



DISSEMINATING
URBAN
HEALTH
models for
SCALING

Glossary of Terms

AFHC	Adolescent Friendly Health Clinic
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
CHN	Child Health and Nutrition
EHSAS	Empowerment, Health and Sexuality of Adolescents
ICDS	Integrated Child Development Services
IFA	Iron and Folic Acid
IMPRESS	Impactful Policy Research in Social Science
JPAL	Abdul Latif Jameel Poverty Action Lab
M&E	Monitoring and Evaluation
MAS	<i>Mahila Aarogya Samiti</i>
MCGM	Municipal Corporation of Greater Mumbai
MHRD	Ministry of Human Resource Development
MMR	Maternal Mortality Rate
MNH	Maternal and Newborn Health
MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHM	National Health Mission
NSS	National Sample Survey
PHC	Public Health Centre
PVWC	Prevention of Violence against Women and Children
RCT	Randomised Control Trial
RKSK	<i>Rashtriya Kishor Swasthya Karyakram</i> / National Adolescent Health Programme
SDG	Sustainable Development Goals
SNEHA	Society for Nutrition, Education and Health Action
UCL	University College London
ULB	Urban Local Body
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WCD	Women and Child Development

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SNEHA's Programmatic Approaches

The centrality of health outcomes to India's overall development cannot be over stated as poor health is not only a consequence of but also a major cause for persisting inter-generational poverty. SNEHA's interventions at the critical junctures of adolescence, pregnancy, child birth, post-partum and early childhood are keys to ending this vicious cycle and target the most vulnerable members within society. These interventions that strike at the intersection of gender and public health are geared towards producing not only healthier, but also more prosperous and equitable communities.

A strong belief in the reach and capabilities of the public health system has led SNEHA to 'partner with systems' rather than replicate delivery channels. Similarly, the parallel need to work with communities in order to address environmental and social issues while instilling health-seeking behaviour has resulted in SNEHA's practice of 'community engagement'. Further, partnering simultaneously with communities and systems ensures 'sustainability' as does SNEHA's meticulous gathering of data and its publication of research. 'Building evidence' additionally allows the dissemination, replication and subsequent scaling of successful Urban Health Models.

CHALLENGES FACED WITHIN A COMPLEX URBAN LANDSCAPE

The aforementioned strategies have come to represent SNEHA's unique response to issues commonly faced while implementing programmes in a complex socio-political landscape of informal settlements in Mumbai. The approaches are simultaneously intuitive, cutting edge and holistic and are a result of years of experience and creative problem solving in the field.

Challenges Within Communities:

- Widely held **myths and misconceptions** surrounding themes such as sexual and reproductive health and family planning
- **Normalisation** of problems such as malnutrition and domestic violence
- **Gender norms** restricting **mobility** and affecting access to health facilities
- **Lack of awareness** and **sensitivity**, particularly towards mental health issues, resulting in low detection as well as inadequate demand for services
- Challenges of **migration** making it difficult to work with families continuously

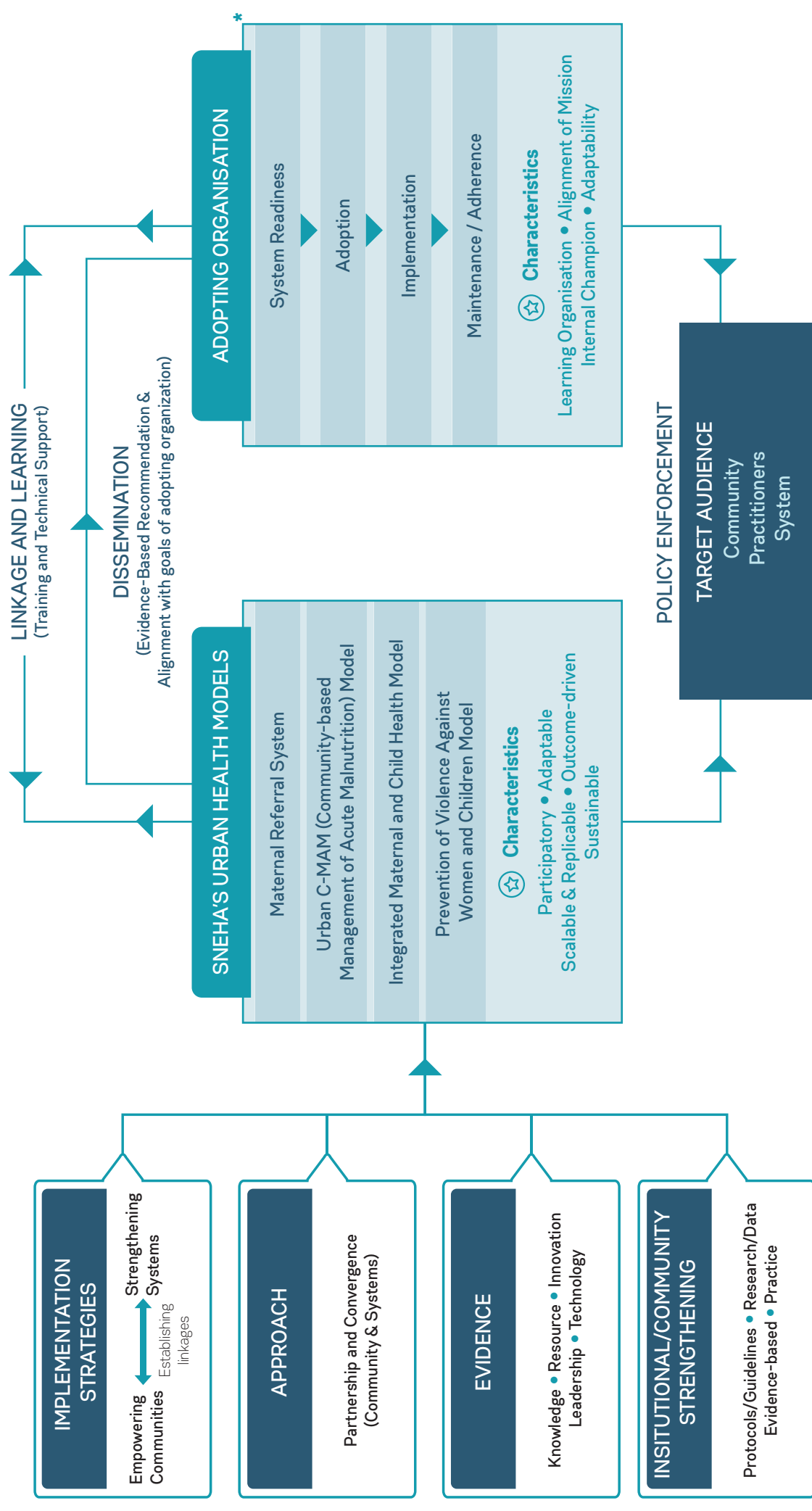
Challenges within Health Systems:

- Piece-meal or **incomplete implementation** of all the mandated provisions of policies such as the ICDS and the RKSK
- Challenges with internal systems and **basic protocols** such as referral networks as well as criteria for the detection and risk-based classification of specific health conditions such as malnutrition
- **Resource constraints** and division of work into **compartments** due to parallel state and national health systems
- **Limited response of the health systems** towards specific population groups leading to inaction due to widely held notions such as domestic violence being a 'private family matter'
- **Inadequate training** and capacity building of Front-line health workers

Our four key programme areas are **Child Health and Nutrition, Maternal and Newborn Health, Empowerment Health and Sexuality of Adolescents** and **Prevention of Violence against Women and Children**. Each of SNEHA's programmes employ a slightly different mix of its core strategies to meet their objectives. These strategies are **partnering with systems, community engagement, evidence building** and **moving towards sustainability** which will be discussed in depth during the 'Dissemination of urban health models for scaling'.



Conceptual framework: Scaling Urban Health Models



Modifiable Outer Context: Network, Policies, Funding

Unmodifiable Outer Context: Socio-Political, Economic Condition

*Diffusion of Innovation theory: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2957672/>

Partnering with Systems



India is a welfare state in which health is considered a universal right regardless of socio-economic status. Subsequently, the Indian state remains the largest healthcare provider constituting 60% of all hospital beds across the country¹. Engaging with the public health system is therefore a necessity for any organisation that wishes to **scale its impact** and reach India's most vulnerable communities. SNEHA believes in the ability of the public health system to deliver quality service to the poor with enhanced efforts to **build capacity** and **internal systems** as well as **engage more deeply with communities**. It therefore utilises these pathways to enhance public health delivery instead of taking the service delivery route.

The importance of partnerships for development has been stressed under Goal 17 of the SDGs² and the definition of partnerships that most appeals to SNEHA is as follows – “A partnership entails cross-sector collaboration in which organisations work together in a **transparent, equitable and mutually beneficial way towards a sustainable goal** and where those defined as partners agree to commit resources and share the risks as well as the benefits associated with the partnership³.” The values of **transparency, equity, mutual benefit** and **sustainability** are therefore foundational values that inform SNEHA's partnerships with systems.

PARTNERING WITH SYSTEMS IN PRACTICE

At SNEHA, we believe in forging strong bonds with different **municipal, state and central government** systems to maximise our impact and sustain our work effectively. We work closely with a range of stakeholders across government systems – from public health leaders and service providers to police officers, institutions and community-level workers.

PARTNERING FOR CONVERGENCE

Both the health and WCD departments are closely engaged in the fight against malnutrition. The identification and referral of malnourished children is a responsibility of ASHAs (appointed under the NHM) as well as ICDS *sevikas* (appointed by the WCD). Logically, these systems should be seamlessly integrated, however in practice they function separately. SNEHA's partnerships with ICDS and the public health department has fostered convergence and cross-referrals while its meticulously planned community meetings bring together health workers from across these structures on a regular basis to facilitate coordinated community action towards addressing malnutrition amongst children.

Amongst children under 5 years of age in urban Maharashtra
29.3% are stunted,
24.9% are wasted and
30.7% are underweight⁴



PARTNERING FOR COMMUNITY OUTREACH

SNEHA's most significant government partnership till date has been its role of 'Mother NGO' to facilitate the setting up of **Mahila Aarogya Samitis** across **95 Urban Local Bodies** in partnership with **NHM, Maharashtra**.

This effort covered **27 municipal corporations, 64 councils, four cantonment boards** in which **1600 NGO and ULB trainers** and **3600 ASHAs** were trained. In the end, **8075 MAS** were formed and **5733 bank accounts** opened. MAS are groups of 8-12 women formed for every 100 households.

They are intended to promote community health engagement at all levels – planning, implementation and monitoring. They are also trained to provide

information about government health services and raise awareness on all health and allied themes within their communities while referring people to government health services.

Not only did SNEHA partner to form and train these *samitis*, it also helped the government recruit **32 other partner NGOs** under the mission and facilitated MoUs between them and the NHM, Maharashtra.

POLICY OPPORTUNITIES

While the government is a vehicle whereby **scale** may be achieved, civil society partners support with **good practices** as well as **innovation**. Non-profit public private partnerships provide an opportunity to **simultaneously tackle supply-side and demand-side gaps** and if effective interventions become ‘embedded’⁵ within the institutional structure of the state, they may achieve **long-term sustainability**. Partnerships of this nature may take multiple forms such as **technical advice, service provision** for **capacity building** and **contractual outsourcing of service delivery**.

1. Commissioning non-profit partnerships:

- State government could **officially constitute teams** of development professionals to focus on **facilitating government-NGO partnerships** for collaboration across the policy continuum i.e. policy planning, implementation and monitoring
- These teams preferably could be housed within ministries that have socially oriented programmes such as the **WCD** and **Public Health department**
- Example of the **Delhi Dialogue Commission**⁶ that functions simultaneously as a policy think-tank and programme unit to source ideas on specific thematic areas from civil society, facilitate **structured partnerships, organise consultations** and constitute **multi-stakeholder taskforces**

2. Increased partnerships with NGOs for policy implementation:

- Example of **one-stop centre for women and children** agreed to be jointly run by the state WCD department and SNEHA - Government to provide **basic infrastructure** such as shelters and police and medical services while SNEHA will conduct **community outreach**, carry out **BCC** and work on **re-integration** of victims of violence and sexual abuse into communities
- The municipal public health department, municipal medical college, along with SNEHA to facilitate establishment of **10 AHFCs** mandated under the RKSK across primary, secondary and tertiary health facilities:
 - Infrastructure and human resources to be provided by the health department and medical colleges and SNEHA will provide **capacity building** and **community outreach** support including the setting up of **peer groups**
 - This partnership model could **scale** to set up AFHCs at PHCs and district hospitals across the state
 - A **protocol** is suggested to be jointly created by municipal medical colleges, the public health department and SNEHA, along with representatives from the primary, secondary and tertiary level health facilities to specify provision and monitoring of services at AFHCs as well as selection criteria, training, incentivisation and evaluation of Peer Educators and their groups (based on the RKSK guidelines)
- SNEHA’s **referral system** for maternal and new born health has already been institutionalised and adopted successfully by **7 municipal corporations** in and around Mumbai city. This model must be scaled not only at the state level but also at the national level

Evidence Building



Traditionally, **theory and practice** have always been placed on either side of a pedagogical chasm, prompting numerous dialogues on how best to align these two important yet distinct components of learning. SNEHA has deliberately chosen not to confine itself to either one of these sides and successfully straddles both. The consistent collection and analysis of **qualitative and quantitative data** provides valuable insights as it covers output as well as **outcome level data** to establish not just correlation but also **causation**. This is critical for internal programme **assessment and planning** and to **share learnings** with partners.

Over the years, SNEHA has published more than **50 articles** in leading international peer-reviewed journals, which has given our work the widest possible reach. SNEHA utilises cutting-edge research methodologies such as **Randomised Control Trials** and has had over a decade-long association with the **University College London** on three such studies with more in the pipeline. Our willingness to engage in self-evaluation stems from our values of integrity and transparency and a genuine willingness to **innovate and learn** as we seek to deliver the best possible results while making prudent use of our resources. We believe that our approach, which is both results oriented and cost conscious, holds learnings for all including the public health system.

In addition to producing evidence for external dissemination, we are equally committed to our **internal M&E process**. Over the past year alone, **50,000 households** were covered, which generated **290 data points** on the health status of women and children in our communities. In addition to the real-time tracking, referral and follow-ups that this data makes possible, it is also used for **evaluation of intervention processes and performance management**.

EVIDENCE BUILDING IN PRACTICE

Using Data for Responsive Programming:

In the year 2018, about 40% of adolescents covered under the EHSAS programme were found to be anaemic in the baseline. The national average for the same is 54%.⁷ In the mid-line test conducted three months post treatment through IFA and nutritional supplementation; the reduction in anaemia was found to be merely by 4%. This alerted the programme to the need for strengthening behaviour change communication with repeated home visits to ensure treatment compliance and iron-rich diets. Creative games were also introduced to teach adolescents the components and importance of a balanced diet. In the following year, we saw a marked improvement with **23% reduction in the number of anaemic adolescents**.



REFERRAL SYSTEM

While there may be a concentration of health infrastructure in India's urban areas, public health systems in large metropolitan cities are often challenged by inequitable spatial distribution of health facilities, unsuitable distances from urban informal settlements, and weak referral systems with poorly-utilised primary care institutions and overloaded tertiary hospitals.⁸

The public health department provides maternity care through a network of maternity homes (level 1), a mother and child hospital (level 2), general hospitals (level 2) and tertiary medical colleges/hospitals (level 3). The purpose of SNEHA's maternal referral system is to initiate referral processes and strengthen communication channels among the facilities and to help mothers receive the most appropriate and timely care. This is done by collecting data on referred women and creating a platform for providers and administrators of all linked facilities to discuss referral data, issues and solutions in a participatory manner. This system was co-created with the MCGM who has formally institutionalised it through an order. It has also been scaled to **six more municipal corporations** and has caught the attention of the **NHM** who has requested SNEHA's model for its LaQshya programme that seeks to improve the quality of care in labour rooms.

A recent UNICEF report concluded that
80% adolescents
 suffer from 'hidden hunger'

i.e. deficiency of micro-nutrients like iron & vitamins.

The same study also shows that less than 10% adolescents reported daily consumption of fruits and eggs while over 25% reported no consumption of leafy vegetables even once a week.⁹

The tripling of institutional deliveries through the public health system from 18% in 2005 to 52% in 2016 (including private deliveries this number is 79%) has contributed to better maternal health outcomes.¹⁰

POLICY OPPORTUNITIES

1. Capacity Building and Civil Society Partnerships

- The government is already collecting an enormous amount of **output level data** from its delivery of services as well as **household data** through the NSS. Opportunity to partner with research organisations for producing **actionable insights** from this data
- Such analysis may initially be outsourced but over time such partnerships could be re-oriented to **build capacity within government systems** for data analysis and planning
- Can easily be integrated under initiatives such as the **Digital India Mission** and the **Smart Cities Mission**

2. Investing in data collection and management

- Apart from making government data freely available, it is suggested for the government to invest in linking data from different datasets or data sources in order to get complete information about any issue and to make well-informed decisions
- **NFHS surveys** could be conducted **more frequently** to assess whether policy targets are being met
- Strengthen provision of **basic infrastructure** such as desktops at health posts and PHCs that can be used exclusively for data entry and reports

3. Policy Innovation Lab

The Indian government has taken positive steps to introduce research methodologies into its programme planning process with the increased use of RCTs.

- Example of the **IMPRESS scheme** under the **MHRD** that has assigned INR 414 crore to support **social science research** with policy implications.¹¹ Government may consider setting up an **innovations lab** in partnership with researchers to ensure that IMPRESS funds are allotted systematically and that insights from these studies are utilised
- Example of **The MineduLab** constituted through the joint efforts of the government of Peru and JPAL to improve education outcomes.¹² Such a lab would conduct **audits of policies**, identify problem areas, **crowdsource solutions** through civil society engagement, **design pilots** and then assess them for their efficacy
- Transformation of **policy-making into a science**¹³ to produce objective solutions and introduce **transparency and accountability** in the policy planning process

Community Engagement



Health inequalities have a significant correlation with socio-economic inequalities, indicating that health outcomes result from a complex interplay between inherent health and genetic factors as well as environmental factors (Agency for Toxic Substances and Disease Registry, 2015)¹⁴. This is particularly true of some of SNEHA's focus areas such as nutrition, maternal and new born health and mental health where environmental factors like diet, stress, sanitation and access to primary health services have a significant impact. It is with the conviction that environmental factors can be alleviated through increased awareness, health seeking behaviour, community action and the adoption of prudent habits that SNEHA engages with its communities.

SNEHA's community partnership efforts have highlighted two instances in which such engagement can go a long way: (1) where preventive measures assume prime importance such as in the case of domestic violence and (2) in instances where communities normalise or neglect problems such as malnutrition and mental health, it results in inadequate demand. Addressing these conditions requires a challenge to entrenched beliefs and behaviours, which necessitates earnest community engagement to re-imagine social realities and co-create solutions, which is far more effective and durable than employing a prescriptive top-down approach.

Furthermore, SNEHA views its programme participants not as mere recipients of aid but as powerful change-agents with the inherent capabilities to uplift themselves and their communities with a small amount of guidance and support. One of the key learnings from engaging with communities has been that it creates ownership, which not only results in improved outcome indicators but also forges a path towards sustainability.

PARTNERING WITH COMMUNITIES IN PRACTICE

Prevention of Violence Against Women and Children (PVWC):

SNEHA's PVWC programme has created a cadre of 500 volunteers who identify and provide first psychological aid to the survivor of violence. The volunteers intervene and refer the survivors to services such as SNEHA's counselling centres, which provide crisis counselling and psychosocial interventions, and screens women for mental health conditions. Secondary interventions are provided through counselling, family intervention, enlisting a police complaint, medical care and mental health screening. Tertiary interventions minimise the impact of violence and restore safety, mental health and well-being through an extended response. Specialist services of clinical psychologists and lawyers are crucial in carrying out tertiary interventions. The mental health assessment carried out is followed by a long-term plan for the

49% women

surveyed through the NHFS: 15-16

felt that domestic violence

was justified (News and News, 2019)

in cases of 'disobedience' reflecting a normalisation
of intimate-partner violence.

22% Indian women

had survived physical violence, another

22% had suffered psychological abuse,

7% sexual abuse and

30% multiple forms of violence

(Daruwalla et al., 2019)¹⁵

survivor to undergo therapy for mental health restoration and well-being. Legal intervention is planned based on the survivor's need and her situation. In extreme cases of mental health conditions, survivors are referred for psychiatric treatment. Our theory of change focuses on participatory community engagement with multiple stakeholders to encourage critical thinking about Violence Against Women and Girls (VAWG) and its consequences, promote equitable gender norms, and reduce tolerance of VAWG (Daruwalla et al., 2019)¹⁶.

PARTNERING WITH COMMUNITY GATEKEEPERS

The biggest challenges to SNEHA's work on immunisation and nutrition are poor health practices and widespread myths and misconceptions. Addressing these gaps is a key to moving the needle on health indicators of children and adolescents. Sometimes the most efficient way to get through to communities is through its gatekeepers who have a significant influence on target beneficiaries. We realised that one of the most powerful ways to influence people's behaviours would be through messaging from religious leaders. SNEHA therefore shared its baseline results with *Maulanas* from the mosques in communities with a sizeable Muslim population and sought their buy-in for addressing community health through announcements in meetings and *azaans*. This proved to be an effective way of engaging with the community as was evidenced by a significant increase in immunisation rates.



Maternal education is an important factor

as children belonging to mothers with secondary or higher education have high coverage (67%) than those without formal education (52%) (Rudra, 2019)¹⁷

POLICY OPPORTUNITIES

1. Partnering with NGOs for Community Engagement:

Several existing government schemes such as **ICDS** (under the WCD) and **RKSK** (under the MoHFW) make provisions for community engagement. This feature is found most prominently in schemes that involve **targeted outreach, discussion of sensitive topics and changes in attitudes and behaviours**. In most of these schemes however, the government has struggled to forge close community partnerships. This could in part be due to overburdened frontline workers who don't receive adequate training or also because community engagement hasn't ever been developed as a core competence of the administration.

Possible solutions include:

- **Partnering with grass-roots NGOs with deep roots within communities.** Grass-roots NGOs can assist the government with outreach, behaviour change communication as well as the formation of community groups
- In cases where community groups have to be constituted, **NGOs could be tasked with identifying members, and training** them while facilitating convergence between frontline health workers working under different departments
- **Replication and scaling of Mahila Arogya Samitis** formed under the NHM in partnership with organisations like SNEHA for community based health monitoring
- **Each ULB could have a Managing Committee for Community Engagement** comprising NGO representatives who are tasked with providing technical support, training and monitoring

2. Provision of Discretionary Funds for Local Planning:

A number of community-based government programmes mandate the setting up of local committees. However, these groups lack any real power due to any formal control over the administration as well as a lack of resources with which to determine and act on local priorities. If such groups are to be activated, it is recommended that a **small discretionary sum be transferred to a bank account** set up for the registered entity. This would not only give it some power to **act on local priorities** but also make it an **officially recognised entity**.

Moving Towards Sustainability



At the very outset, the lack of a comprehensive and universally accepted **definition of sustainability has been a challenge** for implementers. At its core, sustainability refers to institutional and programmatic arrangements that seek to ensure **implementation over the long-term** and the ability to withstand a number of contingencies. 'Project sustainability is defined by many economists and international development agencies simply as the capacity of a project to continue to deliver its intended benefits over a long period of time.'¹⁸ The USAID definition on the other hand emphasises that 'a development programme is sustainable when it is able to deliver an appropriate level of benefits for an extended period of time after major financial, managerial and technical assistance from an external donor is terminated.'¹⁹

In SNEHA's view however, complete withdrawal of developmental organisations is undesirable. Instead, we believe that the role of the NGO could change over time such that certain aspects of its programmes are taken over by the community and/or the government and it is able to adopt a 'lighter-touch' approach.

Another difference in conceptualisation is that sustainability is viewed by some as a process and by others as an outcome. For SNEHA it is a bit of both but above all else, it is an operating principle more than a theoretical construct. Furthermore, it is an overarching principle that encompasses all of its programmes and is reflected in its implementation models.

SNEHA's operational view of sustainability takes two distinct forms:

1. COMMUNITY CAPACITY BUILDING



This focuses on the processes of building the problem-solving abilities of individuals and the larger community for the betterment of their health. The aim is to build ownership and shift the locus of health promotion to the community by using behaviour change communication approaches for long term sustainability.

2. THROUGH INSTITUTIONALISATION



This objective is realised through actively partnering with public health systems. The nature of these partnerships simultaneously builds capacity within different levels of public health officials and also sets up systems and protocols, the most successful of which are incorporated into the regular functioning of the government. E.g. CHN, PVWC and MNH referral protocols.

SUSTAINABILITY IN PRACTICE

Goodman and Steckler observed that 'sustainability is often a 'latent' concern in many health promotion programs, i.e. various constituencies may well wish the programme to continue but, in the absence of early and active planning, the conditions that would most enhance the prospects for sustainability in the long term are not created and sustainability does not occur.'²⁰ In stark contrast, SNEHA has affirmed its early commitment to sustainability by taking on systemic considerations of human, social, strategic, financial and organisational processes while implementing its healthcare interventions.

Two of SNEHA's programmes i.e. PVWC and CHN (Aahar) perfectly capture our sustainability approach:

SUSTAINABILITY FEATURES OF THE AAHAR PROGRAMME

In its early days, Aahar (SNEHA's flagship nutrition programme working with the ICDS scheme across 150 anganwadi) aimed to build capacity of anganwadi *sevikas* and its communities but did so through active involvement of its community organisers who were directly involved in programme implementation. **Phase II of the Aahar programme** however, has taken a different approach and has shifted its focus to **hand-holding and capacity building**. It was able to shift its approach by gradually building capacity within the ICDS system to deliver six of the mandated services on its own. This was achieved through technical trainings to anganwadi workers, provision of basic materials like growth charts and imbibing knowledge about nutrition. In addition, trainings also encompassed soft skills like communications and leadership.

9.6% children
between 6-23 months of age
are fed a minimum
acceptable diet in India²¹

.....

68.2% children
(706,000 deaths)
under five died of malnutrition in 2017²²

In Phase II Aahar also took on community based sustainability measures by recruiting **744 women** and **249 men - all volunteers** who were extensively trained. By **simultaneously working on the demand and supply side** through institutional sustainability and community capacity building approaches, SNEHA ensured the continuation of its positive outcomes despite a change in strategy. Within the period 2016-19, a **29% decline in wasting** was achieved. This was accompanied by a **158% increase in weighing of 0-2 year olds** and an **improvement in the uptake of ICDS services by 205%**.

SUSTAINABILITY MEASURES IN PVWC PROGRAMME

SNEHA's PVWC programme works with a convergence approach to **prevent and respond to gender-based violence in urban areas** through convergence of a multi-stranded approach by: educating the community to recognise and acknowledge violence, creating an enabling environment for demand from the community to ask for measures towards prevention of violence, empowering communities to address and prevent gender based violence; providing services that enhance the mental health and well-being and secure legal rights of those affected by gender-based violence; and supporting police and health systems to respond to the needs of women and children facing violence. Our engagement with community, police and the hospital system resulted in **SNEHA being selected as an implementing agency for the One Stop Centre at KEM Hospital, Mumbai (2019)**.

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