

# **Improving Maternal and Child Healthcare for the Urban Poor: Sustainable and Scaleable Strategies**

**April 22, 2004**

## **Workshop Review**

ECH organised this Workshop as a response to questions arising from our work with SNEHA and the International Perinatal Care Unit (IPU), UK in developing a comprehensive maternal and neonatal care project for Mumbai. The initiative incorporates four action research projects:

- The establishment of a city-level formal referral system for maternal and neonatal healthcare: the development of a replicable model.
- Assessing the effectiveness of offering basic antenatal, postnatal and neonatal clinics at health posts – the development of a replicable model.
- Assessing the impact of conducting appreciative inquiries at primary healthcare facilities.
- A participatory intervention to improve maternal, neonatal and infant health outcomes in an urban slum setting – a Randomised Control Trial (RCT) of community groups.

While SNEHA has considerable experience working with vulnerable communities and with the BMC, the process of designing this project threw up some difficult questions relating to the specific challenges and opportunities of working in urban contexts. The Workshop therefore focussed on three key challenges – (1) working with the public health system; (2) community mobilisation and participation in urban slums and; (3) different research methodologies to assess and inform urban health initiatives. This note summarises the main discussion points and learnings from the Workshop and the implications for ECH's urban practice:

### **1. Working with the Public Health System**

- Dr. Vinod Paul, Professor of Pediatrics, AIIMS (Delhi) and consultant to GoI on the Reproductive and Child Health – II programme drew attention to an important relationship. The Neonatal Mortality Rate in Urban India is recorded at 48.8, while in a city like Mumbai, institutional delivery is as high as 95 percent. This trend appears to hold for the urban poor as well: according to the SNEHA baseline 91 percent of women in Dharavi delivered in hospitals. **The high urban IMR and NMR in spite of a very high incidence of institutional delivery seems to go against the received wisdom of the entire Safe Motherhood initiative, which has consistently argued that trained attendants and institutional births will mean a dramatic reduction in maternal and neonatal mortality. Why has this situation persisted? Is this a function of poor data? Or as SNEHA's baseline and workshops with service providers indicate it may not be the actual site of delivery that matters, but the fact that most women receive inadequate antenatal care and arrive in advanced labour. Many mothers and infants suffer injuries and infection as a result. In such a context, a formal referral system to improve services provided to pregnant women and newborns is likely to have a significant impact. Moreover, community outreach systems need to be strengthened.**

- The first session benefited from the participation of Dr. Damle, Joint Municipal Commissioner, BMC. In response to data on the poor coverage of BMC facilities in reaching the most vulnerable populations, especially migrants, Dr. Damle pointed out that the public health system in Mumbai was designed between 1935-1960 and has not been significantly upgraded since then. **The changing demographic profile of the city, therefore, has not been adequately addressed through increasing infrastructure or staff in the health system.** In addition, for the city of Mumbai, the Central Government contributes approximately 2.2 percent of the total budget, whereas some 20 percent of BMC's budget is allocated towards healthcare. **Further, low public expenditure is the only means by which the BMC has pulled itself out of the red. More telling, however, was Dr. Damle's comment that there are 'tax payers' and then there are the 'migrants', who impose severe demands on a system that was not meant to serve them.** This remark seems to reveal a common perspective of government functionaries and their understanding of their responsibilities in a constrained environment.
- **According to SNEHA's baseline, upto 40 percent of women in Dharavi went to private health service providers.** Although Dr. Fernandez suggested that the poorest and therefore those with the least choice use the public health system, while even the slightly better off are likely to prefer approaching private providers, **the interaction between the private sector and the urban poor seems to remain, as Dr. Masee Bateman of USAID put it, a 'dark area.'** This is in large measure due to the variety of actors subsumed uncritically into the 'private' sector – from large, commercial hospitals to community clinics and 'quacks'. In opening up this territory, **it is very important to identify the kinds of 'private' providers used by the poor and the reasons associated with these decisions. Can a minimum package, which could be delivered by both public facilities and certain private providers, be developed and monitored? Is engagement with these providers more likely to lead to an unjustified validation of their (illegal) practices?** CINI ASHA has had some experience working with private providers, in addition to encouraging uptake of Kolkata Municipal Corporation (KMC) services, however their engagement appears to have been incidental, rather than planned and they still seemed uncomfortable with the relationship. **Even in urban areas, is it clear that preventive, promotive and primary care for the poor should be provided almost exclusively by the public health system?**
- Dr. Siddharth Agarwal, EHP/USAID raised an important question: **in designing interventions that strengthen public systems, what is the appropriate scale at which to work in order for the model to be viably replicable?** What is the mandated level of service delivery at which to set the unit for replication? In the case of a referral system, for instance, SNEHA and IPU had decided that this would have to be a city-wide model, with zonal implementation, since it needed to connect delivery points from the slum-based health posts to maternity homes and peripheral hospitals and tertiary care facilities for high risk cases. The introduction of Antenatal, postnatal and neonatal (APN) clinics, on the other hand, can be tested and replicated at the health post level, covering a population of approximately 60,000 to 100,000.
- Drawing on recent improvements to the public health system in London, Prof. Anthony Costello described some of the ways in which the NHS has used **communications technology** to (1) Introduce NHS Direct, a 24-hour hotline for patients and (2) Establish a centralised bed management system to co-ordinate

between different facilities. He suggested looking into the potential of adapting such communications technology to public health systems in cities such as Mumbai. In an earlier conversation, IPU had also been keen to integrate some component of **GIS mapping** into the SNEHA project to better understand usage patterns, especially among poor populations.

## **2. Community Mobilisation for Improving Health Outcomes**

- Dr. David Osrin of the International Perinatal Care Unit (IPU), UK presented the results of a community-based participatory intervention implemented over two years in Makwanpur, rural Nepal. The socioeconomic context of Makwanpur was an extreme contrast to Mumbai, but the approach and preliminary outcomes raised some important points. The intervention engaged local facilitators, who worked through action-research cycles with rural women. Each cycle begins with discussions on how women approach maternal and neonatal issues, proceeds to understanding the common problems that they face, before discussing strategies to address these problems and share strategies with the wider community. **Only 8 percent of the women in each cluster (of approximately 7500) were covered in the women's groups. Based on a randomised control trial methodology, the preliminary results are impressive: a 30 percent reduction in neonatal mortality and an unexpected 74 percent reduction in maternal mortality.** IPU was hesitant to make too much of the latter figure since it was not a primary indicator for the trial and the numbers are very small (11 deaths in the control versus 2 in the intervention clusters). **This result seem to suggest, however, that improvement in hygiene practices and community based caring practices through low-cost participatory interventions can have a significant impact on maternal and neonatal health outcomes.** The findings are also consistent with Prof. Costello's view that infection is primarily responsible for high maternal and neonatal mortality among poor communities. **One of the most striking aspects of the presentation was the power of representing the outcome through strong, measurable indicators and the positive implications of this data for policy and practice.** In contrast, the two following presentations on initiatives that had run for comparable time periods, conveyed rich experiences and sighted important trends, but were not able to share data on outcomes indicators at this stage.
- Dr. Charulatha Banerjee of CINI ASHA presented their work in slum communities in 2 boroughs of Kolkata. CINI ASHA has implemented a model using **community health volunteers** at 1000 population, supervised by Swasthya Sevikas and overseen by a full-time CINI employee per 40,000 population. **The programme has translated CINI's lifecycle approach in an urban context, where they have capitalised on the presence of youth clubs and other community-based groups.** They also have a community-based host mother initiative, which functions as an informal crèche providing early childhood stimulation. The community health volunteers work closely with adolescents and eligible couples (ELCOs), using tools such as the ELCO map and register to improve and track the nutrition, family life and health seeking behaviour at the individual and household level. In the process, the programme works with the KMC, has had to cultivate ties with local political leaders, and has also set up a private medical practitioners' network. CINI faces two major challenges: **(1) Ensuring co-ordination and convergence between the community health volunteers and the government's field level workers; and (2) Sustaining the motivation of the community health volunteers without remunerating their services with a salary.** This last point initiated a heated

discussion on the **ethics of community health workers/volunteers**, a discussion with a long history that needs to be addressed especially urgently in the context of **RCH – II and the introduction of the link worker concept into government programming.**

- Dr. Siddharth Agarwal of EHP/USAID presented the experience of a participatory health vulnerabilities assessment implemented in Indore. The programme in Indore was implemented through **community-based organisations (CBOs)**, which were in partnership with, but were not paid by NGOs. The other model that has evolved is a ward co-ordination model. **In both models, the emphasis has been on slum-level institutional and individual capacities for problem analysis, strategy development and implementation. This, in Dr. Agarwal's view, was the best way to ensure ownership and sustainability.** The programme development process consisted of four main stages: (1) situation analysis; (2) vulnerability assessment and mapping of slums; (3) stakeholder consultations (individual and group) and; (4) proposal development process & NGO contracts. The approach of this programme has been to identify and target the most underserved slums in Indore. Starting with a list of 438 official slums, the project, in consultation with communities, evolved vulnerability and classification criteria and mapped all slums, including an attempt to locate hidden pockets. In the process, a total of 545 slums were identified, of which 157 were classified as the most underserved. **In this experience, it was the slum communities who were best able to identify pockets of greatest vulnerability,** while there were also physical markers, such as the *absence* of Anganwadi Centres (it was a common observation, that urban ICDS centres tend to be located among relatively better off and well serviced settlements. **These 'unofficial' slums, commonly comprising the most vulnerable individuals and communities, raise a very complicated issue: on the one hand, the government cannot disown them entirely, while on the other, because they remain 'unofficial' and therefore unrecognised, the state cannot channelise resources to provide them with the necessary basic services.** The Indore Programme faces two continuing challenges (1) working effectively with the private sector (unorganised providers, corporate sector) and (2) enhancing the role and capacity of Urban Local Bodies for improving health and sanitation services.
- The following important points were raised during the discussion:
  - Analysing information along with communities and stakeholders can lead to effectively establishing health as a priority issue.
  - Vulnerability assessments are crucial in urban slum contexts. Through such a process, a vast slum complex such as Dharavi can be understood in terms of varying health vulnerabilities and different levels of service provision and outreach.
  - It is difficult to establish any level of trust in slum communities due to high levels of suspicion. On the other hand, Dr. Fernandez pointed out that there is often greater openness to new ideas and practices in urban communities than in rural contexts. The proliferation of information providers in urban areas, however, may also mean that messages are harder to sustain against multiple influences. Domestic workers, for instance, tend to be influenced by their middle or upper class employers. In another point of view, migrants tend to be flexible with regards to economic opportunity but often express their social identity through a strong assertion of cultural practices from their place of

origin. In these cases, introducing new and different attitudes and practices may be seen as challenging cultural identity. Clearly, diverse urban communities need to be understood within their individual social, cultural and economic contexts.

- Qudsiya Contractor spoke in the session on research about a CEHAT research study on the impact of **slum resettlement on health, education and social life of communities**. As a result of the resettlement process, especially the move from horizontal to vertical housing structures, community interactions and health and education services have suffered. In addition to daily inconveniences such as carrying water up many stairs, service providers have reported to adopt an attitude that the multi-level building is a sign of economic improvement and therefore do not continue outreach services. **The orientation of the health system in the context of slum resettlement needs to be analysed.**
- **This session raised some important issues for SNEHA, IPU and SIG to grapple with in designing the community mobilisation project.** A health vulnerability assessment along the lines of the EHP process in Indore is likely to significantly improve the impact of the other health systems oriented projects as well, especially at the health post and community outreach levels. The project will also need to consider the implementation location: should it expand to M-East as well as G-North Ward, where the slums are not as settled or as well serviced as Dharavi? IPU is keen to take the project to M-East, whereas the SNEHA team are less sure about such a move away from their field area. We would also need to better understand the range of slum-level CBOs and their role in the health intervention.

### **3. Designing and Conducting Research in Urban Settings**

- One of the major issues repeatedly raised during this Workshop was the need to identify, assess and serve the most vulnerable communities in urban contexts, especially those that live in hidden pockets and 'unofficial' slums. **There is a significant gap in the health data available for urban slums.** As Neha Madhiwala of CEHAT and Sahyog mentioned, **one important step would be to de-link surveillance data from the monitoring function of field level workers, as this severely compromises the reach and reporting of health indicators of the poorest.** Sahyog has conducted basic health 'survey's using a team of school children to build a health profile for a newly resettled and unserved slum population. Neha advocated **experimenting with such alternative, community-based data collection exercises to gather more reflective information.** In a conversation following the Workshop, Dr. Siddharth Agarwal mentioned that EHP is planning to engage in a discussion to **improve the quality of urban data collected through NFHS-3**, which will begin data collection next year. **ECH needs to undertake a review and analysis of health data on the urban poor** and continue the discussion with EHP on their engagement with NFHS. In addition, it would be useful to better understand CEHAT's data collection methodologies.
- Prof. Costello noted that **RCTs have a strong value when there is a policy case to be made** and cautioned against always assuming that common sense works, citing the example of common medical practice that used to advocate seven days bed rest after pregnancy. When an intervention is well proven, but not practiced, however, as is often the case (frequent number of antenatal check-ups for

example) then there is no need for a trial, but other policy strategies need to be developed. **RCTs in an urban context will be difficult to conduct due to the contamination factor.** Dr. Masee Bateman also added that **quasi-experimental designs** could be good value for money in the production of useful information.

- Dr. Geeta Sodhi presented Swaasthya's approach of community-centred research and discussed the ways in which **community's can be involved in developing appropriate indicators.** For instance, the community rejected a proposed indicator – unmarried girls who had had sex – on the grounds that this information would not be truthfully revealed. Swaasthya's experience demonstrates the potential to use strong qualitative methodologies and innovative indicators – such as 'self-determination' – to track community level changes. There was more debate, however, on the viability of collecting good quality quantitative data through community based interventions. This is specifically the case if one attempts to track outcomes in terms of birth weight, where it may be necessary to develop strong proximate indicators. **Dr. Masee Bateman, however, stated that certain critical indicators, such as anemia and he added low birth weight, should be monitored, even if they increase the costs and resource inputs to the research study.**
- **Is there a trade-off between more effective interventions and those that reach the poorest?** Prof. Costello made the point that community-based interventions may often have less of a measurable impact, but are more likely to serve the poorest sections of the population. In his concluding remarks, he said that it is unethical to do bad research but it is also unethical not to do research.