Maternal Newborn Health and the Urban Poor: A Global Scoping

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AVERTING MATERNAL DEATH AND DISABILITY (AMDD)

Urbanization

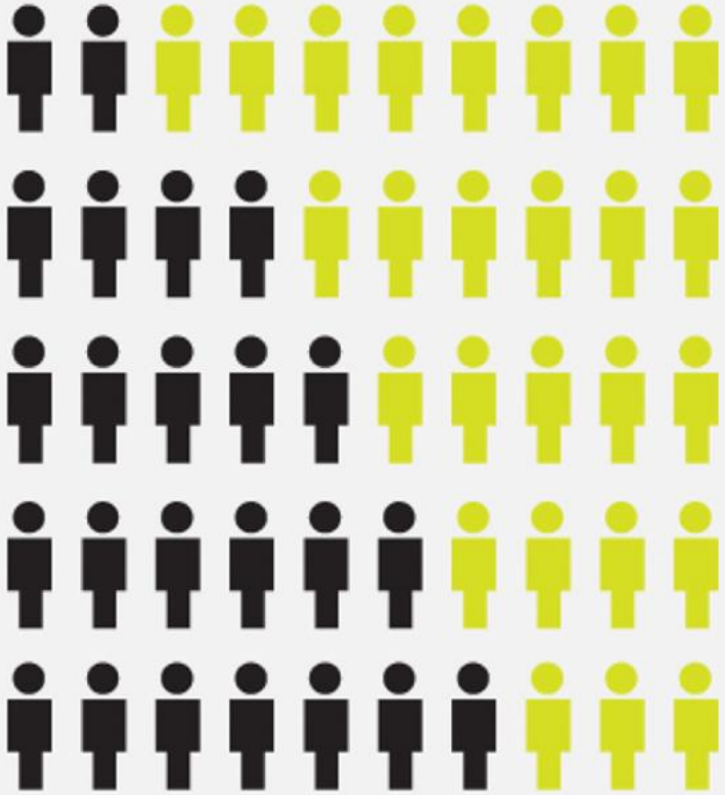
1900 | 2 out of every 10 people lived in an urban area

1990 | 4 out of every 10 people lived in an urban area

2010 | 5 out of every 10 people lived in an urban area

2030 | 6 out of every 10 people will live in an urban area

2050 | 7 out of every 10 people will live in an urban area



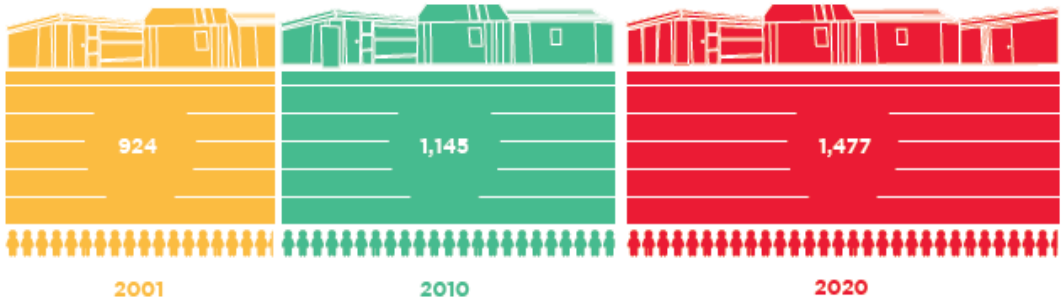
Defined by UN Habitat

Urban “slums”

- Globally, nearly 1 billion people live in slums
- In Africa, 61.7% of the urban population lives in slums
- In Asia, 30% of urban population lives in slums

(State of the World’s Cities Report 2012/2013)

PEOPLE LIVING IN SLUMS GLOBALLY



Slum population projections in millions (based on slum annual growth rate from 1990-2001)

source: UN Habitat

= 50,000,000 PEOPLE

WHAT IS A SLUM? A DWELLING WITH ONE OR MORE OF THE FOLLOWING:

UNSAFE WATER

LACK OF SANITATION

POOR HOUSING STRUCTURES

OVERCROWDING

LACK OF SECURE TENURE*

Sourced from UN Habitat

** Secure tenure is the ability to live in a place without fear of eviction.*


MULING THALA!!
TURO AGUILAR
PARA KAGAWAD

Informality

A situation in which the conditions of life are not "fixed and mapped according to any prescribed set of regulations or the law." *(Roy 2009)*

- ownership and use of assets such as land and housing,
- the terms and conditions of labor,
- the means to secure and protect wellbeing

MNH mental map is rural

Includes assumptions about:

- What people want for their lives
- How communities organize and function
- How behavior change happens
- How norm change happens
- How people access services
- The basis for people's rights and entitlements

Headline: The field is wide open

Despite growing recognition of its importance for future of the planet and of human health:

- Very little happening in urban MNH space
- No systematic effort to re-think MNH for cities
- The field is WIDE open for shaping priorities and approaches and for innovation

Questions of basic orientation

An strategy for urban MNH will have to ask and answer some fundamental questions:

- **Urbanization**: encourage or discourage?
- **Slums**: demolish or defend?
- **Informality**: regulate or build on “practical norms”
- Who’s got the **power** and how does it work?

Voices of the Poor

Urban poor are **invisible**, in many ways

- Informality (no legal recognition or regulation of many aspects of life – housing, employment, health services)
- Little voice in political processes, policymaking

What role should the urban poor themselves play in SAVE's strategy?

- Co-production of knowledge
- Social accountability
- Strengthen civil society

Objectives

- Review the literature & status of urban MNH
- Document successful and sustainable approaches
- Understand the influencing factors and gaps in MNH services in urban settings
- Identify key stakeholders and potential partners
- Provide recommendations and direction for future programming and resource investments targeting the urban poor

What's omitted from the scoping?

We did NOT

- Summarize data about urbanization generally
- Describe clinical interventions for newborns
- Model or estimate current coverage of interventions for urban poor or for slums.
- Determine whether there is a different pattern of causes of newborn death in urban poor or urban slums

Scope & Methodology

- Scope:
  - Global perspective with focus on 7 SNL countries
  - Urban poor: Focus on slums (per literature)*
  - MNH services
- Methodology
  - Literature review
  - 22 Key Informant Interviews (for global)
  - Case study in Bangladesh (Lit Review + 14 KIIs and 1 focus group discussion)

1. Glossary

The lack of uniform or consensus definitions of terms such as ‘urban’, ‘slum’, or ‘urban poor’ causes confusion in the literature, uncertainty in the data, misdiagnosis of problems and an inability to document trends or compare across different settings.

2. Demographics & Health Status: Diversity

- Generalizations concerning the men, women, and children who reside in slums should be made with extreme caution
- The heterogeneity of slum populations defies generalized conclusions or simplistic statements
- Within one slum, dwellers may differ on economic status, place of birth, language, religion, ethnicity, or length of residence in the current slum (all of which have MHN implications)

Movement

- Highly mobile populations – from rural to urban, between slums and from home to home within slums
- High turnover rates for programs
- Within this mobility – slum dwellers are highly mobile during the day

Health Status

- In many countries disaggregated data is ‘completely absent’
- Urban advantage is a myth:
  - Studies on MMR, NMR, Stillbirth rates show worse outcomes than urban averages, and at times worse than rural
- Epidemiologic transition: burden of NCDs is adding to the complexity of the slum population health challenges

3. Determinants of Coverage

- Availability:
  - Public Sector
    - There is no existing network or hierarchy of public sector health facilities to use as a platform for introducing or strengthening newborn interventions at community or primary care level.
  - Private For-Profit Sector
    - Fills the gap of the non-existent health system, often first point of contact for slum dwellers
  - NGO and non-Profit Sector
    - Often work in slums renting rooms or provide mobile clinics; several national gov’ts conflate the role of NGO service delivery with the public sector service provision

Accessibility

- Women's availability: women typically work long hours outside of the home, and many work 7 days per week
- Typical facility hours (8am-4pm) are not conducive to women's schedules/realities
- Extended hours is not necessarily a solution:
  - Women have families to take care of at night
  - Many slums are dangerous to walk through at night
  - Transport costs at night can double
  - Opportunity costs are too high to take time off wok

Care-Seeking

- Health care is still largely considered a luxury
- Factors leading to low facility delivery/care seeking are similar to rural – manifested differently:
  - Failure to recognize severity (messaging)
  - Disconnected referral system (private to public)
  - Crime within slums
  - Limited access to adequate cash (transport + informal fees)
  - Fear disrespectful treatment at facilities (low status)

4. Urban exposures & health determinants: Living Conditions

- Clean, safe water is not available in slums without payment (and often is still run through illegal pipes through feces and mud)
- Access to toilets is a luxury in many slums
  - In Clara Town, Liberia: 11 public toilets for 75,000 people *(UN Habitat Report 2014)*
- Waste management is often described as the most pressing issue for slum dwellers – no way to dispose of waste

Living conditions, cont.

- Air pollution in cities, caused by increases in ubiquitous outdoor pollutants due to urbanization, affect those in slums and informal settlements most *(Bruce et al., 2000)*
- Housing type and location: insecure physical structures and often on least desirable, polluted, dangerous land
- Crime: a study of 4 Dhaka slums found that 93% of respondents had been affected by crime and violence over the previous 12 months *(Rashid, 2011 + World Bank)*

Micro-dynamics of household and local community

- Social networks: friendships have a role in care seeking, but ‘friends’ are hard to make
- Limited or ‘different’ types of networks
- Intimate Partner Violence:
  - Described as ‘rampant’ by several informants
  - Insecurity of housing, insular/unconnected lifestyles, reliance on financial support, dangerous slum environment make it very hard for women to leave

Micro-dynamics of household and local community

- Power/Agency
  - Economic and political isolation + disconnect and limited sense of community prevent cohesion
  - Informal actors have tremendous power
- Trust
  - Inherent distrust of government, NGOs, and other perceived 'outsiders' within slums
- Role of municipal government
  - Municipal gov't usually responsible for slum health yet without the funding, technical capacity, bandwidth or incentive to do so

5. MNH Policy and Program Landscape:

- Very few countries have clearly stated urban health policies
- There are limited examples of ‘large’ urban MNH that can be replicated
- No clear donor emerged who would be able to integrate necessary cross-cutting issues to address urban MNH

6. Programmatic Approaches and Research Initiatives

In an effort to improve the MNH outcomes in slums, NGOs and research institutions have adapted several of the more typical 'rural model' approaches as well as trying some new interventions:

- Community health workers
- Women's groups
- Referral
- Financial models
- Community engagement
- Exclusive breastfeeding

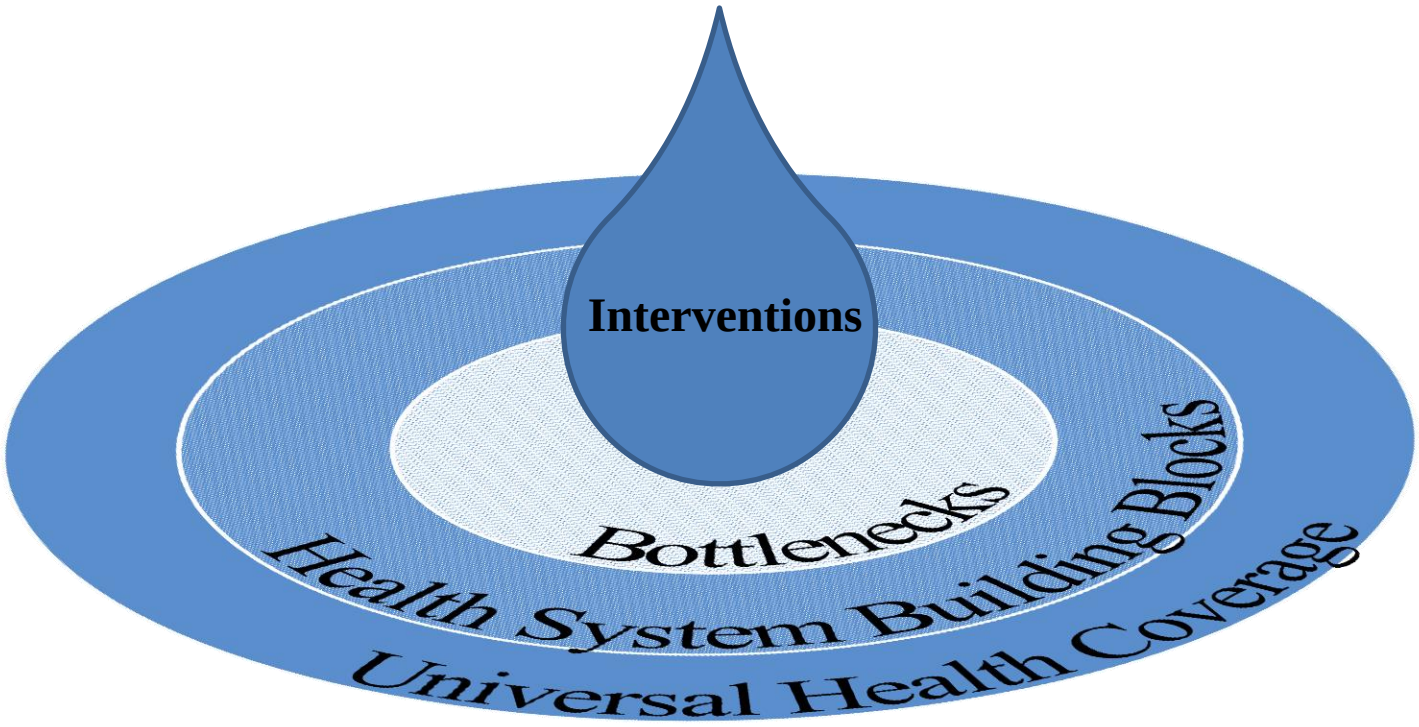
Implementation: What Worked?

- Flexibility and the ability to adapt quickly
- Be present and prepared for the long-term investment
  - "Don't paratroop in on communities"
- Depth rather than breadth
- Link MNH specific issues with other 'popular' general health issues
- Link MNH efforts with on-going WASH programs

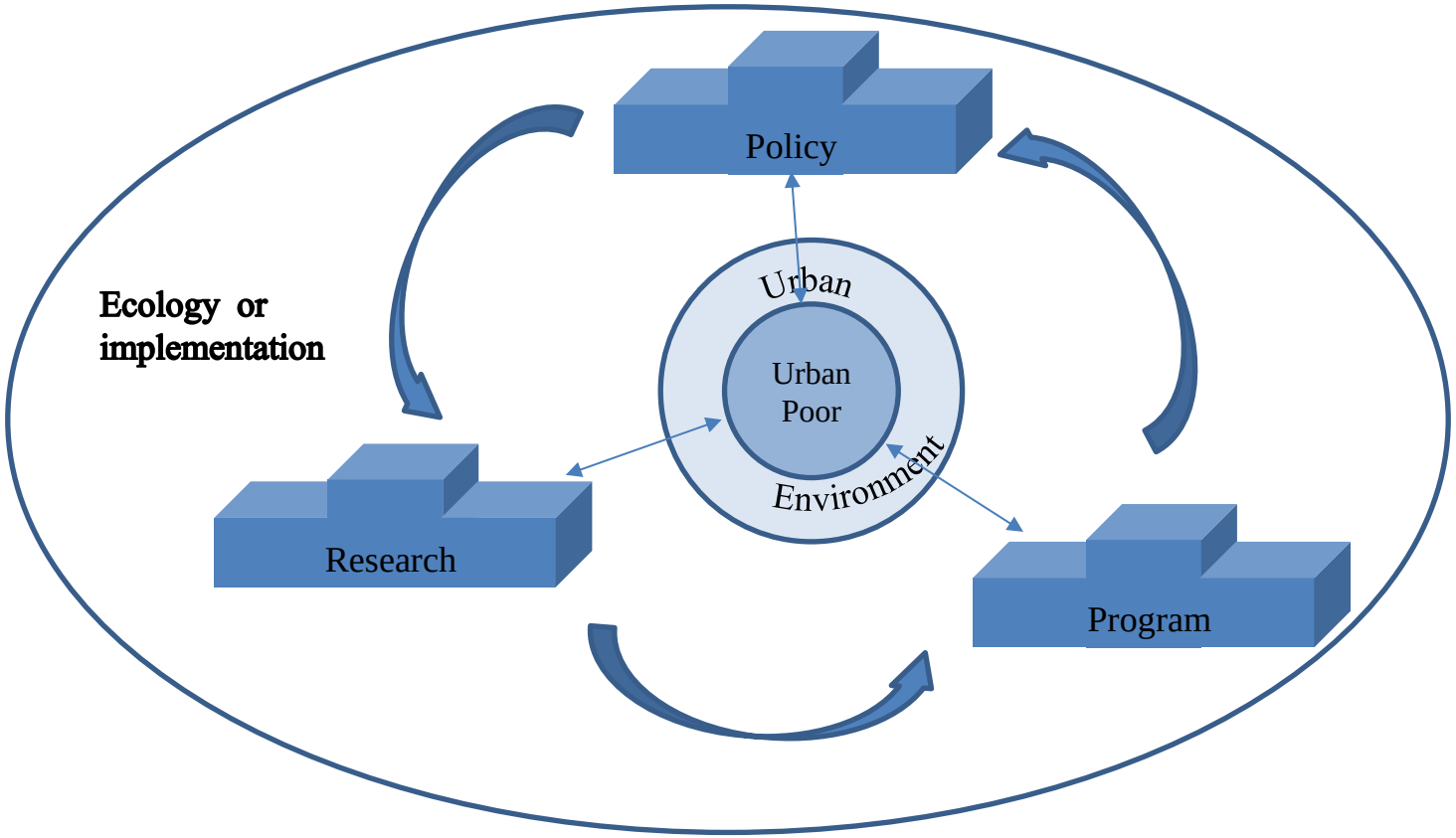
Implementation Challenges

- Lack of accurate data
- Limited or non-existent coordination within slums
- Municipal governments are VERY different from the rural health system governance systems
- Difficulties in communication and outreach/establishing trust
- Acknowledging and working in reality: heterogeneous, and constantly changing population
- Time and finance heavy

Intervention-Centered Strategies



Ecology-of-implementation approach to urban MNH



Thank you!

Beware the definitions

What is “urban”?

Sweden: built up area with >200 households no more than 200 meters apart

Mali: Census in 1987: >5,000 population

1998: >30,000

2009: >40,000

What is a “city”?

NY = 8 million population

NY metro area = 9.3 million

NY-north NJ-LI consolidated metro = 21.2 million

Ex: Community health workers

- Volunteerism is dead
- Social status is not experienced same way – the prestige experienced in villages does not translate
- Women have plenty of income generation options to compete with CHW
- Women are ‘hard to find’ – huge challenges in UHEW program in Ethiopia
- Many competing health issues: need to increase their training to include NCDs, and generate demand
- Lack of coordination of NGOs, local government and private actors take too much of women’s time
- Crime and violence permeate slums – CHWs are expected to work within these conditions