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WEST BENGAL

CINI - ASHA MATERNITY VOUCHER SCHEME

CASE STUDY

2006

SUBREGIONAL OFFICE FOR SOUTH ASIA, NEW DELHI

West Bengal

CINI - ASHA
Maternity Voucher Scheme

Case Study

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West Bengal: Case Study, CINI - ASHA Maternity Voucher Scheme

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ACRONYMS

ADB	Asian development Bank
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
CA	CINI-ASHA
CDL	Calcutta Diagnostic Laboratory
CDMU	Central Drug Manufacturing Unit
CINI	Child in Need Institute
CHV	Community Health Volunteer
CRRID	Centre for Research in Rural and Industrial Management
DH&FW	Department of Health and Family Welfare
EHP	Environment Health Project
ELCO	Eligible Couple
FA	Field Associate
FP	Family Planning
HIHT	Himalaya Institute Hospital Trust
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
KABP	Knowledge, Attitude, Behaviour and Practice Survey
KMC	Kolkata Municipal Corporation
LIP	Local Initiative Program
MIS	Management Information System
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OPD	Out Patient Diagnosis
PA	Project Associate
PHC	Primary Health Centre
PMP	Private Medical Practitioner
PNC	Post-Natal Care
PNS	Purwanchal Nagarik Samity Diagnostic centre
PO	Project Officer
PP	Post Partum
PPP	Public-Private Partnership
PRC	People's Relief Committee – Janasawathya Kendra Diagnostic Centre
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
SEVA	Seva Medical Diagnostic and Research Centre
SS	Swasthya Sevika
STEP	Strategies and Tools against Social Exclusion and Poverty
STI	Sexually Transmitted Infection
TAI	Technical Assistance Incorporated
UHP	Urban Health Program
UHRC	Urban Health Resource Centre
ULB	Urban Local Bodies
URT	Urinary Tract Infection
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

CINI ASHA (CA) is the urban unit of Child In Need Institute (CINI), a large NGO, which was started in the outskirts of Kolkata to meet the nutritional and health needs of newborn children and mothers living in the periphery of Kolkata. CA works with vulnerable populations in the slum communities of Kolkata. CA is primarily engaged in promoting rights of children to life and childhood through their education, nutritional support, half way homes, child help line and health programs. From 2000, CA has been implementing a comprehensive health program aimed at improving access to quality health care services by poor women and children, which included a health voucher component. This case study is an attempt to analyze the features, potential and limitations of the user fees and health voucher scheme introduced by CA within the larger health framework.

A typical maternal health voucher scheme would target pregnant women from vulnerable communities and provide a set of health vouchers, at the outset, against a payment of a very minimal sum. Those vouchers would entitle them for a package of maternal health services by professionals from either public or private sector, thereby giving them a choice. The services usually include, three antenatal check up, safe delivery, one or two postnatal check up within 6 weeks of delivery, and referral services for obstetric complications. Some may also include transport cost. The system does not involve any cash transaction at the service delivery points and the providers get reimbursed as per the services provided, based on the number of vouchers collected. The reimbursement is made for the services rather than inputs. The principle of providing a set of vouchers at the outset is to ensure continued utilization of the services by pregnant women without interruption by using a network of professional providers. The entire effort is supported by a strong community education and awareness component.

CA's program has adopted the spirit of the maternal health voucher scheme but not the whole process. While it aims to increase access to services to pregnant women by professional service providers, the subsidized service access is limited to times, when a need is perceived by the users and on payment for each visit. CA's emphasis is on encouraging women to use the Government facilities for antenatal care and delivery as much as possible, while providing a range of family planning and early childcare related interventions at the community level. CA began charging user fee of Rs.2, which entitled the families to access the services of Private Medical Providers (PMPs), as a means of creating a sense of financial discipline of paying for services, rather than as a maternity protection measure.

In 2004, CA brought the focus back from whole family, to pregnant women and children under 2 years of age, for accessing the subsidized services provided by the PMPs. The user fee was also revised. By early 2005 adolescents have also been included in this group. The health post located in the community collects the fee of Rs. 5 per visit for the PMP referral and Rs.10 per referral to diagnostic centers and provides the women with a voucher, or a referral slip. On presenting the voucher, the PMPs provide services at a subsidized rate of Rs.15, while the diagnostic centers offer services for various tests at very competitive rates, as negotiated by CA. There is no cash transaction involved at the service provider level. Women from slums have gained access to a network of twenty-five private physicians, five diagnostic laboratories and full course of generic medicines from CA. The voucher is issued and used based on the needs of the client and not for accessing a whole package of pre-determined services exclusively aimed at improving maternity protection.

CA addresses the preventive aspects and information needs at the health post by using community health volunteers. At the referral level, developing a network of PMPs has given

options to choose a provider. The use of vouchers has drastically reduced in the last two years as compared to the first three years of the program. This could be attributed to limiting the use of subsidized services to pregnant women and children less than 2 years of age from 2004. Breakup of data of the number of vouchers used in the year 2004 and 2005 show that more PMP visits have been made to meet the needs of children as compared to pregnant women, reflecting that women use PMP services for child care rather for pregnancy related issues.

The strength of CA's method lies in the fact that they have been able to introduce the user fee for services as part of a large comprehensive health program. The effort also has created awareness in the community regarding the use of professional services, even when priced. This experience has enabled CA to get a better understanding of reproductive health needs of poor women in the larger context of urban health and has helped to evolve a methodology to work with urban poor.

Despite such gains, a number of aspects require strengthening including streamlining the management of the user fees and establishing indicators towards measuring improvement in maternal and child health. To move towards a social insurance scheme using health voucher, the program requires serious efforts both at management and implementation levels.

A number of suggestions have been made to strengthen the initiative including, building capacity of CA staff in gaining an in-depth understanding of the management of voucher system and user fees, better monitoring of progress through setting measurable indicators, institutionalizing linkages with service providers from private sector and government health system, strengthening counseling and advocacy skills of field staff and enhancing community involvement and ownership through frequent sharing of analysis of field data and discussions.

INTRODUCTION

One of the most important challenges faced by many developing countries today is to guarantee to all citizens an appropriate level of health care in terms of access, quality and opportunity regardless of ability to pay.

For a variety of reasons, such as the lack or misallocation of resources, the structure of the health systems as well as inequalities that are deeply rooted in the prevailing social arrangements that extend beyond the health sector, many Asian countries have failed in addressing the health exclusion phenomenon through public delivery of health care, which generally remains under-financed, insufficient, ill-equipped and of poor quality

The level of public care spending in India (less than 1% of GDP) is one of the lowest in Asia, explaining why public delivery of primary health care through under-financed institutions remain insufficient and poor in quality. At the same time, a rapidly growing private health sector remains beyond the reach of the most disadvantaged groups.

On the whole, and although there have been significant achievements in some states, basic health indicators still stand very low and a wide gap remains to be bridged to provide the quality health care services expected by the entire population, especially in respect to maternity and infant protection.

There is growing evidence in India that vulnerable groups have poor access to public health services particularly maternal health services even though these services are supposed to be free. This is due to both supply side and demand side barriers. Supply side barriers include non-availability of doctors or drugs, lack of quality services and discriminatory behavior from providers. Demand side barriers include lack of education about when to seek treatment, lack of information about treatment options, high indirect costs and socio-cultural norms.

Due to these factors most mothers-to-be still do not access the full range of preventive health care services and most births remain delivered by unskilled attendants, which is the leading cause of high maternal and infant mortality rates. In order to achieve the Millennium Development Goal (MDG) of maternal mortality reduction the present behavior and practices in seeking maternal healthcare need to be changed.

In recent years, the poor performance of public sector using supply side financing has led to increasing interest in demand side financing as a possible option to influence the demand for health services as well as to increase the access of the poor to health services. With this new focus, the introduction of health vouchers covering the whole sequence of maternity-related health care services has been seen as an innovative mechanism that could contribute to a significant improvement of the health status of poor women.

Since 1999, the urban branch of CINI (Children in Need Institute) has developed this innovative approach to provide maternity protection to poor women living in 12 slums of Kolkata, as part of a large urban health program. The health voucher system provides poor women access to a network of private physicians and diagnostic laboratories, which have an arrangement with CINI for provision of services at agreed rates, resulting in the fact that there is no financial transaction at the point of service. This mechanism encourages extremely poor women to make use of professional services while contributing to their overall empowerment

since they could play a more active role in selecting the health provider offering the best services.

In the Indian context, maternity protection is generally not included among the services covered by the health insurance schemes made available by public and private insurance companies. The CINI-ASHA health voucher experience has initiated innovative ways of addressing maternity protection in an urban context. Though not a typical health voucher program focused on exclusive maternity protection as a package, this effort by an NGO in a very complex urban health environment has potential for wider application and deserve to be thoroughly documented.

OBJECTIVES OF THE STUDY

The case study aimed at documenting the health voucher scheme implemented by CINI-ASHA in the slums of Kolkata. The study was to analyze the various aspects related to the organization and functioning of this experience at its various development stages as well as highlight its present system and performance. In a broader perspective, the study will also identify the possibilities and conditions for the replication of the scheme or for its promotion through other demand-side financing mechanisms such as health micro-insurance schemes.

The following are the specific objectives of the study:

- Analyze the prevailing health conditions in the targeted area prior to the introduction of the voucher scheme
- Analyze, at its various stages, the scheme's setting up process
- Provide an accurate description of the main features of the scheme in terms of: organization, functioning, benefits provision, operational mechanisms, sustainability and impact
- Highlight the role played by the various actors involved in the implementation of the scheme (CINI-ASHA, community health promoters, public and private health providers...)
- Review the partnership/contracting arrangements concluded with the private physicians associated to the scheme
- Review the financial agreements concluded with the various donors contributing to the financing of the scheme
- Provide statistics and data related to the evolution of enrolment in the scheme, use of services, collected contributions and payments made to health providers
- Provide evidence of the changes in health behaviour and improvement of the health status of the targeted group resulting from the implementation of the scheme
- Interview some health providers and some beneficiaries in order to get their point of view on the relevance and efficiency of the scheme
- Identify the gaps and constraints currently affecting the development of the scheme while trying to fully address the maternity protection needs of poor women
- Formulate specific recommendations aiming at improving the scheme's effectiveness, impact and performance
- Formulate overall recommendations pertaining to the possible replication of the scheme in other locations

METHODOLOGY

Most information and data were gathered during a one-week mission to visit CINI-ASHA in Kolkata.

The methods used for primary data collection from the field are qualitative, viz Key Informant Interviews with managers, key staff, service providers and Focus Group Discussions with women and Community Health Volunteers. Personal observations of the researcher on visiting the health posts and private health facilities and interacting with various stakeholders have also been used.

Documentary sources such as forms for membership, claims, etc used by the voucher scheme, current operational documents of membership, information updates for members, information on referral cases & referral expenditure and data on referral centres, which are maintained by CINI-ASHA were used for secondary data review and documentation.

The case study is presented in seven main sections. The first section provides an overview of the health situation in West Bengal and in the particular areas targeted by CA interventions. The second describes CA as an organization. The third deals with the implementation of the overall health program including, service delivery mechanisms, community involvement and innovation in enhancing accessibility by women from vulnerable communities, highlighting the different strategies developed over time and the roles played by the various actors. The fourth section analyses the evolution of the user fee, use of vouchers, potential and limitation of the maternal health voucher scheme introduced by CA. The fifth section analyses the evolution of the main performance indicators of the voucher scheme. The sixth section presents the views of the various actors involved in the implementation of the voucher scheme. The seventh and final section highlights the lessons learned and points out to some improvements that could be brought.

I. BACKGROUND

Provision of assured and credible primary health services of acceptable quality in the urban areas is emerging as a serious issue for the Governments, both at the state and central level. The health delivery structures in urban areas especially for the urban poor have been limited to a few cities based on pilot schemes and programs. In view of the increasing urbanization along with the growth of slums and low-income populations in the cities, enhancing access to services at affordable cost has been accorded high priority in the National Population Policy 2002 and the Reproductive and Child Health Program-II (RCH-II), an umbrella program of the Department of Family Welfare, Government of India.

The Government of West Bengal has articulated their RCH II (2004-2009) Goal as: "To improve the health status of the urban population with special focus to the poor and un-reached by provision of quality integrated primary health care services".

Two key objectives of RCH II are:

- To provide integrated and sustainable system for primary health care service delivery and to increase accessibility to the urban slum population and other vulnerable groups to preventive, promotive and curative services.
- To improve the overall MMR, IMR, Child Mortality, Family Planning and Adolescent indicators in the above mentioned areas, along with overall reduction in communicable, non communicable and nutrition related diseases and disorders.

Key strategies proposed to improve the indicators include: upgrading the existing infrastructure, integration of services, increasing demand for family welfare services comprising of modern contraceptive usage, adoption of terminal methods, delivery care and child health services such as immunization and newborn care. Key Health Indicators in West Bengal, Urban West Bengal and Poorer section of the Urban West Bengal are as follows:

Table No. 1. Health Indicators in West Bengal

Indicators	Overall WB	Urban Poor	Urban Total
Mean No Children Ever Born	2.54	3.04	2.16
Contraceptive Prevalence Rate	50.4	52.9	66.4
% of Births with Skilled Attendants	44.2	55.2	81.7
Mean Age at Marriage for Women	17	16	19
Institutional Delivery	40.5	51.4	80,7
Received N0 ANC	57.0	67.9	82.5
% of Children who Were Given Colostrums	31.9	29.5	28.6

Source: NFHS-II, 1998-99

This renewed focus on urban health and its articulation in RCH II is significant since nearly one fourth of West Bengal's population lives in urban areas as per census 2001.

Kolkata, is the most densely populated city in India. Of the 80.22 million population 28.03% lives in urban areas.

RCH II, for the fist time views at urban health issues, distinct from that of rural health. There is increasing evidence that the free RCH services are not easily accessible to women and children from vulnerable communities in urban areas, despite the fact that they are located in close proximity to the various Government health facilities.

There are both demand and supply side barriers contributing to such a situation. Supply side barriers include non-availability of doctors or drugs, lack of quality services and discriminatory behavior from providers. A demand side barrier include, lack of education about when to seek treatment, lack of information about treatment options, high indirect costs, inter-household preferences and socio cultural norms. Due to these barriers, millions of pregnant women still do not access full range of preventive health care services and most deliveries are conducted by unskilled attendants, which is the leading cause for high maternal and infant mortality.

In the city of Kolkata, the existing Post Partum (PP) centers and the Urban Family Welfare Centres, which are meant to provide secondary care have very poor infrastructure, staff and equipment, which limit the opportunity for the urban poor accessing care from professionals. This also increases the pressure on the tertiary care units for services. It is increasingly realized that, to enable the poor to access services, they need to have choices and a realistic price structure for services. Demand side financing is one such mechanism, where the subsidy is provided on the basis of service provided and creates access to more than one provider.

Through Public private partnership (PPP), RCH II is proposing to explore innovative ways of financing services that aim to reduce some of the supply-side financing limitations. The Government of India, in the RCH -II document, acknowledged the Urban Health Program implemented by CINI-ASHA as one of the best practices for expanding access to maternity and new born care services to the vulnerable population, by directly linking the professional service providers with users, through a combination of community contribution and out put based subsidy.

II. THE ORGANISATION

CINI-ASHA (CA) the urban unit of Child In Need Institute (CINI) was established in 1989 with a mission: “Improving the quality of life of urban disadvantaged population and protect the rights of the child through education, health and social mobilization”.

Towards this end CA has concentrated on child education, health, the basic need for survival, protection, growth and development. To reach its objectives of child protection, healthy growth and development CINI ASHA over the period of time has undertaken various programs such as running half way homes, night shelters, drop-in-centres, coaching centres, preparatory schools, bridge courses, admission in formal school, Child help line, and out door health clinics and sick bays for street and working children. CA began its work with street children in 1989, with children of sex workers in 1992 and with slums and squatter colonies from 1993.

Based on the years of experience in dealing with the deprived children, CINI ASHA has realized the importance of developing a child protection policy for protecting children from exploitation and for ensuring their safety. The organization also provides technical support to Government and other organizations to frame their own policy.

CA’s firm belief is that education is a fundamental right and key to empowerment. There should be formal and informal opportunities made available to children from communities that are excluded from mainstream education due to social, economic or cultural and other compulsions. CA’s education programs therefore are designed in such a way that children from disadvantaged communities get access to learning and education at various stages of their lives, and in their location free of cost.

CA’s entry into health program began in a limited way in 1993, through ‘Mother Sponsorship Program’ which adopted a ‘cohort tracking’ method for providing service to pregnant women from date of confirmation of pregnancy till child reaches two years age. Their next experience came from the implementation of full-fledged Reproductive and Child Health (RCH) program under Local Initiative Program (1999-2002), using a life cycle approach. The LIP experience and CA’s deep appreciation of the emerging needs of the slum communities is reflected in the current Urban Health Program (UHP).

Based on Life Cycle Approach and focusing upon critical periods such as pregnancy, childhood and adolescence, the program aims to bring about a distinct change in mother and child health by meeting the challenges posed by the present system as well as utilizing its strengths. An inclusive health care strategy with focus on improving the access to the poor as well as strengthening the referral linkages leading to quality service delivery through a proper mix of public private partnership is the guiding philosophy for this initiative.

III. CINI HEALTH PROGRAM

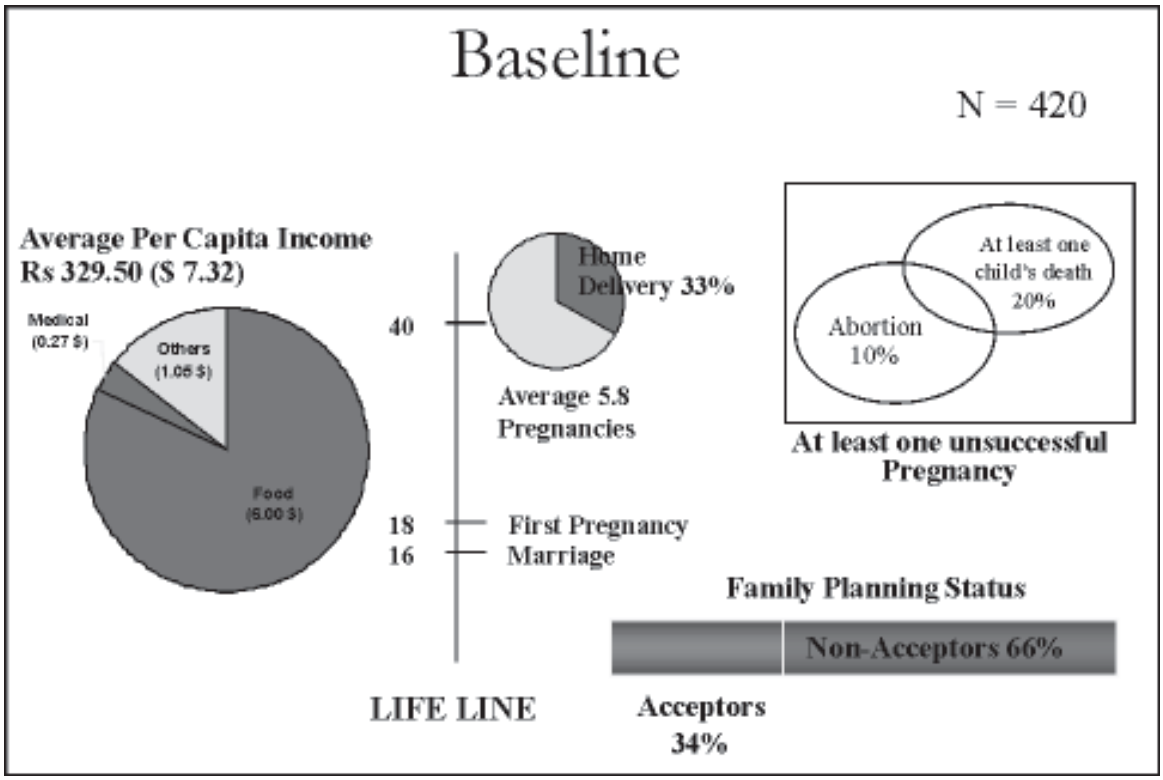
1. Local Initiative Program (LIP) 1999 - 2002

CINI ASHA's (CA) involvement in Reproductive and Child Health (RCH) programs began in September 1999 when CA was identified as one of the three NGOs as implementing partners in the three-year Local Initiatives Program (LIP), supported by Bill and Melinda Gates Foundation. The other two NGOs who participated in the project are: Centre for Research in Rural and Industrial Development (CRRID) in rural areas of Punjab and Himalayan Institute Hospital Trust (HIHT), a large teaching hospital in the hills of Uttranchal. Management Sciences for Health (MSH) Boston and Technical Assistance Incorporated, (TAI) Bangladesh, provided technical assistance to the participating NGOs.

The goal of the LIP was to "Provide high quality gender sensitive reproductive health services and information to a very low income population that lives in the slums of Kolkata through local initiatives".

Though the program got initiated in September 1999, after brief period of preparatory work, actual implementation began in early 2000.The program was implemented in 12 selected wards of Kolkata city.

Figure No 1. Main Findings of the Baseline Surveys



A baseline survey was conducted, using WHO's 30 Cluster Sampling Method. Some of the key findings reiterated the need for a well-designed awareness cum service delivery program. For example, it was seen that mean age at marriage was 16 and mean age at first pregnancy was18 years. Only 47% received complete immunization, 31% received partial immunization while 22% received no immunization at all.

Based on the analysis of base line survey reports, the focus areas for intervention were identified, as improving access to family planning services and products, increasing immunization coverage and enhancing safe motherhood practices and limited curative services. CA's engagement with children on street and young people required that the program focus include adolescent health care, RTI/STI and HIV/AIDS. In the first year of the program, a population of around 85,600 was covered under various services against a target of 250,000 in a period of three years.

1.1. LIP - Key Strategies

The implementation of the program adopted the following key strategies:

- ❑ Use of local resources for increasing health access
- ❑ Expanding access to health care through private health providers
- ❑ Women's empowerment and adoption of life cycle approach
- ❑ Increasing service utilization by the community through subsidized services

A three-tier health system was developed for providing basic health care and the referral service to the pregnant women, lactating mothers and children less than 5 years of age. Any person with minor ailment from the family was also provided service by the health post.

The first tier began at the community level, in a space donated by the local youth or sports club for running health post. Community Health Volunteers (CHVs), identified from and by the community, along with a paid cadre of supervisors, designated as Field Associates (FAs) managed the health posts. The success of the program was dependent on the effectiveness of the CHVs, who established one to one contact in the community.

Box No 1. The Community Health Volunteers (CHV)

Community Health Volunteers promoted by CINI-ASHA are women from the community, aged between 25-35 years, with or without school education, who have gained local acceptance. They must have ability to communicate without hesitation, willingness to work and learn and with some time to spare. There was a lot of pressure from local leaders and ward counselors to choose women of their choice as CHVs. CINI-ASHA had the task of impressing them with the purpose and making it a democratic process directed by the community and guided by CA. Though initially many volunteers viewed their participation from only "employment" perspective, slowly they began to see the intangible benefits such as respect, recognition and inclusion within the community as well. Recognition and inclusion are critical since the volunteers came from various social, cultural and economic backgrounds. The capacity building effort developed during the Local Initiative Program brought a lot of credibility to all women who participated in the program.

The responsibilities of the CHVs included, responding to the needs of the community immediately, conducting cluster meetings, case management and follow up in 50 families through filling up eligible couple register, developing ELCO mapping, and reporting to the Field Assistant (FA).

The CHV visited each household and collected information on the status of the pregnant mother, new born child, immunization status of children under two years and contraceptive prevalence. In addition, the health post staff provided health education, information on care during pregnancy

and family planning and provided condoms and OCPs. The health posts provided limited curative care and medicines for conditions such as first aid, mild infections like cough, cold, fever, management of diarrhea, cuts and wounds, worm infestation and mild anaemia. When a patient required more intensive care the FA referred her to a Government hospital or private medical practitioner. The program also ran need based health camps for RTI check up, child immunization and baby clinics for children's growth monitoring.

The second tier, a network of nearly 40 Private Medical Practitioners (PMPs), provided referral service for PNC, minor ailments and general health. To ensure quality of care, the PMPs were provided with a standard treatment protocol along with a list of essential drugs based on WHO list .The PMPs were requested to prescribe from within that list. The health post based on the prescription provided the medicine. In cases where the patients required medicines outside the drug list, the PMP gave the prescription and the patient had to buy that in the market.

The third level was referral to the Government hospitals, by the PMP or the health post for those who required critical health care. Usually the women were referred to the Government hospitals for ANC registration and follow up, delivery and any postnatal complications.

Once a prescription was brought from either the Government hospital or from the PMP, CA provided them with medicines from their generic drug list. This was considered an investment rather than a cost since community viewed availability of medicines as one visible and important benefit of the program.

Some common curative medicines viz. paracetamol, memendazole, Vitamin-A, replacement drugs like Iron & Folic Acid and contraceptives like OCP and Condoms were procured free of cost from the Government Department of Health & Family Welfare. The rest of the generic medicines required to address the health needs of the mother and children were purchased from the wholesale market.

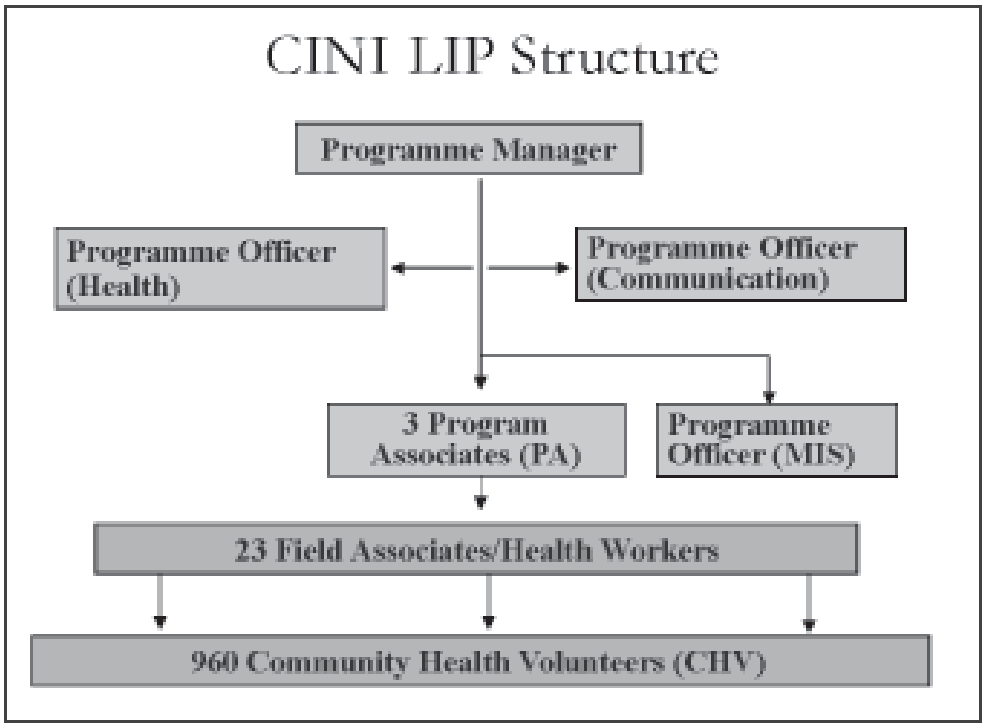
1.2. Field and Managerial Staff Structure

The field staff included the CHVs and the FAs or health workers. Each health post had 50 CHVs, each responsible for 50 families. They received a token honorarium of Rs/200 for a four-hour service in the community and at the health post on fixed service delivery days. In the last year of LIP, the workload of CHV was increased to cover 100 families each. Of the 960 CHVs only a few had high school education qualification. The rest were by and large illiterate or semi literate.

One Field Associate (FA) who was a college graduate supervised several health posts and often managed up to 40 -50 CHVs. Though CA worked in 12 wards, a cluster system was followed for earmarking areas of operation for the health posts and FAs. This was essentially because the boundaries of the wards were intertwined in the various slums. And often a slum fell in two wards. The cluster system helped FAs in reducing their travel time between the health posts, which are located across the wards.

The FAs reported to the three Project Associates (PA) from CINI ASHA, who had direct links with the field. The 3 Project Officers (POs), responsible for documentation, medical care and MIS and monitoring respectively, supervised the PAs and, they in turn reported to senior Program Manager.

Figure N0 2. CINI - LIP Structure



1.3. Community Involvement

One Health Committee /RCH Committee was formed at the community level for each health post. It had representation from the local youth club (where the health post is located), Local Ward Councillor or nominee, CHV, mothers and some local influential person or opinion leader. The committee periodically met to discuss issues related to space, organizing camps, mobilizing community and other relevant issues. This committee though not very structured, (some times the councillor or nominee chaired the meetings and sometimes the local leader) definitely enhanced a sense of ownership in the community.

The community contributed both in tangible and intangible forms. The local youth/sports club contributed their space, the club premises for running the health post. Additionally the health committees helped in the identification of CHVs and mobilized community for services, camps and meetings. The goodwill and support of the local club and the community offered was very critical for effective functioning of the CHVs. In exchange of the space support by the community, name of the club was acknowledged on the signboard of CINI-LIP Health Post. Health posts were used to conduct mothers' meetings, provide services, train CHVs, and store medicines.

1.4. Capacity Building

The team from MSH Boston and TAI Bangladesh was responsible for capacity building. They provided an initial 8-day orientation to all staff including FAs and refresher and continuous training for the project staff up to the level of Program Associates. Technical assistance was also provided for enhancing financial accountability, supervision and training skills, documentation, designing the monitoring formats and follow-up activities. The intensive introduction to RCH was critical since CA had no previous experience in implementing a full-fledged RCH program.

At the field level, CA along with TAI-MSH provided the initial training for FAs and CHVs. The training used empowering training tools such as the pictorial eligible couple register that helped

the illiterate CHVs to get over the initial hesitation of holding a pencil and writing the numbers on the register. CA staff (PAs and POs) provided continuous education and hands on training to the field staff, during their visits to the field. While some of the trainings were structured, the supervisors used each visit for hands on training.

MSH and TAI organized several sharing and learning platforms for the three NGO partners in the course of the three years of LIP implementation.

1.5. Monitoring

The ELCO register provided the basic monitoring tool. The CHVs filled the ELCO registers and prepared the ELCO maps with support from FAs. The ELCO mapping is a process of collation of all the information on FP, ANC, PNC and immunization status in the families at a glance, from the ELCO register. These were submitted on a monthly basis to the FA. In turn it was submitted to the CA program managers for verification by the 28th of every month. The program managers discussed the progress in their monthly meetings and returned the format to the field with their feed back by the 10th of next month.

The monthly monitoring enabled the Program Associates and Program Officers to understand the aspects that required correction. For example, till March 2002, the community contribution of Rs.2 towards service fee was entered in a register and was later verified by the program staff against the total receipt. It was cumbersome for both the field and program staff. From May 2002, issue of coupons for the user fee of Rs.2 replaced the practice of writing in the register and account was verified based on the number of coupons distributed at the health post.

The monitoring formats underwent changes in the three years to make it user friendly, and to get a fair idea of which family required counseling, or who resist the visit of the CHVs. The PAs and POs, when they visited the field, used the opportunity to counsel those families who have specific difficulties based on social or cultural constraints, in addition to economic constraints.

The quality of interaction of the CHVs in the field was also monitored regularly and families gave informal feedback during their visit to the health post.

There was no formal community monitoring process established during LIP. Meetings were held periodically with the RCH /Health Committee, where an update was provided by the CA staff.

1.6. Internal CHV Assessment

In 2002, CA, after observing the performance of the CHVs for several months, decided to understand their level of motivation, since the CHVs were engaged in repetitive tasks. In some cases, it was found that, CHVs viewed the position as a paid 'job' and expected incremental increase in the wages periodically. For many, the honorarium was supplementary income and did not see the difference between wages and honorarium.

An assessment was conducted by CA, towards the end of 2002, in order to redesign the work load and training programs, as well as to find CHVs who have performed better and who could be used in other capacities within the program. The assessment was carried out in consultation and cooperation with the community leaders. Apart from several rounds of group discussions, each CHV was interviewed individually, which enabled them to the purpose of the exercise. The transparent process helped in getting cooperation and support of those local leaders, who at the initial stages, created delays by demanding selection of their own family members as

CHVs. The criteria used were, CHV's understanding of the ELCO register, ability to communicate easily with the user groups on various RCH issues, mapping of the families, their knowledge and motivation and relationship and rapport with the other CHVs in that area.

This exercise culminated in down sizing the number of CHVs from 960 to 600 and enhancing the coverage of CHVs from 50 families to 100 families. Due to increased coverage, the removal of 460 CHVs did not affect the program implementation.

To keep the motivation level of the remaining CHVs, CA conducted several new training programs. A certificate of recognition was also given to those CHVs who had served more than three years in the program.

1.7. External Review

The program was reviewed by MSH in July 2002 and found the initiative had begun several good practices in the community related to health seeking practices and service utilization. Major cost saving was possible, due to community contribution of space for health posts and utilizing the services of the PMPs instead of CINI-ASHA appointing doctors in each health posts. The review also found from the base line that there had been substantial improvement in immunization coverage and use of contraceptives such as condoms.

At the end of the LIP period (October 2002), there were 40 fully functional health posts and around 40 PMPs in the network. Over 102,384 people received RCH services.

Table No. 2. Services Provided during the LIP Period

Number of Children Immunized	22,499
Number of Women Having Received Ante-natal Care	5,640
Number of Mothers Having Received Post-natal Care	4,680
Number of Families Having Accepted Family Planning Services	25,370
Number of Women Treated for Sexually Transmitted Illnesses	3,420

Source: "Communities Taking Charge of their Health - The India - LIP Initiative" by Management Sciences for Health and Technical Assistance INC (2003)

The key achievements of the CINI - LIP initiative include the following:

- ❑ Availability of a cadre of trained line health workers (CHVs) who provided the first contact point with the community
- ❑ New awareness of families and especially mothers to seek professional help during pregnancy and for new born children, instead of seeking help from quacks
- ❑ Enhanced access and choice to the poor families by creating a network of approximately 40 qualified physicians located within or nearby their slum
- ❑ Initiation of an inclusive process by inviting the participation of the youth club members, local popular leaders, ward councilors and families in various activities of the health post
- ❑ Introduction of a system of financial discipline to the community by charging a minimal user fee of Rs.2 per visit to the PMP
- ❑ Creation of an opportunity to the CHVs to earn recognition and respect from the community, irrespective of their social status and cultural differences

2. Transition Phase : 2003-2004

The Gates funding came to end by October 2002. It was therefore decided to go ahead with the program from 2003, without further support from Gates Foundation from 2003, since CA wanted to explore a broad based approach to health, from that of LIP.

CA did a series of discussions among the staff, and with the Local ward councillors and community leaders on the lessons learned from LIP, progress of the health program and identified the following aspects that required attention.

- Reproductive health needs are to be understood in the larger context of urban public health and not in isolation. Towards this end adopting a "program" mode of implementation would be more appropriate than a "project" mode as it was under LIP
- A number of good practices introduced by LIP (e.g: introduction of user fee, subsidizing the service cost provided by the PMP based on output, stringent monitoring of the program progress), have to be institutionalized
- Linkage with Government during LIP was rather weak. It is important not to duplicate the efforts of the existing Government health system but to energize the system by making functional linkages with them
- The program focus must be made sharper to ensure care for pregnant women and children under 2 years of age
- A system must be established to ensure that the subsidies given are accessed only by the poorest of the poor
- Adolescent reproductive health care must be paid attention
- The involvement of the Urban Local Bodies (ULB) and the Department of Health and Family Welfare should be institutionalized
- The local health committee must be encouraged to be proactively involved in the program implementation

CA did face a vacuum for a very short time in terms of funds due to the end of grants from the Gates Foundation. However, in early 2003, CA got funding support from two sources- USAID and "Adopt a Mother and Save Her Child", a sponsorship program which is part of CINI's own fund raising efforts. This facilitated the continuation of the program.

Fund support from two different donors with different objectives and approach did have implications for CA, in terms of program implementation processes, CA's workload, and the way community perceived the changes.

2.1. USAID Support

USAID provided a bridge fund to CA for a period of one year, which enabled it to take up some preparatory activities to strategize the continuation of the health program from 2003 onwards. With support from the Environment Health Project (EHP) now Urban Health Resource Centre (UHRC) of USAID, CA conducted slum assessment in Borough V and Borough VII of Kolkata. A Borough consists of a cluster of Wards on the basis of their geographical location and is an administrative unit for the Wards under it. CA has been implementing education, child rights and health programs at different stages in 10 of the 22 wards that were surveyed. This assessment and mapping of the wards was important, for it gave a good opportunity to

CA to get clarity on the types and quantum of local resources, their accessibility and availability, Government system, community needs, expectations and capacity building requirement etc from a different perspective.

Box N0 2. Involving Government Health System

From 2003, CINI-ASHA began exploring ways to involve the medical officers of the Kolkata Municipal Corporation (KMC) and ward councillors. For example, while preparing EHP and developing the necessary tools to support the training activities in conducting the assessment, CA staff made the process participatory by inviting the respective ward medical officers to make necessary modifications to the tools, in order to address specific local issues. The whole questionnaire was designed using this participatory approach. Focus group discussions were conducted to identify the priority issues in each ward. For example in ward 66 child immunization was considered as a priority while in wards 61 and 62, birth spacing and use of contraceptives emerged as critical issues. This exercise helped the Medical Officers of KMC to better understand the work of CA and build rapport with it.

PMPs, training and honorarium for CHVs. The USAID support also required that CA began an experiment of working in a facilitating mode using a 'convergence model', instead of direct service provision, in two of the wards with poor health indicators.

Introduction of convergence model meant that CA had to make a shift in terms of program implementation strategies. The convergence model encouraged the organization to achieve results by networking, establishing enabling systems that can facilitate service delivery rather than providing service delivery themselves. This in effect meant that the organization plays a complementary role in energizing the Government system and not run parallel service delivery schemes. Implementation of convergence model also requires strong advocacy with various stakeholders and continuous interaction, supportive supervision and participatory monitoring. Implementation requires skilled staff, time, and resources.

The health section staff of CA spent considerable time in exposure visits to understand the convergence model implemented by Environment Health Projects (EHP) of USAID, out side Kolkata.

In itself an interesting concept and practical model, the convergence model requires a lot of 'breaking in' time and adequate time for the staff to learn the skills. The CA staff is at this stage now.

2.2. Sponsorship Model

CA, during the same period (2003) also received fund support from "Adopt a Mother and Save Her Child', a sponsorship program, which is part of CINI's own efforts in fund-raising. This program supported the maternal health part of the program implementation and cost of medicines. The program adopted a method of tracking the pregnant mothers from the time of confirmation of pregnancy and provided follow up services till the child attained the age of 2 years.

The sponsorship program brought a shift in terms of accessing medicine, using a reimbursement model. All the sponsored mothers were entitled to for free medicines. The patients had the freedom to buy medicines from the pharmacy based on prescription by PMP or KMC maternity homes or Government hospitals, pay the bill and get the full amount reimbursed later from the project.

CA did not want to discriminate between the sponsored and non-sponsored families in terms of reimbursement for medicines. This put a financial strain for CA, since some patients ran bills up to Rs.1000 in some months.

To have some control over the costs, CA decided to reimburse, on an average, Rs.700 - Rs.800 for C-section and PNC bills. The community perceived this decision as a discriminatory practice since they did not understand modalities of payment.

The reimbursement practice raised the following issues:

- Only those who could afford to pay upfront and get reimbursed later used the facility, which excluded the poorest of the poor from availing the services
- It increased the administrative work for CA since, bills got submitted several weeks later, despite a deadline for submission. Verification of each bill by PO, which got submitted at various times of the month was very time consuming. It also consumed time of the field staff who had to explain why certain amount is slashed from the bills and why some one got and others did not
- The effort to retain the emphasis on use of generic medicine also got affected in this process since many could request doctor to prescribe outside the generic list, bought medicines and put up the bill for reimbursement
- Monitoring the use of all the above also posed a logistic problem for CA field staff

Despite the pressure and constraints faced in understanding the new strategies under the convergence model, as well as catering to the demands of the sponsorship program, the CA team managed to continue to work on revamping the health program implementation from a project mode to program mode and began the new phase of the program from early 2004.

3. Urban Health Program (UHP) : 2004-Onwards

The analysis of the LIP and the results of slum assessment enabled CA to restructure the program in the field. The new title “Urban Health Program’ (UHP) was adopted in order to make implementation of RCH aspects in the larger context of urban public health and provide integrated interventions. Simultaneously a number of administrative management decisions were taken and implemented. Key changes included:

- Redefining the program focus
- Rationalization of CHV work and induction of Swasthya Sevikas (SS)
- Modifying service delivery system, monitoring and staff capacity building
- Introducing a new fee structure for various services
- Expanding service providers network
- Strengthening the network with the Government hospitals
- Strengthening the Health committees and identification of innovative ways to involve the ward councillor in each ward
- Reorganizing the work area from clusters to wards in consonance with the urban local bodies

3.1. Redefining the Program Focus

2004 was also the year when the Government of West Bengal had articulated its RCH II policy, which could facilitate the march towards achieving Millennium Development Goals and the National Health Policy 2002. As a learning organization, CA used several ways of enhancing

their understanding about the prevailing Government policies, community needs, staff capacity, and gaps in their efforts in the field, that could facilitate sharpening the program focus and developing appropriate strategies.

The slum assessment in collaboration with USAID-EHP, the internal CHV assessment exercise, the Knowledge, Attitude, Behaviour and Practice (KABP) survey among over 600 adolescents in the slums of Kolkata are some of the examples of CA's willingness to explore, learn and evolve the program. Monthly monitoring meetings, between PA-POs and PAs and field staff, are used as opportunities to learn about community perceptions, requirements, response and decisions for taking the program forward. In addition CA also conducts annual retreat for their staff to reflect on the performance during the year, understand the gaps, and plan the next year. Inviting external resource persons, who can analyse specific aspects of the program, or encouraging college interns to analyze various aspects of program for learning and sharing, are other methods adopted by CA. The study done by interns from 'S.P Jain Institute of Management 'of Mumbai, on the role of CHVs in early 2005, is one such exercise

To understand the evolution of the programme approach adopted by CA , it is essential to understand the journey CA had walked through with their donors. It was also possible for CA to bring linkage between and among the various programs (education, early childhood stimulation, reproductive health, and adolescent reproductive health care) as an integrated whole despite receiving support from three to four different donors. All the programs have a common thread in them; ie addressing safe motherhood issues, promoting responsible sexual behavior among adolescents and improving child survival opportunities.

In 2004 CA received a grant form 'Comic Relief' through "Interact World Wide" for working with adolescents for 2 years. In 2005, CA received a substantial grant from the Irish Embassy for promoting safe motherhood and child survival practices aimed at reducing maternal and infant mortality in the community. A fund from Johnson and Johnson, a multinational company has also been made available for achieving the same objective, under their Corporate Social Responsibility initiative, for one year.

Such timely fund support has given a rare opportunity to CA for consolidating the program implementation, based on their learning in the last five years, In order to prepare the community to take on more ownership and control in the next three to four year, the program focus was redefined in early 2004.

- Service delivery focus to remain targeted only on pregnant women and children under 2 years of age, as a strategy to increase safe motherhood practices and child survival
- Birth registration and completion of immunization under 12 months for all children must be followed vigorously
- User fee to be enhanced suitably keeping a balance between equity and sustainability
- Community capacity to be built to sustain the health improvements
- Develop a sustainable and replicable urban health strategy
- CA to act as a facilitator in the community, so that, the Government health systems can become more responsive to the needs of the poor and the community to be more responsible users of services
- To develop skills within CA team to emerge with time as a Resource group on Urban health issues

3.2. Lessons from Slum Assessment

The slum assessment and analysis of the results gave five different perspectives to CA:

- ❑ Phase out of some of the slums that have better access and service utilization
- ❑ Provide full service where the indicators are very poor
- ❑ Provide partial service where more clarity is required on continuation or expansion of service through continuous assessment
- ❑ Introduce pilot efforts where more learning is required
- ❑ Predominantly use the convergence mode for facilitating expanded access and increased service utilization in pockets with better service facilities

Accordingly, CA identified that they could phase out of 4 of those pockets with several functional service providers and people have begun to access them. Only five wards (ward number 56, 57, 58 59 and 36) were identified for full service as against the earlier 12 wards. Wards 61, 62 and 66 were identified for working in the convergence mode, by establishing strong links with ward medical officer and ward councilor.

CA also extended facilitation support to 800 families as part of the KEIP (Kolkata Environment Improvement Project) an ADB funded project, which aims to improve environmental sanitation in slums of Kolkata. Role of CA is limited to promoting community participation through mothers' groups and provision of service to pregnant women.

Adolescent Sexual and Reproductive Health Care program was introduced in five wards and community based 'Early childhood stimulation program' in one ward, both as pilot programs, to understand the processes better.

The slum assessment gave clear indication where CA can allocate the resources (fund and staff) and choose the mode of implementation according to the needs of the location rather than adopting 'one size fits all 'model of implementation.

3.3. Rationalization of CHV Work and Induction of Swasthya Sevikas (SS)

This exercise also gave an opportunity for CA to take stock of the workload of the CHVs and their perception of their work. It was found that many of them still nurture a view that their work requires more appreciation in terms of increased wages. The proposed integrated approach under UHP would require more counseling and communication skills, than that the CHVs bring. While their presence in the community has been and is very valuable, CA found that it is time to review the skill set required to achieve the results and decide to introduce a cadre called 'Swasthya Sevikas' (SS) above the CHVs and reporting to FA. Towards this, those with school leaving certificates from among the CHVs, were identified. This also was a strategic move since the community did not feel that CHVs are being sent out, but some are getting upgraded within the program.

Despite being a very transparent exercise, downsizing the cadre of CHVs from 600 to 147 was a very difficult and time-consuming exercise. Convincing the Health committee, local leaders, ward councillors and the CHVs themselves was the most difficult task. CA had to be very tactful in conducting the cluster meetings, individual interviews with the CHVs and informing the community at large. This exercise did not affect the program quality for the following reasons:

1) The wards under the 'convergence model' work through existing Government health system, supported by only SS and no CHVs are required.

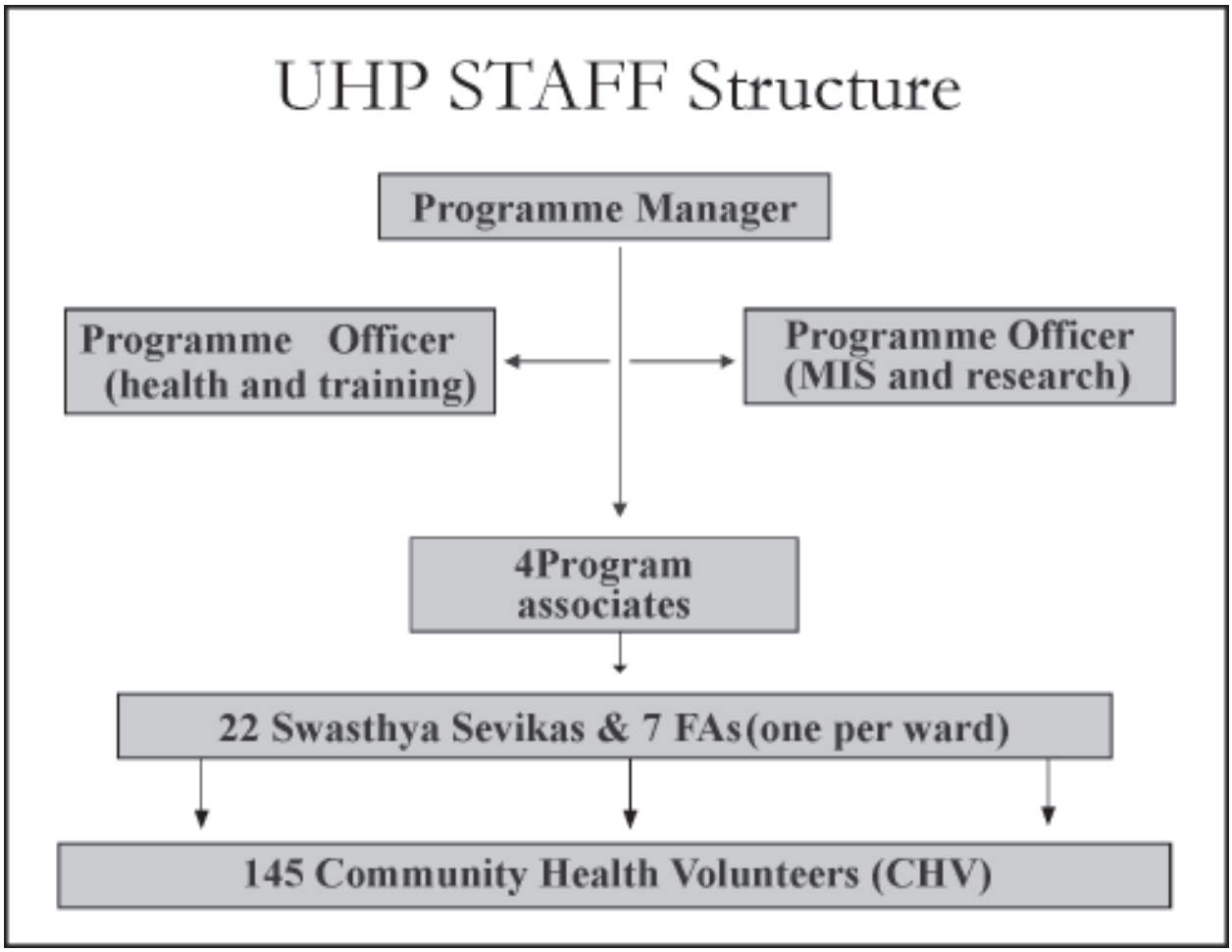
2) For the remaining CHVs, the workload was reorganized to cover 1000 population instead of 100 families.

3) From among the CHVs, 17 Swasthya Sevikas (SS) were inducted into the program. Criteria for selection of SS include, CHVs with high school certification, knowledge and skill level, their performance during LIP, self- motivation, and credibility in the community.

Correspondingly the managerial staff structure also went through some changes. In the sprit of an integrated approach, the managerial staff have been made responsible for a particular aspect(s) (e.g: training and clinical support or MIS and research) of the programs, irrespective of the unit. The number of FAs also was reorganized, in keeping with the number of wards where CA is engaged.

This structure provides an opportunity for each one to have an overall understanding of the programs instead of limiting themselves to one's own unit. However, it has put certain amount of strain on the staff that had to manage changes frequently in the past five years. The changes have been in terms of donor expectations, community demands and demands form the urban local bodies-political pressure, changes in program implementation approach, and Government policy. The UHP from 2005, is moving consistently in one direction. The next two to three years will be crucial to consolidate the work and learning, without making any drastic changes, in order to optimize the productivity of the staff.

Figure No. 3. CINI - UHP Structure



The UHP service delivery facilitation and provisions have resulted in visible increase in children under 2 years receiving complete immunization and birth registration. The other area of visible progress is in the use of OCPs and condoms (Table 3). Spacing methods are not very popular in the community. Though men are not part of the target group, the field staff makes an effort to include them as much as possible.

Table No. 3. Health Program Coverage in 2005

Total No. of Population Covered	154,000
Total No. of ELCO	20,953
No. of Pregnant Women	479
Total No. of Children (0 - 1 year)	1,212
Total No of Children (1 - 2 year)	1,198

IV. THE VOUCHER SCHEME

1. Organisation of the Scheme

When CA introduced the voucher fee as an integral part of its overall health program, it was meant to be a simple step to promote a sense of value for services. Enabling poor women to choose their providers and encouraging them to seek professional advice were the primary reasons for the voucher fee.

During LIP, CA set up a network of approximately 40 qualified medical personnel located within or nearby the slum area. To access the services of the PMP, the patient had to pay to CA a nominal fee of Rs.2 per visit. The PMPs provided consultation, referral and prescription for a nominal sum of Rs.15 against the normal fee of Rs.50, as per the agreement with CA. This mechanism helped the very poor to get access to services provided by qualified providers instead of turning to quacks. This also gave a freedom to choose the provider.

As the program progressed, CA included adolescents into client group. CA believes that, enhancing access to good quality sexual and reproductive health services to adolescents will contribute to postponing early sexual debut, promoting responsible sexual behavior, avoiding early/unwanted pregnancy, preventing unsafe abortions, preventing and treating RTI/STI and encourage marriage only at an appropriate age. In practice, adolescents do not have access to counseling or diagnostic facilities, resulting in silent suffering or reaching out to the quacks.

Monitoring in the field revealed that, a number of women and adolescents face difficulty in getting access to diagnostic facilities in the Government hospitals, which often contribute to discontinuation of their treatment. When women discontinue their ANC check up due to lack of timely access to diagnostic services, it affects the pregnancy outcomes.

To facilitate timely diagnostic services at reasonable rates, CA identified four diagnostic laboratories to provide services at competitive rates. The response from the community in the past year and a half has been very encouraging, despite a small fee of Rs.10 for each visit to the laboratories. From the point of view of sustainability, a small fee of rupees 10 was charged for collection of medicines from the health post, against prescriptions.

In all when a woman invests Rs.35, (of which Rs.10 is one time for mother and child cards) she will have access to services of PMP, diagnostic laboratories and a full course of medicines. Also she has choice among the providers. Once the user fee is paid at the health post, the client does not have to use cash for receiving services and payment is made by the project directly to the providers, based on output. This cashless system minimizes leakages and provides a win-win situation for both the clients and the providers.

The first implementation of the voucher scheme during LIP period brought about some difficulties:

1) Difficulty in convincing people on the user fee: The community viewed health services as free services and resisted the fee of Rs.2. The services like counseling, weight monitoring, BP check and family planning were expected to be provided free of cost and not included in the fee. So CA decided to use the fee for PMP referral.. Though the total amount collected through user fee remained limited at the end of LIP, it brought some kind of discipline among the users.
2) Use of coupons: Several people, who did not require professional help, used the voucher since it costs only Rs.5 to register. Since anyone could access PMP services by paying the fee, the focus on women and children got diluted

3) Limiting prescription within the generic drug list: Though there was understanding with the PMPs for making prescriptions from the generic drug list, it was found that the patients often insisted on certain other medicines for which they had to pay out of pocket. This to some extent nullified the efforts of CA in trying to provide health care at low cost.

4) Involving Urban Local Bodies: Despite repeated efforts, it was very difficult to involve the Government system and local ward councillors on a regular basis in the initiative.

5) Limited focus: Despite a well thought out implementation, there was a greater emphasis on family planning as compared to the rest of the project objectives.

During the LIP period, CA collected approximately Rs.100,000, which in itself was inadequate to offset any of the costs. Nevertheless, it reflects the creation of an innovative mechanism for encouraging community to use the services, even when they are priced. The system continued even after completion of the LIP phase, but with some modifications.

Table No. 4. Main Changes Brought to the Voucher Scheme

LIP	UHP
Service Provided to all	Service restricted to pregnant women, children under 2 years of age and adolescents
No stipulation to get a voucher	Only those with mother and child card (one time payment of Rupees 5 each) are entitled to get a voucher
On paying user fee of Rs.2 per visit, clients receive a coupon	On paying user fee Rs.5 per visit, the client gets voucher to visit a PMP
There is no referral to laboratories	On paying Rs.10 per visit, clients get voucher to get subsidized services from the diagnostic centers
On getting prescription, generic medicines provided free of cost	Clients pay Rs.10 to receive a full course (e.g. antibiotics for 3 - 5 days) of medicines

While raising the price of the voucher from Rs.2 to Rs.5, CA had to carefully balance equity along with sustainability considerations.

2. Management of the Coupons

The amounts paid for coupons were collected and recorded at the health post in a register held by the CHV. At the end of the month, the FA send a report to the Program Officer at CINI ASHA along with the money collected. Managing the coupon was a learning process for CA. During LIP implementation, the patients were given three colored coupons- one white to be given to the PMP for the first visit, a pink for the second visit (for which the PMP could charge only Rs.5 if the patient comes back with the same illness) and a green for the third visit which should be free of cost if the patient comes with the same problem.

Several practical difficulties were found in this system. Clients found it difficult to manage the multiple coupons. Often coupons got misplaced or interchanged, even at the end of the PMPs clinic.

It was also observed that many patients did not go for the second and third time. Sometimes they changed the service provider if they were not satisfied.

To avoid complication and misuse, the other two coupons were withdrawn and only the white coupon was retained. The doctors were advised to take their own decision regarding the follow up visit

Currently, each PMP, on an average receive only 6-8 vouchers per month, whereas they used to receive 80-90 vouchers each per month during LIP period. The two PMPs working directly with adolescents receive 30-35 vouchers every month reflecting increased awareness among the adolescents.

There are several reasons for such a drop in the number of PMP referral vouchers. Limiting the access to services only to mothers and children under 2 years of age is one. In addition the following were observed in the field:

- There are instances where, very poor women request for a voucher from the health post but have no money to pay. They write 'due' in the register. But not all of them pay the due, once the service is received.
- Sometimes, a patient makes a request for a second voucher due to damage or loss of the first one. The health post issues an additional one without additional fee. The discrepancy in the number of vouchers issued, and the money collected is identified only when the CA staff collects the vouchers from the PMPs for reimbursement
- Discussions with the PMPs reveal that, in times of emergency, women do come rushing to the clinic and request for treatment, on the promise that the voucher will be produced the next time they come. The doctors consider this as a 'work for a good cause' and do not insist on getting the voucher.
- There are a number of women who get registered in the ELCO register but do not purchase a mother or child card. For example, in the month of November 2005, of the total of 342 pregnant mothers registered only 261 had cards. Similarly for the same period, of the 1,209 children under 2 years, only 903 had cards. These families usually are not very keen on seeking professional help. These women may not use the services of the PMP or the diagnostic laboratories since they could not or did not purchase the Rs.5 voucher to start with. This requires a lot more monitoring.

The training of CHVs needs strengthening since they are the first contact with families and remains in one- to- one contact with a 1000 population in their area. An observation by SP Jain Management Institute, Mumbai, in their study on the "Motivational Factors of CHVs" mentioned that some of the CHVs were not sure of the reason for CA charging Rs.5 for the voucher, indicating that CHV training needs to be strengthened as well.

In the last year and a half CA staff have learned a number of issues related to the use and management of voucher. Introducing the voucher was simpler when CA negotiated the fee with the PMPs. It was much more complex to negotiate with the diagnostic laboratories, due to the different types of tests and the prevailing market rates. To be able to apply the concept in yet another service area, CA may have to work much harder. Therefore it will be beneficial for the staff to gain in-depth understanding of managing voucher system.

3. Utilization of Community Contribution

The funds collected through PMP referral voucher (Rs.5), mother and child card (Rs 5+5), laboratory voucher (Rs 10) and medicine fee (Rs10) are funds of and for the community. FA brings the monthly collection and the contribution format from each club, which is checked, verified and signed by the PA and FA. The fund then is deposited in an account section of CA

in the name of the club where the health post is located. The principle that the funds would be spent on community improvement, as decided collectively by them, has been helpful to overcome the initial resistance by the community when they had to pay for the referral coupons.

However, the donor, Gates Foundation considered Rs.100,000 collected by way of PMP referral fee during the three years of LIP, as part of the community contribution to the project expenses and the balance of the fund was given to CA for the project implementation. Therefore the funds did not reach the community.

To avoid such experience, currently CA is in the process of developing clear guidelines as to how to make the transfer to the community. The various discussions with the community include, opening bank account for each unit separately, identification of signatories, modalities of use of funds, system for record and account keeping, plans for sustainability and identification of suitable health programs.

Potential services identified include, community emergency services, basic medicines for general community, special help to any family member or a family, community health initiatives, health camps and club maintenance.

It is important to draw clear guidelines with participation of the community, since the clubs are primarily sports or youth clubs, where health is not a priority. Currently, CA supports the request of the clubs for small funds for minor repairs of the roof or the walls, since the premises are used as health posts as well. Defining a clear organizational structure, building their capacity and leadership would be precondition to handing over the funds to the community. Additionally, by the time the program begins 'phasing down' in three or four years, the health committee/ clubs should have ability to sustain the first level contact and services by an honorarium or making output based payments. To develop a core fund for each club, it would be important to strengthen the community education. Sharing the status of the program and contribution at the end of every moth with community and the club members will help in them understanding the progress.

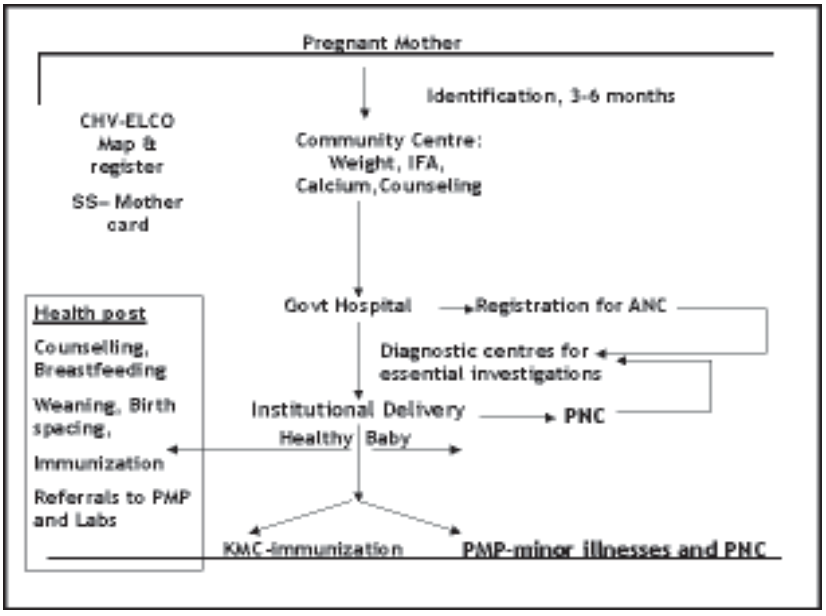
4. Service Delivery

The service delivery under UHP began with a clear focus on pregnant women, children under 2 years of age and adolescent reproductive health care. The entire design is made in such a way that, a pregnant mother is tracked through ELCO registration anywhere between 12 weeks to 6 months. Despite a one to one interaction by the CHVs with women, often a pregnant woman may be registered after 3 months due to their mobility. Sometimes they do get registered in the ELCO register, but after 7th or 8th month they move to another slum or another city in search of work or due to family movement. This is a typical feature of an urban slum.

By purchasing a mother card, the woman is entitled to services from the health post, such as counseling, information, IFA and calcium, weight monitoring and referral. It is a precondition to possess the card for getting a paid voucher from the health post, which she can use, for consultation with PMP.

CHVs or SS or FAs do not conduct any ANC check up or delivery. All the pregnant women are encouraged to register with the government hospitals for ANC check up. Getting registered for ANC, entitles her to get access to an institutional delivery facility. The health posts function as facilitation centers, by providing information on the various aspects for getting services from diverse providers.

Figure No. 4. Service Delivery Flow Diagram



On getting ANC registration, the women require three ANC check up. During the check up they receive prescriptions for various tests, including ultra Sonography, urine, PPBS, VDRL to identify if she has any pregnancy related complications.

The CHV through ELCO register monitors whether the pregnant woman gets the three check ups done. If she misses any one or all of them, CHV consults SS or FA for counseling. The following are the common difficulties that women face in getting the ANC check ups done from the Government hospitals.

1) As per Government rules, every patient from the poorer families has to obtain a BPL certificate from the respective ward councillor, prior to the check up. The hospital gives her the due date for check up and the certificate has to be obtained only on the previous day of appointment. This is time consuming process and deters many women from getting the check up done.
2) Even when they get the BPL certificate, the date allotted for the tests often is not suitable for the woman. Sometimes the waiting period is 6-8 weeks. This is because the Government laboratories are overworked and understaffed.
3) Often the patients from the communities have been asked to do PPBS and VDRL from outside, which are expensive tests.

CA, based on these observations, in early 2004, entered into contract with four diagnostic laboratories, so that women from the poorer families have equal opportunity to get timely and quality services. (See section on diagnostic laboratories network). This has helped a number of women from the community to detect complications in time and save the baby and herself. Once the tests are done, the patients have a choice to consult the Government hospitals or PMPs for getting prescriptions, thus giving an option to the patient.

Discussion with the superintendents of two of the large the Government Medical College and Hospitals revealed that, the Government hospitals have to abide by the rules of the government, which lays out that 30% of services are to be charged and 70% has to be free. The hospitals due to over crowding for free services (except for OPD (Rs2) and Ecocardiogram for which every one has to pay) have to establish the authenticity of the patients through certification

from the councillors. However, they are willing to cooperate, if CA organizes an interaction with the ward counselors to explore ways of reducing number of steps or time loss in getting the certification.

One of the key objectives of Government of West Bengal's RCH policy is to increase institutional delivery. Health posts try and motivate the pregnant women to go to Government hospitals for delivery for two reasons.

1) The Government hospitals are expected to have expertise and equipment to meet any emergency. This is very critical for bringing a reduction in neo natal mortality.

2) Once the woman delivers in a government hospital, birth registration becomes an automatic process and the child gets a certificate within a couple of months.

Discussions with the women and the hospital superintendents revealed that, though the Government hospitals have a mandate, they do not have adequate space. Often in a labour ward, two women share a single bed. Many are seen lying on the floor. The demand for bed space is so much that the women are discharged within a few hours of delivery, within which time the over worked nursing staff do not get time to counsel the women on postnatal care, breast feeding or hygiene.

Women themselves feel hesitant to go to the hospitals, since there have been incidence of them being turned away by the hospitals, since the due date given for delivery is a couple of days later. In such cases, some have delivered on their way back home or as soon as they reach. The postnatal complications get aggravated due to such conditions.

The most common reason for not going to a hospital for delivery is the presence of a very small baby at home or a few very young children with no one to care for them. The social systems that provide a solidarity in such occasions in a rural area, is not available in an urban slum.

Health posts recommend that those women delivering at home seek the help of PMPs to avoid any postnatal complications by purchasing child card for Rs.5. This card entitles the child to growth monitoring, referral to PMP as well as diagnostic laboratories, and medicines. The health post follows up on the child immunization.

Since it is not possible to increase the number of institutional deliveries in short term, it is important for CA to focus on promoting safe delivery practices in the community. Primarily the effort of the health post is to promote the use of institutional facilities for deliveries and energize the system through advocacy. This is a long process, and may or may not be able to bring changes in the Government system. As an immediate measure, CA is working on training the birth attendants available in the community, as well as mid wives on safe delivery practices and accompany the women to hospital if need be.

The CHV monitoring format from March to October 05 shows the following figures.

Table No. 5. Main Health Indicators in 2005

High-risk Pregnancies (Cumulative)	97
Low Birth Weight	36
Under 1 Year Death	12
Neo-natal Death	9
Maternal Death	4

These figures show where the service delivery needs to be strengthened. Accordingly, CA has begun training the FAs and SS on birth preparedness in terms of five cleans, money, transport, referral slips, BPL certification etc. The training has to focus on enhancing their counseling skills as well, since family counseling is important part of birth preparedness. They are also trained in conducting verbal autopsy in the community, on neo natal, still born and infant death, in order to find the correct reasons for the death and help the families for better childcare.

Another important change in the ELCO register and mapping is the inclusion of birth certificate and more detailed immunization status. The follow up is to ensure that all children get complete immunization by the time they reach the age of 12 months.

Box N0 3. Birth Certificates

CA as an organization dedicated to promoting the right of children emphasizes on children getting birth certification as soon as they are born since that is a right and a passport for their education, employment and other services. To create awareness on the birth registration, CA has introduced that as part of the ELCO register and has been educating the community continuously. Getting a birth certificate from Government hospitals is a process. Women often come without family member and cannot take decisions and as per their custom, do not name the babies as soon they are born. But the hospital requires a name for registration. Hospitals take between 6 weeks to 6 months to provide a certificate. In the case of home delivery, the mother has to obtain a certificate about the birth (even when not delivered by the doctor or by a skilled birth attendant) providing details on the date, time and status of delivery, place and address, and forward it to the ward councilor who in turn forwards that to Kolkata Municipal Corporation for issuing a birth certificate. This process takes anywhere between 6 – 9 months.

5. Dispensing Medicines

Though a high cost item in the budget, CA continues to dispense medicines since it is a direct benefit to the community. A fee of Rs.10 has been introduced for full course medicine. The patients have the options to bring prescriptions from the Government hospitals, KMC maternity centres, PMP or CA doctors. POs with medical background from CA conducted a few rounds of 2-3 day workshops on 'reading the medical prescription', for the FA and SS. This training is repeated as and when required.

Avoiding over prescription and quality control are the two main concerns for CA. Providing the PMPs with a generic drug list to avoid over prescription and simultaneously educating the community on the results of over medication, are the two steps taken by CA. In practice it is found that PMPs prescribe outside the list when the patients insist on a different medicine. While the patients have the choice, CA feels it is a mater of concern, since it nullifies the effort to reduce the medical expenses for the poor families.

To ensure quality control, CA has begun procuring bulk medicine from Central Drug Manufacturing Unit (CDMU), through CINI, the parent organization, instead of procuring from different wholesale vendors. The various supplies, that is given free of cost from the Government such as IFA, condom, OCPs etc are procured by sending requisition form to the District Family Welfare Bureau, by CINI ASHA.

For procuring medicines, a stock register is maintained by the health post, which gets filled and verified on a daily basis by the FA. The register provides information on each item, with details on opening stock, stock received, stock utilized and balance in hand. The health post fills

requisition format and forwards it to PA and PO, who in turn verifies the list and prepares the purchase order. Based on the consumption report, and purchase order, the accounts section forwards the request to CDMU.

Since the focus shifted form, 'all patients' to only 'pregnant mothers and children under 2 years of age, the drug list was modified to suit only those users. The following changes were also made in order to streamline the medicine supply.

- Control and handling of medicines is restricted to the level of SS and FAs only
- Supplies of anti-allergic and antacids were withdrawn since there was tendency to over use the drugs
- The drugs that were not used were given to local doctors or health camps, especially those with early expiry date

6. Service Network

Principles that guide CA's engagement in the slum communities are, 'empowerment' and 'enhancing access and options' at affordable cost, for women from very poor families. As the program evolves based on field insights, CA has been innovative in strengthening the network of service providers. Currently, CA is working with four diagnostic laboratories and 25 PMPs. Efforts to build a network with the five government hospitals as well as KMC clinics and KMC maternity homes are in a nascent stage.

6.1. Private Medical Providers Network

The LIP document placed emphasis on project identifying qualified medical practitioners located within or near by the slums. In the initial stages, the FAs were trained to dispense medicine as per prescription brought from doctors and by themselves for minor ailments. Soon, some of the community members started to demand prescriptions directly from FA, which they could not entertain.

CA sensed the need for increasing professional service access to communities directly. FAs were given the task of identifying qualified medical practitioners in the near by areas so that medical camps can be organized periodically. Several health camps were organized in all the 12 wards, which resulted in a number of requests for follow up with doctors.

To meet such demand, CA organized meeting with some of the private practitioners who came to the camps and requested them to provide service, especially PNC care. Based on this 40 PMPs were identified between 2001 and 2002. CA oriented them on the principles and mission of CA, work and objectives, what is expected of them, the process and the procedure for billing and mode of reimbursement. Those who wanted to join the program submitted a copy of their registration certificate to CA.

Currently there are 25 PMPs in the network. Some have dropped out voluntarily while some had to withdraw since CA had phased out some of the wards. They are mainly allopathic doctors, with a number of years of experience in KMC clinics, Government medical colleges or in their private practice.

There are five women doctors and one of them has Unani specialization. Recently 2 PMPs have joined the net work to work exclusively with the adolescent boys and girls in the red light areas.

CA has not made any formal agreement for service with the PMPs. CA negotiated fee of Rs.15 initially per voucher and that continues even today. Most of them are content with that payment for they consider this as a service to the poor. Though all the 25 PMPs have thriving private

practice, they seem to have given same quality of care that they give for any full fee paying patient. The patients after a couple of visits, by and large meet the same PMP. However, it was found that some women do change the provider.

CA organizes a meeting with the PMPs once in six months. During that, several issues are discussed and a special discussion on a specific theme is also organized. Some of the past topics of discussion include, rational drug use, standard management of ARI and diarrhea, modern contraceptives, addressing ARSH issues and doctor as a counsellor etc.

The PMPs have stayed in the program any where between three to five years, despite a very low income earning potential. They have very good understanding of the profile of people and health issues in the respective wards where they work. Apart from their professional knowledge, experience and credibility in the community they also bring institutional linkages, which is very valuable to CA. Some have retired from medical colleges, some from KMC and some from large private institutions. This gives CA an opportunity to get entry into these institutions more smoothly. CA could use this social capital in amore proactive way.

6.2. Diagnostic Laboratories Network

One of the significant improvements in the program from 2004 is the identification of diagnostic laboratories and negotiating a competitive rate for services. This particularly is a critical support for the pregnant women, children and adolescents.

During 2003-2004, women and children used a number of laboratories. There were variations in the rates, qualities of reports, billing pattern and service quality. Many of them were registered and some were not. CA had to bring some amount of quality control and standard in rates for the diverse services relevant for pregnant women and children.

CA made a list of the diagnostic centers from where the bills came from the different health posts. CA compared the rates among the providers by making excel sheet and identified the laboratories, which were frequented by women. It was decided to follow the lowest rate with good service quality provided by two non-profit organizations. Their charge included material cost and doctors reports and no profit. It became the baseline rate chart.

From the list of laboratories frequented by the clients, 25 were identified for visit from different areas. 17 were contacted over phone and a team of doctors and program staff visited 10 of them. During the visit, CA checked the registration, lab facilities, availability of equipment and doctors, billing system, bank account for payment, rate chart, and reporting duration and other aspects related client dealing. CA began rate negotiation as per the base line rates identified and short listed five and four agreed to become part of this process. However, there are variations in the rates for the same services among them, based on their location and market condition.

An initial meeting was organized by CA to orient the labs on CAs methods, program and the need and the profile of the clients. CA staff meets with them as required.

Three slips are made in the health post -green for the diagnostic centre, white for CA accounts and pink to be retained at the health post.

CA trained SS and FA on understanding the vouchers, procedure for handling the vouchers and dealing with the lab in case of need. FA and SS put a check mark against the test required based on the prescription brought by the woman from KMC maternity centre, Government hospitals, PMPs or CA doctors.

In the initial stages SS accompanied the client, in order to support the handling of the vouchers as per instruction. CA handed over the voucher to the client, when she pays rupees ten to the health post. After a couple of months the clients began to go by themselves. The client carried the white and green vouchers and handed it over to the lab.

The diagnostic centre has to collect both green and white slips and hand over the white vouchers to CA for collection of fee. In the initial stages, the voucher colors were frequently interchanged or lost from the labs. Now the system is getting more organized.

In the initial stages, it was found that some clients tampered the vouchers, by putting tick mark against more services than required/prescribed. In order to avoid misuse, FA and SS were asked to put their initials beside the tick mark and cross the rest. The labs were asked to verify the voucher for initials and then proceed.

End of the month FA goes to the diagnostic center and verifies the white vouchers against the agreed rate chart and submit the bills and vouchers to PA/PO for approval. In turn the vouchers get submitted to accounts department.

Approximately, 80-90 vouchers are collected currently per month by the four diagnostic centers. CA has not so far entered into a formal contract or MOU with the diagnostic centres. Currently, they have agreed to work based on understanding with specific individuals in the diagnostic centre, who may or may not continue in the coming years.

6.3. Establishing Closer Linkage with the Government Health System

During LIP CA's engagement with the Government was limited to mobilizing community for immunization and procuring free supplies for FP services and IFA for pregnant women. Under UHP, there is a concerted effort to enhance the cooperation and collaboration between the community and the Government health system.

Using an alumni status of a staff member (PO-clinical services) from one of the popular Government Medical Collages and Hospital, CA is in the process of exploring possible linkages, for enhancing their support in service delivery to the poor. Essentially, the effort is to impress upon the need for timely and responsive services to women, patient handling with care, timely diagnostic services and not to refuse admission when they come for delivery.

The reason for the Government hospital's inability to accept voucher system is well known. The rules have already been laid out on paid and free services and the entitlement, which they have to abide by. Despite collecting large sums though paid services (some collect up to Rs.60,000 - Rs.70,000a day), the fund cannot be utilized for improving the infrastructure of the overcrowded delivery wards. The fund is deposited in the treasury. There is a move to decentralize the system, which may be a long drawn process.

The superintendents assured help to women from CA project areas for diagnostic facilities without delay if they are already registered in their hospitals for ANC. This is a person oriented assurance and not an institutional arrangement.

Efforts are also under way to strengthen linkage with the KMC maternity homes and the KMC clinics. Some of the CA field staff were included in the immunization training provided for KMC staff. The clinics also offer their venue for training and participate as resource persons in the training when invited. Again the linkage is based on personal rapport of staff with the KMC Medical officers. This needs to be institutionalized.

Institutionalizing linkages with the Government requires strong advocacy skills, persistence, and frequent follow up with evidence based data to support issues. CA needs to strengthen staff skills in advocacy, to take this process forward.

6.4. Strengthening the Health Committees

The health committee has a key role in the community. They provide active support in terms of providing space, mobilizing families for immunization, and participating in the meetings.

However, the survival requirement keeps the members of the community busy in their livelihood activities, which may often be outside the slum. Though, very enthusiastic, the mothers and CHVs have limitation in taking lead in the process of convening the meetings of the health committee, because of social and cultural reasons. Leadership is usually provided either by the local ward councillor or his/her nominee or by the local popular person. The popular persons may change often due to their political affiliations. However, getting time from the ward councilor is a time consuming process. The health post staff has been facilitating to convene the meetings periodically.

Enhancing community ownership through the health committees would require building capacity of the committee on various aspects. Especially if the community contribution is to be managed by the committee they need to gain skills understanding the health issues, prioritizing them, and allocation of resources, accounting, and paying an honorarium to the community health worker based on out put.

The involvement of the ward councilor on an ongoing basis would be critical requirement for such activity since it involves community-generated funds.

The FAs have begun a process of informing the councillor on a monthly basis on the progress (number of children immunized, pregnant women received services, adolescents received RTI// STI services etc). They also invite them to training and meetings on important days such as World AIDS day, child rights day, International women's day etc. Such measures help in building rapport with the councillors and generate more interest from their perspective to see the progress in their wards.

Simultaneously, CAs program management has decided to do away with the cluster system, and adopt a ward system for service delivery. This provides clear area of operation, enabling the FAs and her team to set clear targets and indicators for their specific wards and share the same with respective councillors.

In addition to building skills to manage the program in future, focus should also be from the point of view of the current programs. Currently, the committee gets information on the progress of the work only during the meeting which is not very structured .It would be useful to have specific agenda for the meetings and make the meeting participatory by sharing the results (pictorial depiction or dramas) of the analysis of the monthly monitoring and hold discussion, so that they understand the efforts made by the program..

The health committee can take more proactive role in enhancing male involvement in the program.

The Government of West Bengal has been very actively energizing the neighborhood committees that have been dormant for several years, in the slum areas. There are opportunities for potential partnership as well as competing/conflicting interests. It would be useful for the health committees to gain skills in negotiation and develop productive linkages with the neighborhoods committees.

7. Capacity Building

CA's capacity building method is a mix of structured programs as well as hands on experience. CA generally tries to promote no/low cost training by using the Government premises, NGO or community space, and use a mix of internal and Government resource persons.

Training needs assessment is not done separately. Training needs are identified during the PA-PO, FA-PO and monthly staff meetings at different points. Quarterly training and event calendar is prepared by each program officer, which gives details on training venues, topics, participants, and budget, based on information from the field and monitoring of performance.

7.1. Community Health Volunteers

From 2004 onwards, special efforts are made to ensure that, reduction in the number of CHVs does not compromise service quality. CHV capacity is enhanced through new training related to birth preparedness; development and application of innovative BCC materials, maintaining quality of care during immunization, and birth registration.

Despite such efforts, internal and external study teams have observed that, the repetitive nature of their work does lend to some kind of monotony and reduced motivation. Perhaps, working almost five years in the same job has taken the novelty and challenge out of their jobs.

A study by SP.Jain Institute of Management, Mumbai in June 2005, on the motivation levels of the CHVs, found that the CHVs value the recognition that they have gained. But their morale is low, since they feel that they have stagnated in the same position without a raise or increment. The study suggested that, CHVs job profile may be redefined or they may be given new work. Exposure visits to other wards and an opportunity to review the new area were also suggested.

The CHVs have a fundamental role of keeping contacts alive on a one - to one basis. Using innovative methods to make their job interesting and creating skills that will help them to earn a bit more outside the CHV work could improve their motivation.

CHVs have a major limitation in terms of literacy skills. Even after four years, several of them seek the support of SS or FA to fill the forms and for ELCO mapping. While their confidence level has gone up to meet the community, filling the improved version of monitoring formats does pose a challenge to them due to their lack of literacy skills. This in turn consumes the valuable time of the FAs. CA, as an organization committed to education, could help by designing short functional literacy courses exclusively for the CHVs.

Training them in new aspects such as conducting safe delivery (earning potential) and training on HIV/AIDS awareness and inclusion in the staff training schedules of KMC clinics could improve their interest level.

Though some of the issues are common for all the health posts, not all have the same focus areas. While CHVs job description falls within a general framework, their capacity could be built to understand work on certain specific issues deeper (E.G: Neo natal care, caring for high risk cases, RTI/STI), thereby enhancing their skills in specific aspects.

Their skills also could be enhanced in analyzing the data collected from their respective area, developing innovative BCC strategies to improve indicators, and for sharing the results with the community. It would also be useful to recognize them publicly in the community/health committee meetings.

7.2. Field Assistants and Swasthya Sevikas

Based on the emerging needs, hands on training is provided to FAs and SS on reading medical prescriptions, conducting verbal autopsy on neonatal, still born and infant death, ensuring quality of care in child immunization and improved birth preparedness. Very recently in December 2005, FAs were trained in analyzing the ELCO maps and posting the results on a chart, in the health post. The objective is to enable the FAs and SS to analyze the results and by posting it in the health post, create an opportunity for the mothers, club members and others to see, question, discuss and understand them.

For the managerial staff, in addition to the trainings, capacity is built through annual reflection retreat in which the entire team reflects on the past year's performance and develop new work plans. Exposure visits is another mechanism adopted for staff capacity building. For example, all the health unit staff were sent to EHP program in Jamshedpur and Indore as preparatory exposure visit for starting convergence mode work by CA

The managerial staffs require orientation, especially when a change is introduced in the program. The method of providing support by PA/POs on a specific area irrespective of the unit has helped in certain ways. It would be useful for CA to conduct a resource audit/ review to find a balance between field, office, advocacy, networking, requirements and the skill mix available in order to make optimum use of the resources and to meet the emerging requirements.

8. Monitoring

Monitoring Community Services: The various monitoring formats at the field level were developed during LIP period. Under the UHP, attempt has been to make the formats user friendly, in order to help the field to use them as learning tools rather than control tools.

Additionally, birth registration status and more detailed information on immunization to ensure that primary immunization is completed by the time child completes one year. Other than that, the system under UHP remains the same as it was in LIP.

- ❑ Collating ELCO format data by CHV and submission to SS by early last week of the month
- ❑ The data is further collated by the FA, and sent to the CA Program Associates (PAs) on the 28th of every month
- ❑ PAs discuss data with POs on the last day of the month on the progress during monthly meeting
- ❑ On completing the collation for their reference, PA sends it back to the field by the 10th of every month

Monitoring Community Contribution: Similarly, between 28th and 30th, health post wise, the community contribution is collected by the FAs, recorded in a format and submitted to PAs. On verification of the format, PAs sign the format and collect the money and submit it to the accounts department. During the subsequent community meeting, the community contribution status is shared with the community.

Monitoring of Medicine Distribution: Very stringent monitoring is done for medicine requisition, use and maintenance of stock in the field.

Monitoring Referral Vouchers: At the end of every month, FA collects the vouchers from the PMPs and the diagnostic laboratories and submits them to the PAs for verification. The FA pays the money to the service providers as per the number of vouchers and in the case of

laboratories according to the service provided. The vouchers are then forwarded to the accounts section in CA.

Monitoring the field financial practices has helped CA to introduce new financial system. During LIP, the FAs had access to a system of 'standing advance', where at any given time they had funds up to Rs 5000 with them. They had the responsibility to make payments to the doctors (reimbursement against vouchers), CHV honorarium, training/workshop of CHVs, ward committee meetings, transportation, purchasing of stationeries and utilities at health post. FA submitted accounts to PO, according to the budget line, on a prescribed format. Based on approval by the PO/PA, the fund got reconciled and the accounts department replenished the balance. All advances were closed at the end of the financial year. This practice continued during 2003-2004.

From April 2004, under UHP, the financial system got revised. Under the revised system, the FA has to make a projection for monthly expenditure, under various heads. FAs take advance from CA, only close to the due date for payments for a particular period and get it reconciled within the stipulated period. Their transport expenditure is reimbursed separately. This system has reduced the potential of bulk fund lying unused in the field area.

V. PERFORMANCE OF THE VOUCHER SCHEME

1. Evolution of PMP Referral Vouchers

The number of coupons used with PMPs shows a sharp decline over a 6-year time span. This partly results from the reduction of financial resources over time, which led to significant changes in the number of beneficiaries targeted by the program. However, this declining trend is also apparent while implementing the different phases of the program.

In particular, the real causes explaining the negative variations observed during the LIP period (2000-2001), the transition period (2002-2003) and the UHP period (2004-2005) should be further investigated.

Table No. 6. Evolution of PMP Referral Vouchers (2000 - 2005)

No	Months	Slips (No.)	% Variation
1	January - December 2000	18,175	
2	January - December 2001	16,015	- 12%
3	January - December 2002	9,436	- 41%
4	January - December 2003	1,248	- 86%
5	January - December 2004	1,186	- 5%
6	January - December 2005	885	- 25%

The distribution of PMP referral vouchers during the last two years does not show a particular peak pattern. The vouchers spread over the whole year, which is consistent with the randomness of pregnancies/deliveries.

Table No 7. Monthly Distribution of PMP Referral Vouchers (Jan 05 - Nov 05)

No	Months	Slips-2004 (No.)	Slips-2005 (No.)
1	January	141	81
2	February	139	69
3	March	101	74
4	April	129	77
5	May	93	85
6	June	92	78
7	July	88	66
8	August	76	74
9	September	85	79
10	October	74	48
11	November	85	66
12	December	83	88
	Total	**1,186**	**885**

2. Evolution of Laboratory Referral Vouchers

The evolution of vouchers used for laboratory services while slightly increasing over the last months of the year shows a positive trend over the last two years. For the last year under review (2005), the ratio of laboratory referrals compared to PMPs referrals amounts to 57.7%, which remains rather normal, demonstrating that this important part of the health expenditure structure is kept under control.

Table No 8. Evolution of Laboratory Referral Vouchers (2004 - 2005)

No	Months	Slips-2004 (No.)	Slips-2005 (No.)
1	January	0	48
2	February	0	39
3	March	0	32
4	April	0	35
5	May	0	40
6	June	0	46
7	July	5	49
8	August	24	59
9	September	34	36
10	October	32	37
11	November	42	41
12	December	39	49
	Total	**171**	**511**

3. Distribution of Visits to PMPs

The distribution of visits to PMPs over the last two years provides a better understanding about the nature and frequency of service utilization. In terms of service utilization, there is an apparent shift towards providing more childcare services, which now exceeds the number of consultations made by women. This trend is already obvious in the following figures:

- In 2004, child care accounted for 58% of the total number of consultations
- In 2005, child care accounted for 65% of the total number of consultations

In terms of frequency, most women do not demonstrate going to PMPs for regular prevention services:

- Most users only go to PMPs for a single visit (86% in 2004, and 77% in 2005)
- The percentage of users going for three visits remains quite negligible (around 2% for both years)
- The double and triple visit pattern is more apparent for childcare than for women
- As mentioned above, the sharp decline (by some 47%) in terms of women's service utilization over the two-year period should be further investigated.

Table No. 9. Distribution of Visits to PMPs (Jan 04 - Dec 04)

Beneficiaries	Single Visit	Double Visit	Triple Visit	Total Indiv.	Total Visits
Women	370	51 (102 visits)	7 (21 visits)	428	493
Children	452	101 (202 visits)	13 (39 visits)	566	693
% Women(Col.)	45%	33 %	35 %	43 %	
Total 822	**152 (304 visits)**	**20 (60 visits)**	**994**	**1,186**	
% Indiv (Row)	**83 %**	**15 %**	**2 %**		

Table No. 10. Distribution of Visits to PMPs (Jan 05 – Dec 05)

Beneficiaries	Single Visit	Double Visit	Triple Visit	Total Indiv.	Total Visits
Women	194	51 (102 visits)	6 (18 visits)	251	314
Children	318	113 (226 visits)	9 (27 visits)	440	571
% Women (Col.)	38 %	31 %	40 %	36 %	
Total	**512**	**164 (328 visits)**	**15 (45 visits)**	**691**	**885**
% Indiv (Row)	74 %	24 %	2 %		

4. Evolution of Contributions

The table below clearly shows that slowly but steadily, people are willing to use services despite the fee. For CA the objective in the initial stages was to inculcate financial discipline rather than covering the cost through the collection of user fee. To that extent, the program has already established a model.

Table No 11. Evolution of Community Contribution

No.		Per Unit Cost	2003-2004	2004-2005 Up to Oct.
1	Mother Card & Child Card	5 + 5	2,602	2,532
2	Doctor Referral Voucher	5	1,831	2,202
3	Laboratory Referral Voucher	10	2,506	2,753
4	Medicines	10	2,698	3,524
5	Others			447
	Total Receipt		**9,637**	**11,458**
6	PMP Payments		18,341	17,735
7	Laboratory Payments		21,536	42,658
	Total Expenditure		39,877	60,393
	Expenditure Over Receipt		**30,240**	**48,935**

VI. ACTORS' POINT OF VIEW

The program as it grew over the five years, brought in new stakeholders. During the LIP days, by and large the major stakeholders were the clients in the community, service providers in the health post, CINIASHA staff and PMPs. Subsequent to LIP, efforts have been stepped up to include the Government health system, municipal ward councilors, diagnostic centers, Government medical collages and external technical institutions among the stake holders. The following paragraphs bring some of the viewpoints expressed by key stakeholders regarding the diverse aspects of the program.

1. Discussion with Women

10 mothers were present at the time of visit to the health post located in the tannery area. The location also houses CINI ASHA's bridge school for about sixty children in the age group of 9-14 years. In the bridge school, children, who have dropped out of school for various reasons, get coaching to be placed in a formal school in the next academic year. CA provides breakfast and mid day meals through a Government scheme. Another school for children from 3-8 years is also located in the same place, run by CA.

For several women, the health post is a place to congregate and discuss some of the family and community issues. Their response to a question on their understanding of the program brought out the value addition that UHP brings in terms of increased awareness. Though they knew about the Government health program earlier they were not taking the immunization as a serious issue. In the course of the past four to five years, most of them have understood the value of immunizing the child at the correct time, due to continuous advice from the health post.

On the question of choices for seeking health services, they responded that their choice of provider depends on the situation. Some of them even now go to the local medicine man for ordinary problems. For serious illness, they seek the advice of the PMP, especially when it concerned children.

When asked whether they go to the same PMP or keep changing the service provider, some of them mentioned that they choose another provider when the recovery is not fast or when the patient does not recover in one or two visits. In the last year and half, they seek the help of PMPs in a limited way. Usually they see the same provider because of their location. But some times, they do see another PMP.

On the voucher, they did not have any particular understanding except that the fee is charged by CINIASHA. They mentioned that they buy the voucher when there is a real need.

The mothers in another health post in Pagaldanga, also had high awareness about the immunization of the children. Two mothers with very small babies, a pregnant woman and three community women joined the group of 2 FAs, one SS and one CHV, in the health post during the visit.

2. Discussion with Community Health Volunteers

The 5 Communty Health Volunteers (CHV), also met in the tannery area health post showed that they had basic understanding of the RCH components. In response to a question 'why they chose to be CHV' they listed out the advantages. Recognition and acceptance by the community, despite their varied social and economic background is considered as the major

advantage. Some of them did agree that the honorarium of Rs.200 is a big motivation because it is an additional sum in their hands to do some thing for the children. They feel that that they have contributed something to their community but have also gained a lot of new knowledge. When asked if they would continue their services without honorarium, some expressed that it is necessary to continue the honorarium.

The CHVs were well aware of the various steps and procedure for program implementation (family follow up, filling ELCO register, ELCO mapping and monthly reporting on the MIS format). They look upon the FAs for support and guidance in doing their day to day work.

The RCH Committee member explained how the youth club members use the premises. In the morning it is for watching TV news and in the evenings for indoor games and also for get together. They feel the CA initiative is good and they need to support this in whichever way possible, because it is a community requirement. They usually do not get involved in programmatic decisions or day to day operations of the program.

3. Discussion with CINI ASHA Field Staff

Discussion with the Field Associates (FA) brought out their high level of motivation and ability to work with the community under adverse circumstances. They explained the ELCO mapping process, family follow up method, new BCC initiatives to work with adolescents, and importance of working in close coordination with the ward councilors. The new format for sending monthly program progress with the ward councilors was shared.

The FAs have very busy schedule. In addition to the regular tasks of field visits, meetings with CA program managers, maintenance of records and registers and reporting, participation in trainings, ensuring that the ELCO mapping is done properly and conflict resolution in the field take up their time. They feel that the introduction of the cadre of Swasthya Sevikas has redistributed some of their workload.

They view the various user fees as a mechanism for inculcating a sense of value among the users for the services received, since free service often gets misused.

On the issue of mechanism established for ensuring quality of service from the PMPs, they mentioned that informal feedback is received from the clients. By and large CA clients get the same service as any other patient who visits the PMPs.

One of their concerns is increasing number of prescriptions outside the generic list of medicines, which in a way negates the idea of reducing health expenditure for the poor. The FAs get an opportunity to meet the PMPs when they visit them at the end of the month to collect the vouchers and make the payments. But no discussion takes place on community health issues due to the busy schedule of the PMPs.

4 Discussion with Private Medical Providers

Six of the 25 PMPs were met in their respective clinics. Except for one Unani practitioner, the rest were General Practitioners (GPs). Each practitioner mentioned about their professional background, duration of association with the program and their specialty if any. The range of issues discussed include, reasons for becoming part of the program, their viewpoints on the program concept, requirement for NGO involvement in service provision, profile of the clients and any change in their health seeking behavior as they have observed, use of vouchers, contribution of the program in increasing access to services for the poor and their suggestions for improving the program scope and coverage.

The responses on the reason for joining the program were unanimous - 'it is for a good cause and we should contribute to this effort'. They do not view this as a commercial venture. During LIP and transition period using reimbursement mode, their involvement had commercial viability, due to volume of patients. They feel that the program concept of helping the poor and the effort to create an enabling environment is important. They do not invest any special time to treat the patients with vouchers. In addition, they also have experience of working with other voluntary agencies during their spare time.

A similar response came from all interviewed on the issue of requirement for NGO involvement in service provision, when the Government health system is so wide spread in Kolkata. The response highlighted the role of CA. The slum dwellers do know where the services are available and at what cost. They choose not to use them due to various constraints including paper work, social and economic factors. Facilitation by CA's program plays major role in increasing their level of awareness and linking clients to service providers. This complementary role is critical support to the Government system.

On the profile of the clients, they mentioned that, they generally are repeat clients. There are both dropouts and inclusion of new clients in the course of the year. The health seeking behaviour is changed to that extent that, when children fall sick or if they have complications during pregnancy, they do seek help and do not neglect it. Another change is that often clients ask for a change of medicine from the generic drug list since they feel that generic drugs take longer time to provide relief, whereas injections bring immediate relief. They try and explain to the patients of the value of using certain drugs. But if they insist, they do prescribe outside the list.

Two PMPs working with adolescents felt that there has been a tremendous increase in the level of awareness among the adolescents and the information shared has reduced their fear of seeking help to treat their RTI/STI, and HIV related problems. Usually the adolescents stay with the same providers, because of confidentiality issues.

The PMPs expressed that irrespective of the fact, whether the patients bring voucher or not, they provide service when the clients are from the slums. Sometimes the client promises to bring the vouchers at a later date but often they fail to turn up. On the questions whether the reduced number of vouchers received by the PMPs is a matter of concern to them, the general response was, 'no it does not matter', since it is service to the poor. Moreover, participation in the program does not make any real difference in their income, especially, since the number of voucher using patients does not exceed 6-8 in a month.

However two of them expressed that CA may find a way of leaving some vouchers with the PMPs so that when the clients walk in without voucher, the PMP can use the same immediately. The accounting will be more accurate as per the actual number of users. CA representative explained the process of issue of voucher, accounting and reimbursement and the difficulty in monitoring the misuse of the vouchers, when issued by more than one agency. One of the suggestions was leaving a approximately 4-5 vouchers signed by CA with those PMPs and see how they utilize the same. CA representative mentioned that the possibilities could be explored.

The PMPs had several suggestions for strengthening the program. The key suggestions were:

- Build capacity of the CHVs at the health posts
- Organize more health camps for adolescents in the community
- Increase access to counseling services to the mothers and family members on birth preparedness and on sexual and reproductive health for adolescents

- Speedy distribution of medicines and increasing the number of drugs for adolescents
- Enhance awareness on safe abortion in the community using innovative BCC techniques

Regarding steps that could be taken for strengthening their involvement, the general response indicated willingness to come into the community once a month for a few hours and interact with adolescents/mothers, pregnant women and general community; provide support to the special camps organized for adolescents and attending meetings organized by CA to interact with the other PMPs.

5. Discussion with Diagnostic Centers

Interaction with two of the four centres brought out the following. They have agreed to join the network and provide services at a competitive rate because they already have a social orientation and are convinced that poor need to be encouraged to seek professional services.

Peoples' Relief Committee, a diagnostic centre has a distinguished record for providing relief services all over India for over 50 years, in the event of natural calamities. The center has an OPD, which caters to approximately 300 patients a day and has various specialists. The costs are very nominal for OPD and medicines and for diagnostic facilities comparable to other laboratories. They run a short stay home at a very reasonable cost for the out station patients. They conduct thematic health camps all over Kolkata by themselves or in collaboration with other diagnostic centers and Government hospitals. Recently they have added HIV testing facilities to their services.

CARE is run by a private entrepreneur, who motivated by a personal experience, allots a specific portion of CARE's services to the poor free of cost or at a very nominal cost. For the organization partnering with CA it was a very a natural process, since its philosophies matched.

Both organizations were appreciative of the efforts of CA and are willing to explore further possibilities. For example, CARE has a clinic in another slum, and has storage space, facilities for conducting MTP and training. They are willing to give the pace to CA if they would like to store FP products, conduct MTP and provide counseling services to the adolescents and place a PMP to provide curative services. CA is exploring this possibility.

They both suggested that CA must have a formal contract made with the diagnostic centers and also have mechanism to weed out the not so poor at the health post stage itself in order that only the deserving will use the voucher, which is highly subsidized.

6. Discussion with Superintendents of Government Medical Colleges and Hospitals

Two major Government college hospitals are located in the heart of Kolkata city and cater to thousands of patients including conducting 60-70 deliveries per unit on a daily basis. Their introduction to the CA program is very recent and is in a very nascent stage. The discussions covered a range of issues from their own understanding of the CA program, capacity of the Government hospitals to provide support to maternity care for poor from the slums, support services they can offer to strengthen CA's initiative and suggestions for institutionalizing the linkages with CA.

Both the hospitals come under Government guidance and regulation for their day-to-day operations. By themselves they have very little autonomy to make decisions. For example, as per guidelines, the hospital collects user fee for various services and for OPD, which runs into several thousand Rupees every day. The hospitals are over crowded, especially the labour

ward, and the diagnostic facilities are under staffed and ill equipped. Yet the hospitals have to send the collected user fees to the treasury and cannot carry out any repairs or improvements on their own. The Government of West Bengal is working on decentralizing resource management. However, the process will take a while to complete. Though the hospitals are meant for providing service free of cost or at a nominal cost to the poor, there is limited accessibility to services by the poor for various reasons.

On the question of pregnant women being denied admission by the hospitals, they responded that, due to a dysfunctional second tier (e.g: Post Partum centers), the pressure on the major hospital is very high. For example, the tertiary hospitals should be catering only to high risk and complicated pregnancies and not to normal deliveries. But a number of normal delivery cases occupy the bed space. Often women share beds and some even lie on the floor. This situation at times results in denial of admission.

The diagnostic centers in the hospitals share a similar situation. So often the patients are asked to go a private diagnostic facility to get some of the tests done due to the urgency of the situation.

They are aware of and appreciative of CA's preparatory work with pregnant women, education on importance of complete ANC, institutional delivery and birth registration. Some of the communities living in the slums in the vicinity of the hospitals, have very fixed beliefs and practices which do not encourage safe motherhood practices. They suggested that CA could use innovative BCC materials to bring behavioral changes among these populations.

They cannot introduce the voucher system in the hospital due to Government regulations that have decided the free and paid services in advance and modalities for the poor to access free services.

A suggestion given for strengthening the linkage with the hospitals is to have frequent interaction by CA with the heads of the departments of gynecology, pediatrics and other relevant departments and arrive at areas where the poor can be supported in specific ways. A lot would depend on whether the requests would fall within the Government regulations.

They were willing to explore the possibility of reducing the number of steps in getting the Below Poverty line (BPL) certification from the local ward councillor by pregnant women, if CA would take the initiative and organize the meetings.

A discussion with Medical officer, KMC hospital revealed that KMC hospitals do not conduct delivery or provide ANC facilities. They provide counselling, collect household information on FP status and services, and provide active surveillance for Malaria, TB, and other communicable diseases. They have good infrastructure but are over staffed. They are finding ways of reducing the staff or redeploying them in productive ways. This is mainly because they are project-based staff (IPP-8, Kolkata Slum Improvement program, (KSIP), Kolkata Urban Development Program -KUDP) and have no scope of getting absorbed in the system on completion of the project. For example, almost 1800 health workers (equivalent to CHVs in the CA program) who have the similar responsibilities as CHVs are with KMC, who require new skills and innovative work opportunities.

The support that KMC medical officers' provide to CA's initiative is based on personal rapport. Allowing CA to use KMC clinic premises for training, inclusion of some of CA staff in immunization management training, participate, as resource persons in CA's trainings are examples of such support.

VII. CONCLUSIONS AND RECOMMENDATIONS

1. Conclusions

CA's initiative is an innovative attempt to promote maternal and child health, by linking the clients to a network of service providers and charging a fee through a voucher system, perhaps one of the few in India by an NGO. The strength of the program lies in the strong education and awareness component at the field level, that prepares and motivates the poor women from the slums to seek professional advice and care during pregnancy, post natal period and for care of infants. The program has also responded to the needs of the women, who faced practical difficulties in accessing certain facilities from the Government system, and has created access to professional service providers (PMPs and diagnostic centers) and basic medicines, through purchase of vouchers at a very reasonable cost. The voucher system has been instrumental in introducing a financial discipline for use of services and enhancing a sense of ownership by the users. It is also the community contribution, which eventually will be used by the community to continue the program when CA withdraws from the program areas. Therefore the voucher is used for limited purpose offering limited benefits.

Understanding the differences between a "health voucher schemes" and a "health insurance scheme" would help in understanding the potential and limitations of the voucher scheme adopted by CA.

A health voucher scheme is designed to address the preventive, promotive and curative aspects of pregnancy, ensures continuous access by providing the pregnant woman with a set of vouchers at a very nominal cost, which can be used to go through each step of pregnancy without cash transaction at any point, have choice of providers to guarantee safe delivery, the most costly event in the whole process.

A health insurance scheme, on the other hand, does not offer a full package of services leading to safe delivery, but encourages the user to seek help only in case of need.

The CA program has adopted the spirit of the health voucher system, but uses the vouchers in the principles of a health insurance scheme. The voucher system was introduced with no prior experience, and it has not reached its full potential for reasons mentioned above. Yet, it offers a platform for exploring the possibility of introducing a health voucher system eventually.

In the last two years, in the implementation of the UHP, CA has gained experience in introducing user fee, output based subsidy, addressing adolescent sexual and reproductive health needs, and responding to reproductive health needs of poor women in the larger context of urban health. Building staff capacity to address a range of emerging issues related to service delivery, working with Government system and keeping a strong base at the community level, reflect the willingness of CA to learn and meet challenges. These practices have potential for larger application. This experience provides a foundation for exploring the possibility of building on the strengths and scaling up the program.

The aspects that CA needs to be concerned are, dependency on external funding, which enhances vulnerability of the program, management of the voucher system, developing institutionalized linkages with service providers and Government health system, strengthening the monitoring system and introducing a system for institutional learning including documentation. To enable CA to upscale the program, the already available lessons have to be consolidated and systems have to be in place to strengthen them.

2. Recommendations

2.1 Overall Recommendations

a) Building staff capacity

The CHVs are the first contact point and keeping their motivation level is critical for interacting with the community at large. Towards this, the CHVs could be brought under a functional literacy program, additional skill training related to health with income earning potential and job relation within the system.

The introduction of convergence mode of program implementation requires that staff get equipped with very strong advocacy and networking skills, especially at the managerial level.

The program profile has undergone frequent changes in the past few years and a corresponding requirement for appropriate skill mix at the field and at management level. It would be useful for CA to conduct an audit to find a balance between field office advocacy, networking requirements and the skill mix available in order to make optimum use of the resources and to meet the emerging requirements.,

b) Building institutionalized linkages with the service providers and Government health system

Currently, the PMP and diagnostic centers network functions on a “goodwill” and personal rapport of CA staff. To have sustained support from the health providers, it is critical to enter into formal and institutionalized arrangements through a contract.

Similarly, the effort to network with the Government hospital and medical colleges, KMC clinics, etc, could be strengthened through frequent dialogue with these institutions to identify areas of specific cooperation in a formal manner.

The PMP network is very important social capital. Apart from professional credibility, the PMPs also have institutional affiliations with medical colleges and hospitals. To use this network to its full potential, CA has to create forums for frequent interaction opportunities between CA staff and PMPs, and community and PMPs.

Towards this, organizing meetings once in three months with an agenda, from the current six monthly meetings would be useful. CA staff could prepare agenda points based on the analysis of monthly data from the field on the various aspects to seek suggestions from PMPs for addressing critical issues and gaps.

Similarly, inviting the PMPs to interact with the community, especially women’s groups or adolescent groups once a month will reduce the social distance between the PMPs and the clients. Such public forums could be used for recognizing the PMPs services and support.

c) Establishing learning systems

Institutional memory can be developed only when there is a learning system established within the organization. Systems for sharing of views, field insights and data, problems, solutions, new learning from other organizations, policies, programs and community perspectives need to be documented systematically, analyzed and disseminated to all the stakeholders as per their need.

Especially in an NGO context, where the staff turnover is usually high, establishing such system and building staff capacity to maintain the same is critical. Focusing on this aspect would be

critical for CA, since the program is complex and has undergone frequent changes for various reasons.

d) Streamlining monitoring systems

Currently, the program implementation is monitored on the basis of the numbers enrolled and services provided/received. Under UHP the priority areas and target population is clearly articulated, but program objectives and performance indicators have not been set, which contribute to effective monitoring. The existing well-designed monitoring formats can be put to best use, when the measurable indicators are established and the formats are in the local language along with English titles.

The monthly community contribution-monitoring format provides only a lump sum figure, though user fee is collected through vouchers under five heads: mother card, child card, PMP referral voucher fee, laboratory voucher fee, and medicine fee. Segregating the collection under different heads and then making a collated statement would be useful to understand the gaps, performance of the various vouchers; strong and weak areas.

A higher potential for sustained community involvement and high motivation level of field staff exists, when they have access to information on the program and understand the results of their own work. For encouraging active participation, CA needs to develop systems for formal sharing of the analysis of the monthly data with the Swasthya Sevikas and Field Assistants within a week of submission of data and sharing it periodically with the health committee and community at large.

e) Strengthening health committees and community involvement

A well planned capacity building program needs to be in place to enable the health committees to take over and manage the health program progressively including the management of the contributions collected at the community level, when CA decides to phase out of the wards in a few years.

2.2 Recommendations Related to Voucher System

As a local level initiative, the efforts of CA have proved that there is a demand for professional services and this can be managed by organizing certain systems such as user fee, referral voucher etc. While the awareness/education on service delivery is strong in the CA program, information and education on the voucher system is not shared at all levels. The CHVs and the women in the community are aware of the fee being collected by health post, but do not have an understanding of the purpose or use of the voucher as a tool providing them with choices. CA needs to initiate a process educating the women as well as field staff who have direct contact with the community, on the voucher system.

To scale up, CA needs to invest in managerial staff gaining a deeper understanding of the health voucher system and capacity to establish, manage and show sustained progress in measurable terms.

The potential of a well established health voucher system in promoting maternity care is very high. For CA to establish such a system, it should be backed by a sound financial mechanism such as the government, which has the capability to pledge large amounts on long-term basis, thereby reducing uncertainties. CA saw demonstration of limited dependability of short term external funding, after the completion of LIP interventions. To see clear results in terms of behavioral change in a health program, long-term fund commitment and sustained support are

necessary. CA may explore the possibility of partnership with the Government, if they decide to implement a full-fledged health voucher system.

Should CA decide to further develop this system, it is recommended for the scheme to cover the full range of services contributing to both a safe delivery and better infant health. In that case, the full cost for each pregnant woman would amount to some Rs. 1,000, (Table 12) leaving some flexibility to cover either additional health related services such as laboratory tests, or other opportunity costs such as: transport facility or a compensation for loss of wages.

Table No. 12. Expected Cost for a Comprehensive Maternity Voucher

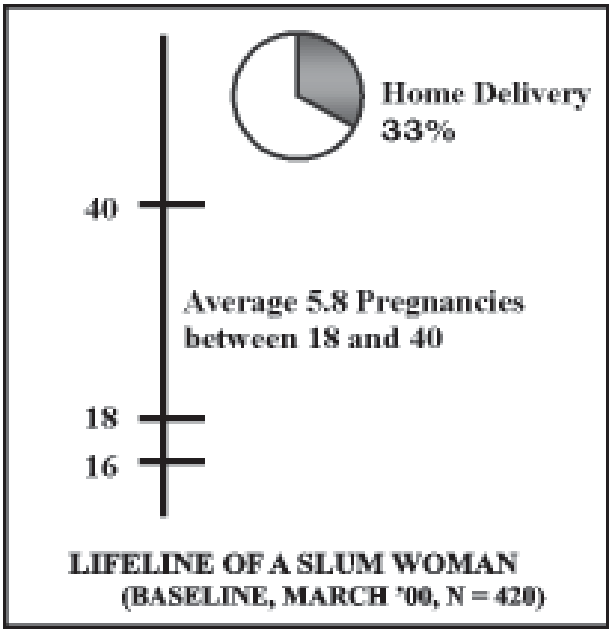
Type of service	Quantity	Cost/service	Total cost
1 Ante-natal consultations	3	15	45
2 Simple delivery	1	800	800
3 Post-natal consultations	2	15	30
Sub-total - direct services			875
Optional additional services			125
Total			**1,000**

ANNEXURES

Annexure 1. Main Health Indicators in Intervention Area

Facts About Kolkata

Kolkata is the capital city of the state of West Bengal and the gateway of Eastern India. Under British rule, Kolkata (Calcutta) was the capital city of India. Local administration of Kolkata is done by Kolkata Municipal Corporation (KMC). The city, divided in 141 wards, has an area of 185 square km and a population of 4.6 million. Decennial growth rate for Kolkata is 4.1 %; Sex ratio 828 females per 1000 males; literacy rates 84% in males and 78% in females.



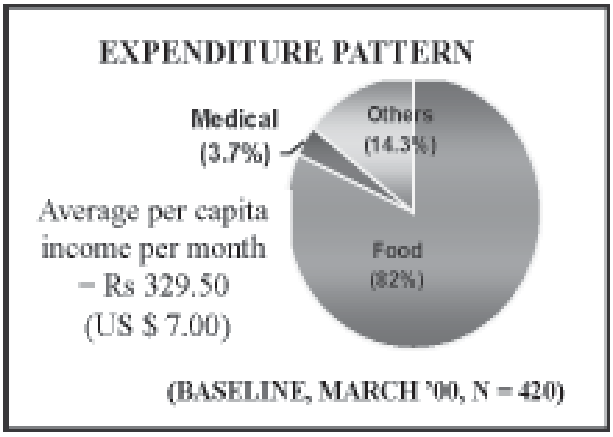
LIFELINE OF A SLUM WOMAN
(BASELINE, MARCH '00, N = 420)

Slums And Kolkata

Kolkata has 2011 notified slums covering an area of 21.35 square km. In addition, an equal number of unregistered slums with no civic amenities have sprung up in adjacent areas. Surprisingly one-third of the population (1.5 million) of Kolkata lives in slums. Slums of Kolkata are four times more populated than the rest of Kolkata.

Sex Ratio in Kolkata slums is 806 females per 1000 males; literacy rates are 78% and 69% for males and females respectively.

Source: Census 2001



(BASELINE, MARCH '00, N = 420)

Important Indicators

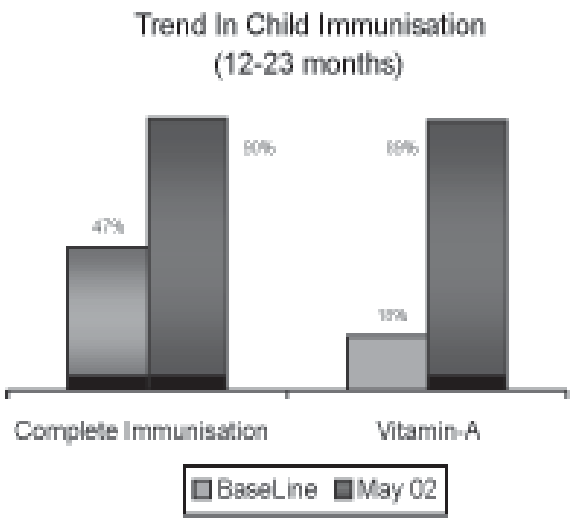
	West Bengal	India
Crude Birth Rate (CBR)	20.80	24.80
Total Fertility Rate (TFR)	2.29	2.85
Infant Mortality Rate (IMR) (Per 1000)	67.60	48.70

Important Indicators

	West Bengal	India
Complete Primary Immunization (Exclude Vitamin-A)	43.80	42.00
Contraceptive Used (Any modern method)	47.30	42.80

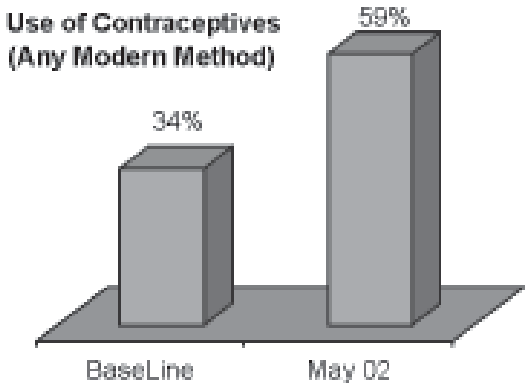
CINI-LIP Project Areas

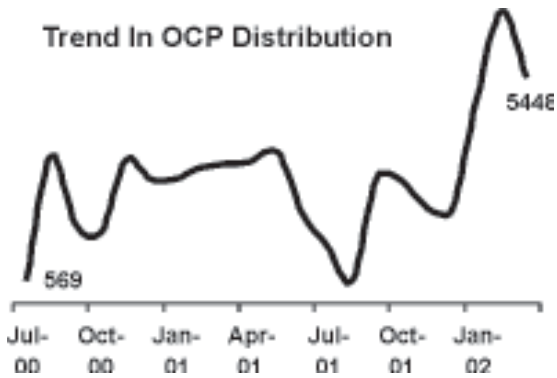
Ward-31 ~ Ultadanga-Narkeldanga;
Ward-36 ~ Kaiser Street, Khaldar, Dharbagan, Guripara;
Ward-38 ~ Amherst Street;
Ward-48 ~ Phulbagan;
Ward-49 ~ Lattupara;
Ward-56 ~ Malipara, Bibibagan, Motijheel;
Ward-57 ~ Betbagan, Pagladanga;
Ward-58 ~ Tangra, Dhobiatala, Dhapa, Hatgachia, Khanaberia, Arupota, Sahebabad, Boinchtala, Durgapur, Padmapukur, Kamadanga, Daspara;
Ward-59 ~ Darapara, Topsia, Gobra;
Ward-65 ~ Tiljala; Ward-66 ~ Kohinoor Market;
Ward-108 ~ Chowbaga

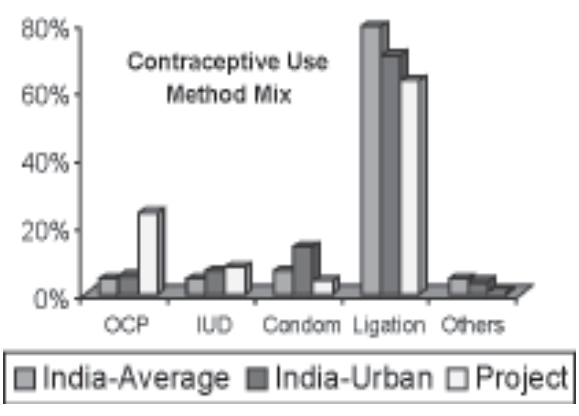


Project Coverage

Total Population Coverage	2,40,000
Eligible Couples	**43,000**
Pregnant Women	6,000
Children below 2 yrs	8,600







Annexure 2. Tariffs Applied by Associated Laboratories

Name of Test	CARE	PRC-JK	CDL	SMD&RC
TC, DC, ESR	30	25	35	40
Hb	20	15	20	20
Sugar (PP)	20	30	20	20
VDRL	26	30	35	25
Blood Group & Rhesus	26	40	35	40
Stool for RE	20	20	15	20
Urine for RE	20	20	15	20
HBsAg	200	100	125	100
Urine for Pregnancy Test	60	60	60	40
USG – Pregnancy (Without Plate)	300	200	-	275
USG – Pregnancy (With Plate)	320	-	-	-
Chest X Ray	80	50	-	60

Annexure 3. Private Medical Practitioner Referral Slip

0599

REFERRAL SLIP: CINI ASHA (UHP)

CINI
Child in Need Institute
CINI-ASHA
Urban Unit of
Child in Need Institute

Sex / Age :

Referred to: Dr

Patient's Name:
C/o (Name of CHV):
Address:
Case History & findings:

Community Centre:
Referred by (FA/SS):
Date:

Urban Unit: 63, Rafi Ahmed Kidwai Road, Kolkata – 700 016

0600

REFERRAL SLIP: CINI ASHA (UHP)

CINI
Child in Need Institute
CINI-ASHA
Urban Unit of
Child in Need Institute

Sex / Age :

Referred to: Dr

Patient's Name:
C/o (Name of CHV):
Address:
Case History & findings:

Community Centre:
Referred by (FA/SS):
Date:

Urban Unit: 63, Rafi Ahmed Kidwai Road, Kolkata – 700 016

Annexure 4. Laboratory Referral Slip

CINI
Child in Need Institute
CINI-ASHA
Urban Unit of
Child in Need Institute

LABORATORY REFERRAL SLIP
Laboratory Copy

1149

Date:…….. Ref:……/……/……

Name of the Diagnostic Laboratory :……

……

Referred by: MPM ☐ Hospital ☐ Project Doctor ☐

Name of the patient:……Age:…….. Sex:……

Address:……

Investigations:

☐ Urine-Pregnancy Test	☐ Sugar (PP)	☐ HBsAG
☐ TC	☐ VDRL	☐ USG-Pregnancy
☐ DC	☐ Blood Group & Rh.	☐ Chest X Ray
☐ ESR	☐ Stool for RE	☐ Others .....
☐ HB	☐ Urine for RE	.....

Community Centre:……

Name of FA/SS:……..Signature of FA/SS:……

CINI
Child in Need Institute
CINI-ASHA
Urban Unit of
Child in Need Institute

LABORATORY REFERRAL SLIP
Laboratory Copy

1150

Date:…….. Ref:……/……/……

Name of the Diagnostic Laboratory :……

……

Referred by: MPM ☐ Hospital ☐ Project Doctor ☐

Name of the patient:……Age:…….. Sex:……

Address:……

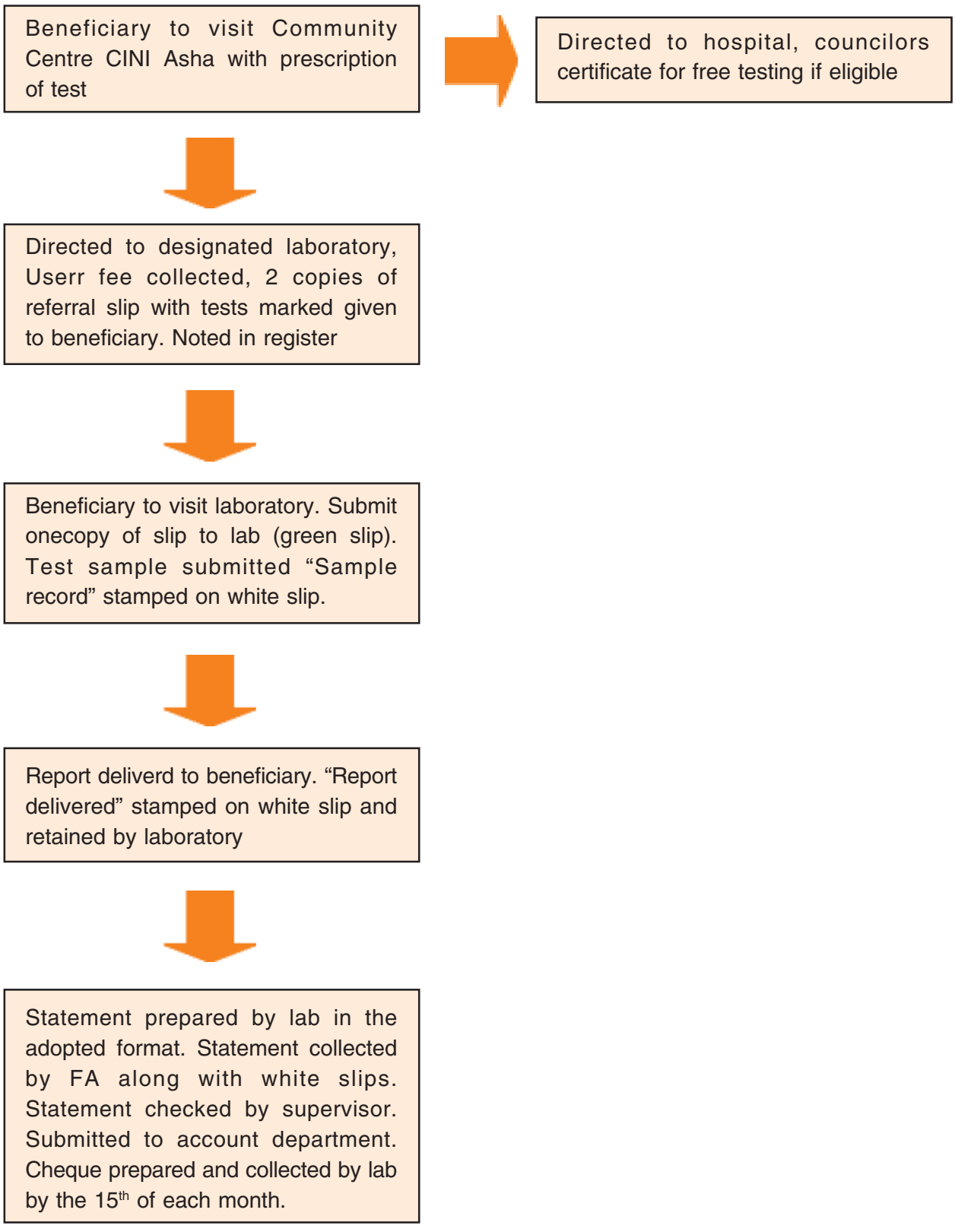
Investigations:

☐ Urine-Pregnancy Test	☐ Sugar (PP)	☐ HBsAG
☐ TC	☐ VDRL	☐ USG-Pregnancy
☐ DC	☐ Blood Group & Rh.	☐ Chest X Ray
☐ ESR	☐ Stool for RE	☐ Others .....
☐ HB	☐ Urine for RE	.....

Community Centre:……

Name of FA/SS:……..Signature of FA/SS:……

Annexure 5. Flow Chart of Processes for Linkage with Laboratories



Annexure 6. Laboratory Statement Form

NAME OF LAB **CARE**

PERIOD OF STATEMENT .....

SUBMITTED ON .....

Sl. No	NAME OF TESTS	RATE PER TEST	NO OF TESTS DONE	AMOUNT(RS)
1	TC, DC, ESR	**30/-**		
2	Hb,TC,DC,ESR	**42/-**		
3	Hb	**20/-**		
4	Sugar (PP)	**20/-**		
5	VDRL	**26/-**		
6	Blood group &Rh	**26/-**		
7	Stool for RE	**20/-**		
8	Urine for RE	**20/-**		
9	HBsAg	**200/-**		
10	Urine for pregnancy test	**60/-**		
11	USG–Pregnancy (without plate)	**300/-**		
12	USG –Pregnancy (with plate)	**320/-**		
13	Chest X Ray	**80/-**		
14	Others			
			Total : Rs.	

TOTAL AMOUNT IN WORDS .....

SIGNATURE WITH SEAL .....

Annexure 7. Community Contribution Form

NAME OF THE F.A. .....

DATE OF SUBMITTED ON .....

Sl. No	NAME OF HEALTH POST	HEALTH POST CODE	WARD NO.	PERIOD (FROM-TO)	AMOUNT (RS)

.....
SIGNATURE OF F.A.

.....
SIGNATURE OF P.A.

Annexure 8. Eligible Couple Register