Sustainability and Healthcare

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The UNICEF defines sustainability and Health care as the ability of the system to produce benefits valued sufficiently by users and stakeholders to ensure resources to continue activities with long term benefits.

India's urban public health system faces the challenge of providing quality health care services to a growing urban poor population, many of whom live in informal settlements[3]. Urban public health systems are structured in a pyramid fashion. Care during pregnancy is provided through a multi-tiered system ranging from primary health centers to tertiary/super-specialty hospitals and some or all levels of care may be available in an urban public health system. Despite the supposed proximity of the urban poor to health facilities, they generally have little access to affordable quality care due to the inadequacy of the urban public health delivery system[3,4]. Poor service provision at lower levels of care and a weak referral system results in overload of tertiary institutions and underutilization of lower levels of care. Substantial reductions in maternal mortality and severe morbidity cannot be achieved without effective referral systems for complicated cases[5].

Ideally sustainable health care should include both- a high quality of public and private health system and facilities & systems and structures to prevent, promote and treat diseases. In order to ensure this, there is a need to plan and implement public health structures for clean drinking water, sanitation, and environment as well as high quality of curative health systems that provide universal health to all its citizens. This necessitates political, financial, social, technical and managerial sustainability. This is a dream that Indians should

dream and help deliver. At an individual level, health can be sustainable with behavior change i.e. by eating healthy and living healthy.

The presentation I make today is to share our experiences as to how an NGO, can plan sustainability by working with existing public health systems and vulnerable communities to improve the quality of health care.

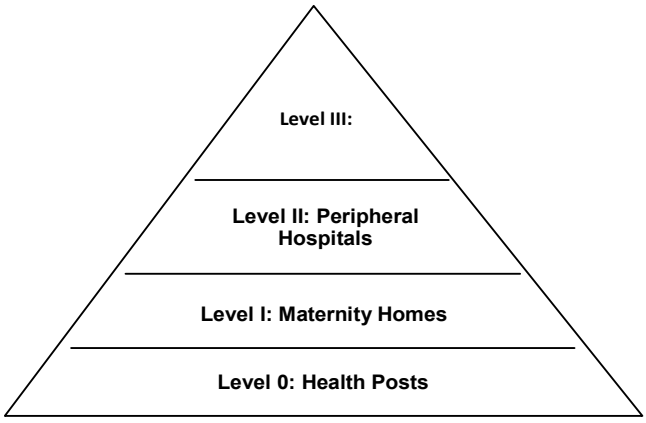
SNEHA (Society for Nutrition, Education and Health care) is an NGO founded in 1999. It was founded by a group of neonatologists from Sion hospital, who had already experienced a very successful project on the Baby friendly Hospital Initiative, wherein we worked with the UNICEF and the Government to ensure sustainable practices and changes in the system to promote breastfeeding.

As an NGO, we plan sustainability before initiating the project and partner with the health system right at the planning stage. Behavior change at the level of the community is also necessary to ensure sustainability, hence we work with the vulnerable communities that access the public health care system as well. SNEHA works on a **life cycle approach** which includes *Maternal and Neonatal Health, Child Health and Nutrition* and *Adolescent Health* and *Gender equity and Violence against women and children* across the life cycle. I will be describing briefly one of our programs on **Maternal and Neonatal Health** and the steps taken to ensure cooperation and sustainability.

The overall Maternal Mortality Ratio in developing regions was estimated to be roughly 20 times higher than that of developed regions in 2015, with developing regions accounting for approximately 99% of the estimated global maternal deaths[1]. Nearly half of all maternal deaths in developing countries occur during labor or delivery, or in the immediate postpartum period[2]

The MCGM is responsible for the health of the city and has a good health infrastructure compared to most cities in the country. At the ground level there are a total of 176 health posts mostly in the more vulnerable places that are responsible for preventive and promotive health. There are hospitals at 3 levels - **Level 1, maternity homes** that have facilities for delivery, **Level 2 Peripheral hospitals** that offer specialty services and **Level3 Medical Colleges and Hospitals** that offer superspecialty services.

The different levels of care in Mumbai:



The first objective of our program was to improve quality of care for maternal and neonatal health by initiating maternal and neonatal clinics at the health posts situated within easy access to the slums and institute a **Referral system**in the health facilities where mothers would be able to access the right institute depending on whether she had a normal or a high risk pregnancy. This would help reduce maternal & neonatal mortality and morbidity. The second objective was to **work with communities** to bring about a change in behavior that they would access health care at the right time both in the antenatal, natal and postnatal period to ensure a healthy pregnancy and a safe delivery. The third objective was to create **communication between communities and public health facilities.**

Methodology:

We used a participatory approach and started by calling for a stakeholder meeting which included administrators, clinicians, doctors and nurses. We used the AI approach where they identified their strengths and formed action groups to address the various processes that had to be dealt with. A total of 5 action groups for standardization were formed which included- clinical services, facility up gradation, administrative protocols, training and I.E.C and Nurses group. These groups met on a monthly basis. Protocols were formed by the stakeholders. Sneha played the role of the facilitator and recorded and circulated the minutes and organized the meetings.

After the protocols were finalized training was conducted across the facilities by the staff of the MCGM and the members of academic bodies.

Upgradation of Health Posts

The lowest rung of the health facilities constitutes Health Posts. There are 126 of them located within the slums or in close proximity. These were used for preventive and promotive services like immunization. Sneha facilitated the initiation of antenatal and postnatal services in these health posts where mothers could have easy and close access to these services.

Referral System: SNEHA has been working with the systems since 2003. Initially we covered the municipal corporation of greater Mumbai and have now expanded to cover the adjacent 6 muncipal corporations that refer their high risk cases to Mumbai.Over these years, a referral system has been set up across 7 municipal corporations.

We have been working in vulnerable slums across the cities simultaneously. This has been possible only because of the continual cooperation of the management of the health systems and the trust and enthusiasm of the communities we work with.

The following table gives the number of cities covered and the lives impacted. These services are run by the public health systems and hence sustainability is ensured.

Community Mobilization Pregnant women and lactating mothers among 43,000 underserved households	**Strengthening Primary Care** 95 Health Posts(UPHC)	**Referral Strengthening** 36 Maternity Homes, 20 Peripheral Hospitals, 5 Tertiary Hospitals

Imapct made:

- **52,000+** High-risk pregnant women assisted
- **42,000+** ANC for Pregnant women
- **1,642** Public health front line workers trained
- **3,000** Clinical staff trained
- **90%** Exclusive breastfeeding rates among babies under 6 months

Work with Communities: Working with communities especially in our slums is also not easy. Families in a slum are non-homogenous, coming from different states with different cultural and social background. These vulnerable families also have different priorities which include mere survival, jobs, housing and education of their children. Health facilities are used only for curative purposes when they or their children are ill. Hence various mechanisms are needed to change behavior towards healthcare which also need perseverance, patience and innovations.

The different mechanisms we have used for successful community engagement are:

1. Microplanning before the intervention starts
2. Community PLA

3. Individual home visits
4. Behavior change communication
5. Regular community groups meetings to discuss health issues
6. Use pictures and stories for these discussions
7. Campaigns and many other community processes which include involving in their specific celebrations.
8. Mobilization of volunteers

Connecting the communities to the Public Health Systems: The question often asked to us is, how we work with the public health system. We believed that the MCGM was open to progress and quality in services . Our principles have been:

1. Believe in the system
2. Build trust
3. Participatory learning approach
4. Use of Appreciative Inquiry
5. Regular reporting and feedback
6. Perseverance and Patience

In conclusion we must remember that-

Coming together is a beginning
Working together is success
Sustaining the work is a challenge

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