sector, under immense economic duress (Goel et al 2007). Over the last three decades the health sector has experimented with public-private partnership in a number of ways, such as contracting out medical services or maintenance of health infrastructure, involving non-government organizations (NGOs) in awareness generation programmes, and pooling technical resources from the not-for-profit sector for training and research purposes. Private players have also been brought in, in order to benefit from their updated technical skills, implementation experience and risk taking capacity.

India has one of the highest levels of private-out of pocket financing to the tune of 87 per cent in the world. Such mode of financing imposes debilitating effects on the poor. Hospitalization or chronic illness often leads to liquidation of assets or indebtedness. It is estimated that >40 per cent of hospitalized individuals borrow money or sell assets to cover expenses and 35 per cent of hospitalized Indians fall below the poverty line in one year. The inequalities in the health system are further aggravated by the fact that public spending on health has remained stagnant at around 1 per cent of GDP (0.9 per cent) against the global average of 5.5 per cent. Even the public subsidy on health does not benefit the poor. According to Goel et al (2007), "the poorest

20 per cent of population benefit only 10 per cent of the public (State) subsidy on health care." On the other hand, the private health sector in India has grown remarkably. At independence, the private sector in India had only 8 per cent of health care facilities (World Bank 2004) but now it is estimated that 93 per cent of all hospitals, 64 per cent of beds, 80-85 per cent of doctors, 80 per cent of outpatients and 57 per cent of inpatients are in the private sector.

Hence the possibility of a PPP in the health sector can be explored to meet the growing health care needs of the population so that PPP would improve equity, efficiency, accountability, quality and accessibility of the entire health system (Goel et al 2007).

This paper summarizes one NGO's experience in building partnerships with the public sector health system with the outcomes achieved sustainability issues involved and lessons learnt presented through of three case-studies. It also focuses on approaches which can lead to building public and private partnership models.

**Background**

The Society for Nutrition, Education and Health Action (SNEHA) is an NGO working for the health of women and children, primarily in communities living in Mumbai's slums. As such, it represents private not for profit sector. The operational definition of PPP must, therefore, involve a loose conception of private provision that includes the possibility of partnership between the public sector, private for-profit and private not-for-profit. We at SNEHA see PPP within the operational terms of our project cycle as an agreement between multiple partners – in this case initiated and facilitated by SNEHA – in which a specific and mutually agreeable role was envisioned for each partner in order to achieve the goal of the City Initiative for Newborn Health.

The City Initiative is an unusual collaboration in which four types of organization are represented: an NGO (SNEHA), a public sector provider (the Municipal Corporation of Greater Mumbai; MCGM), a private sector organization (the Social Initiatives Group of ICICI Bank, now the ICICI Centre for Child Health and Nutrition; ICCHN), and a public sector educational institution (University College London Centre for International Health and Development; UCL CIHD). Each partner has a different role. The MCGM's role is service provision and to take a lead on the integration of activities within the public sector ambit; SNEHA's role is to implement, monitor and evaluate the initiative's interventions. ICCHN's role is to advise on and discuss strategic approaches and provide financial support; UCL CIHD worked with SNEHA to develop robust monitoring systems and a strong research and documentation component. It also engaged in capacity building research skills at SNEHA.

In Mumbai's slums, many vulnerable infants, pregnant women and new mothers are unable to access early and appropriate medical care for a variety of reasons (SNEHA & MARS 2004). To address this issue, SNEHA began work on the City Initiative for Newborn Health in 2004. The goal of the initiative is to improve the health of mothers and newborn babies by reducing neonatal and maternal morbidity and mortality through a series of planned sustainable interventions at public health facilities and in communities. It has two major components:

working with health facilities and working with communities. The first component aims to work with the public health system to achieve continuous quality improvement in maternal and neonatal services at health posts, maternity homes, and hospitals. The second component aims to work with community groups in slum areas to improve maternal and newborn-care practices and care seeking. The initiative's pioneering effort, therefore, is to simultaneously work with the demand and supply side to achieve the improvements in maternal and neonatal outcomes. For the purpose of this paper we limit our discussion to work done so far with the supply side namely with MCGM health facilities.

Characteristically, PPP initiated by the government tends to involve time-bound project-level activities in which the other partner provides a service or fulfils a role, and which end at the close of the funding term. The model that SNEHA tried to develop in the City Initiative is based on an organizational belief that the public sector system can deliver if supported by a participatory facilitation process which leads to sensitive supervision and change in individuals and groups. The City Initiative for newborn health was aimed at improving the quality of care provided at the public health facilities. To achieve this, our facilitators used the method of Appreciative Inquiry which could confront both the 'technical quality' (i.e., the standard of care received) as well as 'attitudes and behaviours' of health care providers. Appreciative Inquiry (AI) was also used as a philosophy underlying all undertaken initiatives, as a training method, and as a tool for data collection. (More about AI in Annex 1)

The data for the case studies has been collected from the project MIS and detailed process documentation which was carried out by a consultant hired specifically for the process documentation. The consultant was appointed during the implementation phase of the project and worked with the respective project teams to prepare the framework for the process documentation. Apart from project MIS, process documentation also involved interviewing the health care providers who participated in the intervention.

Mumbai's healthcare system has witnessed significant developments since independence in 1947. The Mumbai municipal public health care system is regarded as one of the most extensive and multilayered in the country. Though the health infrastructure in Mumbai is good on the whole, there is a need to improve quality and standard of services provided in the hospitals, particularly, those which are catering to the needs of the common people. More than 50 per cent of Mumbai's population lives in slums and are from low income households, therefore, depend on the public sector health facilities. The access to public health infrastructure is not equitable and is more heavily tilted towards Island city, which is disproportionate to the democratic pattern (Mumbai Transformation Support Unit 2006).

However, it still lags significantly behind some of its international counterparts. Despite being the economic and financial centre of the country, there is a shortage of trained specialized staff like fully trained nurses, anaesthetists, and paediatricians. There is also a widespread mismatch between infrastructure, equipment and human resources, which leads to underutilization of resources and suboptimal outcomes (SNEHA 2005).

## Case study: City Initiative for Newborn Health

**Getting started -** emergence of action groups: The project was launched in February 2004. The first phase began with meetings at various levels (deputy Executive health officer, assistant health officer, medical officer of health of the ward (MOH)) within the administration of the MCGM health system. These meetings were instrumental in building good will and buy-in for the project, but also helped the non-MCGM partners to understand the many issues involved in providing healthcare to Mumbai's public sector clients. Though these meetings gave a broader understanding of the issues, informal interviews were also conducted with staff at health posts, maternity homes and with the MOHs in order to grasp the linkages between various health facilities and their gap identification. The data gathered in the process were used in designing and conducting two workshops each involving 60 participants from all levels and cadres of municipal health care providers. These workshops were well received by participants, who expressed satisfaction that they had been able to share their opinions and ideas about the changes that would be necessary to improve access to and quality of maternal and newborn services.

A key outcome of these workshops was a project design for the City Initiative and the emergence of action groups. Gaps were identified at each level of the health system, among them lack of written guidelines or clinical protocols for management of clients at a given level of facility, lack of guidelines on when, where and how to arrange referral or transfer including lack of formalization in the referral system overall, and a need to strengthen health post capacity were some points. Five action groups were formed: for training, information, education and communication; for facility upgrading; for the design and implementation of clinical protocols; for the refinement of administrative protocols; and for nurses working within the system. Action groups drew members from MCGM facilities at health posts, maternity homes, peripheral hospitals and tertiary hospitals, as well as from administration departments. The groups initially met every month, then progressing to regular quarterly meetings for about two years to work on problem analysis and identification of strategies, and prepared plans of action for each level. Particular tasks were the design of clinical protocols and facility assessment tools, identification of training needs at each level, and identification of IEC messages.

**Action arising:** It was agreed that the first phase of the City Initiative (2004–2007) would cover a third of Mumbai's public health system. The project design and interventions were discussed and finalized by action group members through a series of participatory workshops, in which SNEHA played a facilitatory role. Following the workshops, SNEHA took a lead partner role in implementing agreed interventions at each level of the health system and monitoring progress. All the recommendations of action groups were taken up by SNEHA for implementation.

The recommendations were as follows:

- Upgrading of all the health facilities
- Standardization of clinical services

- Regular continuous medical education
- Establishment of Antenatal clinics at health posts
- Establishment of referral system in the public health facilities

This process was simultaneously supported by capacity building of municipal heath care providers to sustain the interventions within the system

## Case Study: ASK Partnership Formed Under City Initiative

**Identified need:** The need for facility upgrading was identified as one of the major gaps by the facility upgrading action group in the MCGM. The group identified 'vital', 'essential' and 'desirable' standards for human resources, equipment, drugs and consumables to enable facilities at each level to provide a designated level of quality care. Specific items of equipment were vital at each of the four levels of health care (health posts, maternity homes, peripheral hospitals and tertiary hospitals). It was clear that the present system of administrative procedures would take some time to make vital equipment level available in all facilities. The nature of administrative policies was that reform was unlikely in the short term. The PPP decided to work towards enhancing the quality of care by supporting the provision of vital equipment.

The support for PPP evidenced in the government's Health Policy (2000) paved the way for a partnership between the MCGM, SNEHA and ASK Foundation, a private sector partner. ASK Foundation was enthusiastic about the idea of upgrading public health facilities. Particular needs were identified with the help of medical offices and sister-in-charge and a team of two facilitators, one from ASK Foundation and one from SNEHA. A proposal was put to the ASK Foundation with the understanding that improved infrastructure would increase the availability of services and thus reduce inappropriate transfers to the already overcrowded higher level facilities. Three maternity homes and one peripheral hospital were selected where CINH was already carrying out interventions such as clinical training and introducing partography. The selection criteria used for selecting the facilities was based on their performance (no. of deliveries in a year) and their association with developing a regional referral system. Equipment specifications were sought from the MCGM, and the process of procurement and supply was coordinated by SNEHA and ASK Foundation. Vital equipment needs have been addressed in all four facilities through the partnership. Monitoring is currently underway to assess utilization and further needs assessment is being undertaken. Impact evaluation will happen in due course.

### Achievements

*Health posts (sourced from clinic data from health pots for the period Aug 2007 to Dec 2008)*

- 8 fully-functioning antenatal clinics with staff trained on antenatal, postnatal, and neonatal care.

- Earlier registration: 20 per cent women register in the first trimester (as there were no clinics before for some health posts this increase is from 0 to 5 per cent.)
- 551 antenatal clients.
- Increase in health care-seeking: 20 per cent make two or more visits.
- More than 1629 neonates have been brought in for normal neonatal care.
- Clinically trained staff across 14 health posts.
- Improvements in motivation and attitude through communication training.

*Maternity homes*

- Standardized evidence-based clinical protocols developed.
- Clinical training: 20 modules in obstetrics and neonatology completed for all the staff of 8 maternity homes.
- Maintenance of partograph by 60 per cent of maternity homes.
- Dedicated hotline connectivity established from maternity homes to peripheral and tertiary hospitals.
- 'Vital' level of equipment installed and functional at three maternity homes.
- Appreciative Inquiry training and communication trainings extended by MCGM across all maternity homes in the city.
- Initiation and maintenance of recording systems for transfers in and out of seven maternity homes.

*Peripheral hospitals*

- Regional referral links established between three maternity homes and two peripheral hospitals.
- Hotline connectivity established and functional.
- 'Vital' level of equipment installed and functional at one peripheral hospital.
- Initiation and maintenance of recording systems for transfers in and out of four peripheral hospitals.

**Other partnerships**

During the project roll-out, a number of other partnerships were formed beyond the core group. New partners included Inner Wheel, the National Neonatology Forum (NNF), the Federation of Obstetric and Gynecological Societies of India (FOGSI), and MTNL (Maharashtra Telephone Nigam Ltd). Each of these partners made a particular contribution based on its skill set. Inner Wheel helped to upgrade one health post where vital level equipments were needed to provide gynecological outpatient services. Private space was created to facilitate the client's check up. NNF and FOGSI helped action groups to draft clinical protocols and also supported efforts to improve coverage of maternity homes by specialist clinicians; MTNL helped to

create and install a Centrex system through which facilities could communicate about client transfer and referral.

## SNEHA's New PPP Initiative

### Arogya Sarita

An Integrated Model of Primary Health Care: The Municipal Corporation of Greater Mumbai, SNEHA, and Mahindra & Mahindra (Private Corporation) have partnered to improve access and uptake of public health services in the vulnerable areas of the R/south Ward of Kandivali, specifically in the two health post areas of Hanuman Nagar and Damu Pada.

The innovative model of integrating the private sector into the government's health care delivery has encouraged enthusiastic participation by all the stakeholders - the public health system, private sector and community. Once participation is initiated, the role of the NGO is expected to become facilitative. It is an impractical expectation for the public health system to ensure 100 per cent coverage and access – the community needs to meet the services midway and ensure uptake. This can be achieved through proven methodologies that facilitate linkage between the community and the providers either public or private.

The goal of this project is to make quality health care accessible to all by building an integrated model of partnerships in the designated project areas. This pilot project will be implemented over a period of 18 month, reaching out to a population of 150,000. While a Primary Health Center (Health Post) is supposed to cover a population of about 50,000, the density in the area is much more. Also, the population is spread over difficult geographical terrain with clusters of tribal areas in the remote hilly tracts with no access to health care. The important deliverables of the project include upgrading health care services, addition of specialist services by the private sector in the health posts, integration of all health care services under the health post, introduction of mobile health units by the private sector, staffed by the public sector to reach the currently inaccessible areas and the formation of Slum Health Action Committees to encourage community ownership of health care.

### Lesson learnt

One of the challenges of partnership is that, despite the equal status of partners, one partner tends to drive the initiative. Indeed, it is possible that individual partners' involvement may be more passive than active. For example, since the City Initiative was conceived by SNEHA, which had the commitment and human resources, SNEHA at times became the de facto executor, taking a lead role in implementation, monitoring and evaluation of the project. This may occasionally have reduced the effectiveness of the initiative. For example, when partography was introduced at maternity homes, although part of the MCGM mandate, staff saw it an external initiative, and there was some reluctance to participate. This would probably have been reduced if the activities had come with the firmer instruction of the MCGM. A similar experience took place with the re-introduction of antenatal care at health posts. This had earlier been part of the MCGM service provision framework, but there was reluctance on the part of overburdened health post staff to introduce what were seen as new activities.

Nevertheless, the officials of the MCGM should be commended for their active engagement in the process of change, instituting regular clinical training across the city, introducing partography at maternity hospitals, and sanctioning the establishment of antenatal clinics at health posts in two other wards. Partnerships take time to mature. It took over two years until ground-level activities were established. Impact evaluation is underway, but the novel PPP seems to be sustainable in the medium term. Sustained partnerships lead to further partnerships and the involvement of organizations in new activities.

For example, this urban health partnership experience helped leverage funding for further work in Ghatkopar under another initiative named Sure Start programme. The Sure Start project is in the 'N' ward of Mumbai covering parts of Ghatkopar and Vikroli (central suburbs of the city) and covers a slum population of 200,000. The Situation analysis revealed that public health facilities were not accessed by the community members due to factors like overcrowding, rude behavior of health staff and poor information about public health facilities. Almost half of the population depended on the private health facilities where there was a need to standardize the health care. Study of the referral system revealed that inappropriate referrals led to increased workload on referral hospitals. Also, lack of decentralization led to crowding at the maternity hospitals affecting the quality of care.

The SNEHA Mumbai Sure Start project thus focuses on the quality aspect of health care and intends to standardize the health care in both public and private sector by introducing clinical protocols, establishing the referral system and making available information on health facilities to the community through the community resource centers.

SNEHA has been invited to be a member of the Integrated Health and Family Welfare Governing Council which is a monitoring body for the RCH II programme undertaken by the Family Welfare and Mother and Child Health department of MCGM. The role of this council will be to plan and monitor the family welfare and mother and child health programme of MCGM.

## *Conclusion*

The engagement of system in the change is seen in the Municipal Corporation's own

initiative or steps taken to sustain the interventions such as instituting regular clinical training across the city, introducing partography at all maternity hospitals, and sanctioning the establishment of more antenatal clinics at the health posts. Impact evaluation is underway, but the novel partnership has demonstrated effectiveness and sustainability, with potential policy implications.

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