Project supported by Cognizant Foundation

PPHF
PEOPLE TO PEOPLE HEALTH FOUNDATION
Catalysing change for wellbeing

POSITION PAPER

Underlying Determinants of Health Seeking Behaviours in Urban Slums: Analysis to Action

PEOPLE TO PEOPLE HEALTH FOUNDATION

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Executive Summary

This position paper presents recent learnings and evidence concerning the health of urban poor in Kolkata slums and an analysis of key determinants of MNCHN service delivery and community health seeking behaviours. The purpose position paper is to document learnings from first year intervention of the SAMARTH project to address barriers to healthcare seeking in the context of MNCHN among urban poor. The paper highlights key practices, approaches & stories of change, and provides practice recommendations to develop and refine operational strategies. The insights and recommendations seem more appropriate for similar urban slums in India.

We suggest five key drivers to intensify actions to improve access to MNCHN service and influence community practices:

- ***Recommendation 1:*** Community Engagement for improved hygiene and sanitation practices- Adopt the evidence-based community empowerment approach like the participatory learning and action cycle which treat the community as active partners rather than as passive recipients of information and services. Create campaigns and movements of champions and influential voices for making essential health and nutrition a community agenda.
- ***Recommendations 2:*** Bridging the gap in outreach and linking households for improved access to primary health care services- Make the service providers across health, nutrition and WASH sectors more responsive and accountable to respond to the demand generated through community empowerment and establish linkages for improved access to essential health and nutrition services.
- ***Recommendation 3:*** Enhance the capacity of service providers to deliver essential health and nutrition services must focus on skill based- Focus on practical demonstrations and 'on-the-job' upskilling of capacity on technical and managerial aspects of the program.
- ***Recommendation 4:*** Invest more in influencing health seeking behaviour of the community and create an enabling environment- Communities, and among them, women as the primary caretakers, are more likely to influence the health and nutrition outcomes of their children and their families with a supportive enabling environment in the community.
- ***Recommendation 5:*** Establish a strong project monitoring system and document processes- Generation and analysis of data, information and evidence to provide actionable recommendations for program strengthening. Both quantitative and qualitative data should be captured to make evidence-based decision-making for programming.

We propose to refocus on these key five drivers to impact MNCHN outcomes significantly in slums, particularly in Kolkata which could be applicable to similar contexts in other parts of India.

Background (The problem)

The growing urban areas pose unique challenges for health and well-being arising due to big human populations, large geographic size, high human density, and perplexing economic activity. [1] More and more people from oppressed and marginalized communities come to the cities in search of better opportunities and livelihood and often end up settling in urban slums.

[1] Jha, R. The impact of urbanization on health. (2020) Observer foundation available from: https://www.orfonline.org/expert-speak/impact-urbanisation-health-67644/

The Urban Poor (The environment)

The urban poor are at the interface between underdevelopment and industrialization. Health care in the slums presents serious public health concerns and challenges. Despite being 'considered' close to the public health facilities, their access to health is severely restricted due to inadequacy of infrastructure, overcrowding of facilities, lack of information about services available, ineffective outreach processes and weak referral system. Poor living conditions in slums play a key role in the amplified burden of diseases. Poor access to water, sanitation, nutrition and social factors such as gender, caste, religion, and associated social exclusion; and hazardous work conditions combine to create facets of vulnerability among population groups in urban areas. Additionally, urbanization also has a profound impact on social organization and family life which often leads to trauma and affects health and wellbeing. Maternal and child health in the context of urban slums presents excess vulnerability with extreme poverty, unsafe social conditions and lack of access to primary healthcare facilities. The COVID-19 pandemic has put a spotlight on an often-neglected India's public health system in urban areas with ineffective outreach, weak referral and inadequate coverage of health services. [2,3]

Recently released National family health survey findings highlighted that health and nutrition indicators in urban areas are as bad as those of their rural counterparts. Around 26% of the total urban population has worse health and nutrition outcomes as a result of a lack of adequate services. Almost 17% of urban children miss full immunization and only 44.7% receive breastfeeding within one hour; these indicators further worsen amongst the urban poor.[4]

Rationale (The existing solutions)

Care that focuses on simple hygiene, careful attention to the antenatal period, feeding, understanding danger signs, identification of infections and immediate treatment are some of the basic building blocks that are being practiced by some countries. Translating knowledge into action through existing health systems platforms requires a focus on various aspects. A global consensus around essential reproductive, maternal, newborn and child health **(RMNCH+A)** interventions and a **continuum of care** approach emphasizing linkages between health-care packages across time and **place of the service delivery** are key milestones that have emerged to support this translation.

Addressing the health of the urban poor is the responsibility of multiple sectors. Unless the social, economic, and environmental factors are addressed in a holistic and coordinated manner, meaningful progress may not be possible in improving the health status of the urban poor. Affordable and good quality primary care is essential for the urban poor. The urban poor should be adequately educated and empowered with optimum health and nutrition practices and utilize healthcare services. Awareness is an important determinant of healthy practices. The urban poor demonstrate low levels of health literacy and suboptimal levels of self-care and attention by the families. Community health workers and volunteers can play important roles in health education and empowerment of the urban poor.

Primary Healthcare System in Urban areas

The National Urban Health Mission (NUHM) was launched by the Government of India as a sub-mission of the National Health Mission (NHM) in May 2013 and was the first major programmatic response at

[2] Mishra, A. Seshadri SR. Pradyumna, A. et al. Health Care Equity in Urban India. Azim Premji University (2020)
[3] Oxfam. Inequality report- India's unequal health care story. Oxfam India. (2021)
[4] National family Health Survey-5- India factsheet http://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf

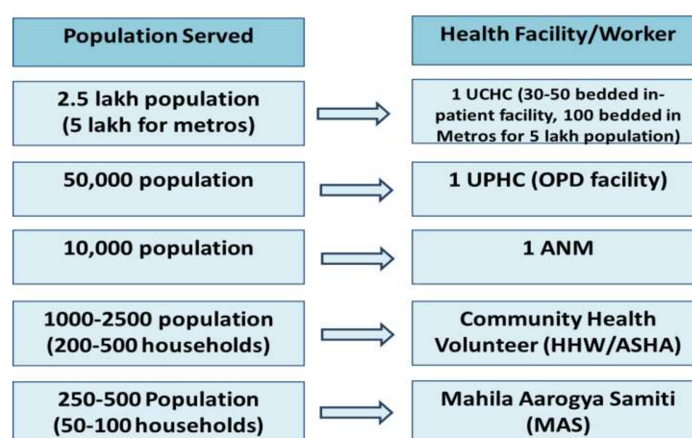
the national level to address the health issues of the urban poor. NUHM was conceived as a holistic, comprehensive, and multidimensional program with the urban poor in focus and working systematically towards meeting the regulatory, reformatory, and developmental Public Health priorities. NUHM is being implemented through Urban Local Bodies (ULBs) and the health care system varies in cities as per state government strategy.

National Urban Health Mission

Objectives:

- To decrease maternal, child and infant mortality by providing better and consistent quality services to families in urban areas with a special focus on urban poor, underserved, and vulnerable populations through enhanced demand and universal access to quality services.
- To reduce the prevalence of communicable diseases currently covered by the national health programs and reduce the risk of epidemic outbreaks by reducing exposure to health risk factors.
- To improve the quality of basic health services by providing supervisory, managerial, technical and interpersonal skills to all levels of health functionaries.
- To generate awareness and enhance community mobilization through IEC/BCC to supplement and make the above interventions effective.

Health care service delivery system under NUHM -Framework for Implementation-May 2013[5]



Purpose of this Position Paper

The purpose position paper is to document learnings from first year intervention of the SAMARTH project to address barriers of health care seeking in the context of MNCHN and WASH amongst urban poor. The paper highlights key practices, approaches & stories of change and provides practice recommendations to develop and refine operational strategies. The theme of this position paper is **'Underlying determinants of health seeking behaviours in urban slums from analysis to Action'**.

[5] https://nhm.gov.in/images/pdf/NUHM/Implementation_Framework_NUHM.pdf

SAMARTH Project - Improve the health and well-being of urban poor women and children in Kolkata

- People to People Health Foundation (PPHF) with support from Cognizant Foundation is implementing an intervention in selected slums of Kolkata city to improve knowledge and practices on healthy behaviours of mothers and children health care during the critical time of the first 1000 days from pregnancy and further on up to 5 years of child age.
- The project is focused on promoting behaviours that are proven to protect and improve the health and well-being of pregnant and lactating mothers and children, such as early registration of pregnancy within first-trimester consumption of diverse foods, exclusive breastfeeding, washing hands with soap and other MNCHN behaviours.

Project Goal

To contribute to the government's efforts towards reduction in maternal and infant mortality.

Project Objectives

- Improve access to MNCHN (Maternal, Newborn, Child Health and Nutrition) services among women and children.
- Improve community and key influencer knowledge and health seeking behaviour on MNCHN.
- Build the capacity of the health and nutrition care providers for strengthening MNCHN skills.

Project Site

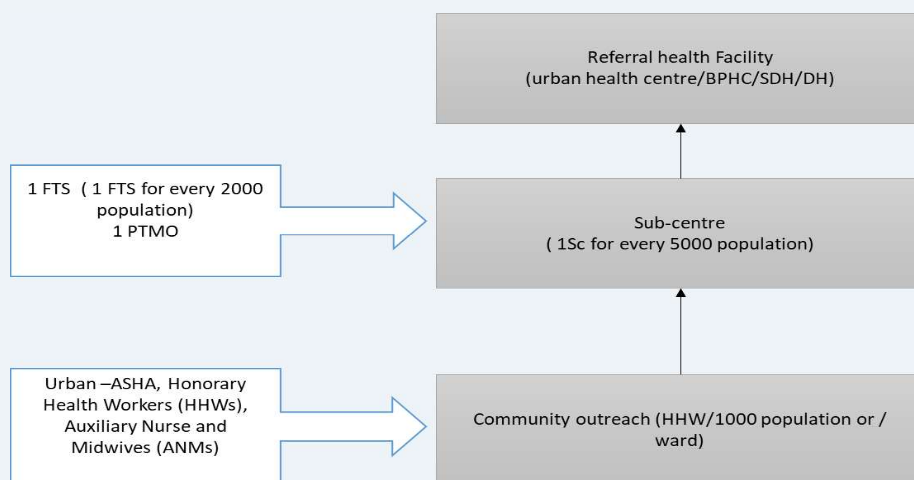
The project was initiated in the Basanti Colony slum area situated in Kolkata (Ward No. 32) of Kolkata Municipal Corporation (KMC) and extended to Ward 29 and beyond. Kolkata is the largest metropolitan city in eastern India. Slum areas of Kolkata grew steadily in the city since the colonial era in the main city of Kolkata along with other surrounding towns. Despite the common perception of easier access to health services and omnipresent private providers, data presents a dismal picture of maternal and child health in the city with high out-of-pocket expenditure.

Primary Health care service delivery structure in Kolkata Municipal Corporation adapted from National Health Mission (NUHM). Urban Primary Health Centre (UPHC) is a nodal institution to provide comprehensive primary health care services to its designated population. The project team is working with frontline workers (HHW, ASHA, AWW and ANMS) and healthcare providers to carry out project activities.

Target Beneficiaries

The project aims to reach out to 20,000 Pregnant women and lactating mothers and their family members.

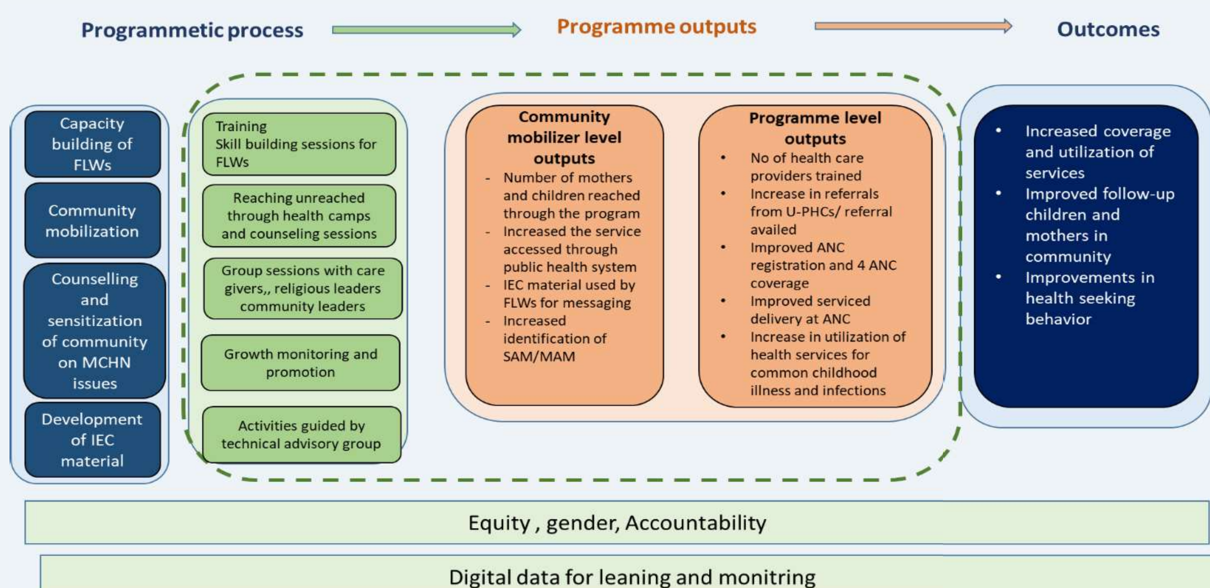
- ***Primary Beneficiaries:*** Women in the reproductive age group of (15-49 years) and children (0-5 years)
- ***Secondary Beneficiaries:*** family members and community



(FTS: First Tier Supervisor, HHW: Honorary Health Workers, PTMO: Part time Medical Officer)

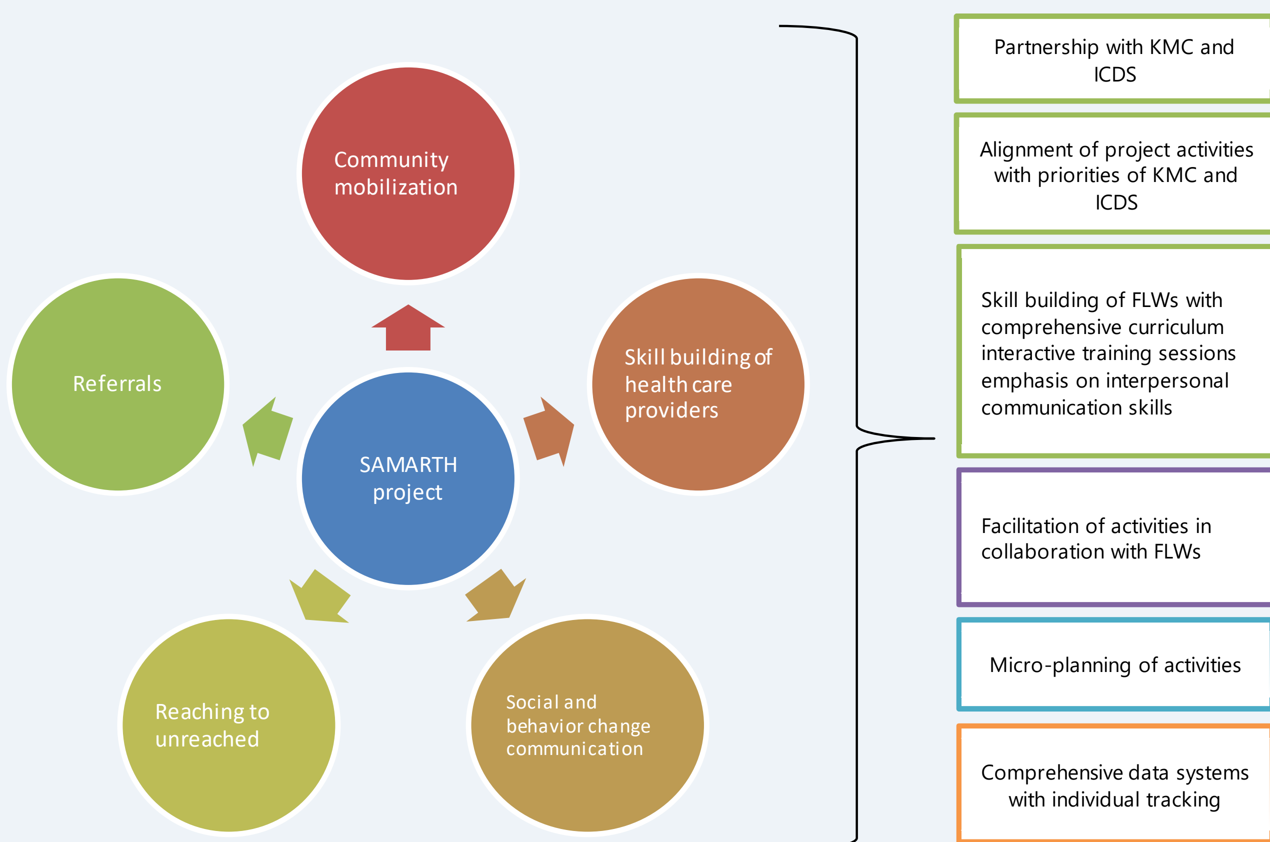
SAMARTH Project Strategy

- The conceptual framework of intervention structure was developed using a common input-process-output-outcome logic model and has three areas- processes, program outputs (measured at the field level) and overall program outcomes.
- The project interventions focused on improving the existing service delivery and mobilizing the community for service uptake in the selected slums and improving the health seeking behaviours of the community and use of data for better programming.
- The project activities focused on community processes and engaging systems for better last-mile service delivery.
- Engaging community groups like youth clubs for community mobilization and sensitization activities.
- The project implementation is guided by a Technical Advisory Group which included public health experts, civil society members and representatives of government bodies.



Implementation process

SAMARTH program responding to improve the outreach of the services and health seeking behaviour at the community level. The project team is working in collaboration with KMC and ICDS to provide innovative and contextual solutions for improving the skills of health workers, conducting intensive community mobilization activities, identification of High-risk pregnancies and referrals, etc. Additionally, program management tools such as micro planning, a digital database for monitoring, and an individual tracking system are supporting the project to achieve the desired outcomes.



Pre-intervention - Baseline assessment

A formative assessment was conducted to understand the existing practices and situation of maternal and child health and nutrition. The uptake of health services and opportunities, scope and methods to improve community knowledge, skills and motivation for health seeking behaviour on MNCHN were also explored through baseline assessment. The assessment was conducted in the Basanti colony slum area covering 130 mothers and families. Information was collected using household surveys as well as in-depth interviews and focused group discussions.

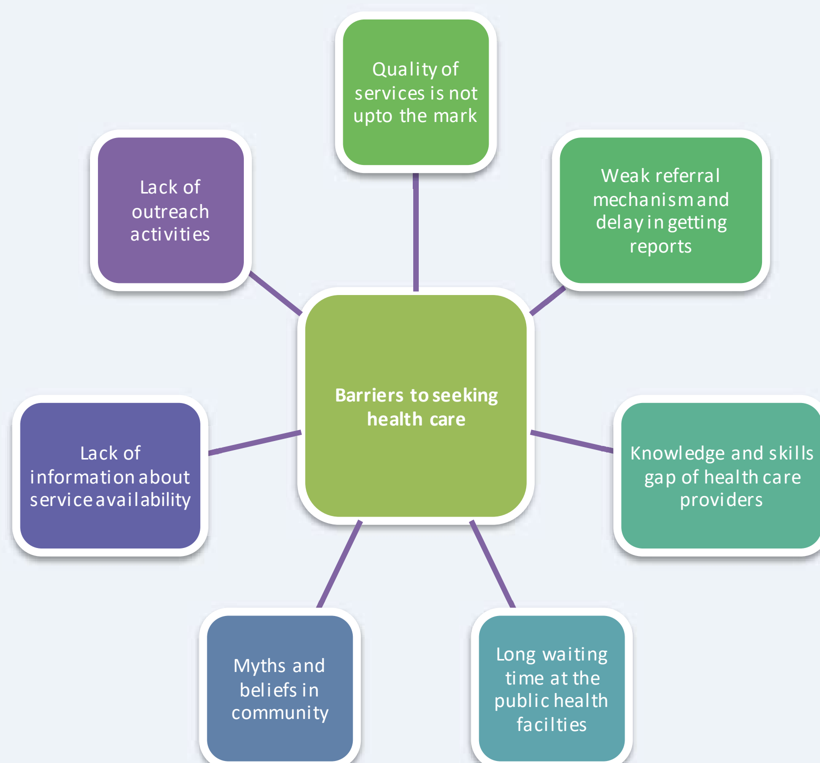
Key findings from Baseline study

Health and nutritional status of mothers and children and healthcare seeking behaviour

- Early marriage is common in the community living in the Basanti colony. High proportion of early pregnancies were reported (pregnancy among women ≤18 years)
- Women are often resistant to registering pregnancy in the first trimester.
- Awareness regarding nutritional care of mothers during pregnancy is extremely low and often mothers' nutrition is not focused on and remains neglected.
- Very low awareness of mothers on optimal infant and childcare practices, recognition of danger signs and hygiene and sanitation practices to prevent communicable diseases.
- High incidence of communicable diseases such as upper respiratory infections, diarrhoea, and typhoid is commonly reported among children under five years of age.
- Adherence to Hygiene and sanitation practices such as washing hands is often challenging and surrounding conditions put a further challenge to follow the correct practices.

Access to healthcare services

- Outreach services lack coverage and reach to mothers and children which often results in a lack of mobilization of pregnant mothers for timely care seeking.
- Local practitioners are preferred service providers for minor treatments of their children or themselves due to easy accessibility.
- High out-of-pocket expenditure is reported for deliveries conducted in public health facilities.
- Long waiting period, Poor quality of the services received from the public health facilities.
- Lack of counselling during ANC visits and outreach sessions.



The recent evidence from different parts of the country demonstrated that barriers to access, both at the individual and system levels, are the primary drivers for inadequate care and unmet needs.

- Access to health care for urban poor is hampered by poor availability of public health facilities and resulting high out-of-pocket expenditure for private care, as a result of which health outcomes of the urban poor are significantly worse than the relatively well-off. [6]
- Social factors such as gender, caste, religion, and associated social exclusion; and occupational challenges, such as intermittent or hazardous work conditions combine to create specific facets of vulnerability in urban slums.[7]
- Private care providers dominate both outpatient and inpatient care and result in a high burden of out-of-pocket expenditure (OOP).
- Traditional beliefs and practices are still a strong barrier to utilizing the MCH services in India. The negative social and cultural practices such as dietary restriction, belief in traditional herbs and healers, and misperceptions regarding colostrum were frequently reported barriers during and after the pregnancy[8] late recognition of illness, delay in seeking medical help and inappropriate treatment contribute to a high burden of illness and mortality among mothers and children in urban slums.[9][10][11][12]

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[6] Mishra A., Rao Seshadri S, Pradyumna A, Pinto P.E, Bhattacharya A, and Saligram P (2021) Health care Equity in Urban India, Report, Azim Premji University, Bengaluru

[7] Vulnerability Mapping and Assessment for Strengthening Urban Primary Healthcare Program in Selected Slums of Mumbai (March 2022), Mumbai Field Office, UNICEF, Maharashtra.

[8] Sushmita Singh, Rahul Rajak. Addressing barriers in utilization and provisioning of obstetric care services (OCS) in India: A mixed method systematic review, 20 December 2022, PREPRINT (Version 1) available at Research Square [https://doi.org/10.21203/rs.3.rs-2363717/v1]

[9] Elizabeth AM, Khan AM, Rashid W. Reproductive health care seeking behavior among urban slum women of Delhi. J Educ Health Promot. 2015 Dec 30;4:87.

[10] Dr. Shweta Singh and Dr. Shrikant Kalaskar, 2017. "Health care seeking behavior and utilization pattern in an urban slum of Mumbai. International Journal of Current Research, 9, (04), 49342-49345. Available from: https://www.researchgate.net/publication/316685828_HEALTH_CARE_SEEKING_BEHAVIOR_AND_UTILIZATION_PATTERN_IN_AN_URBAN_SLUM_OF_MUMBAI_A_CROSS_SECTIONAL_STUDY [accessed Apr 18 2023].

[11] Fernandez A, Mondkar J, Mathai S. Urban slum-specific issues in neonatal survival. Indian Pediatr. 2003 Dec;40(12):1161-6. PMID: 14722366.

[12] Shubha D, Kaur N, Mahabalaraju D. health care seeking behaviour and out-of-pocket health expenditure for under-five illnesses in urban slums of davangere, India BMJ Global Health 2016;1:A11.

Health Seeking Behaviours in Urban Slums – What Works?

The NFHS-5 data showed that private-sector care providers are the preferred choice for health care in India. The most reported reason for not using government health facilities at the national level is the poor quality of care (reported by 48% of households that do not generally use government facilities). The second most reported reason is the long waiting time at government facilities (46%), followed by the fact that there is no government facility nearby (40% of households). Outreach in urban areas is very limited as only 27% of women reported recent visits by healthcare workers to their houses.

Health care seeking among mothers showed that over one-fifth (21%) of women cite money as a problem in accessing health care. Twenty-three percent of women cite the distance to a health facility and 22 percent cite having to take transport as a reason for not being able to access health care. 31% percent of women report concerns that no female health provider is available at facilities. 39% of women report a concern that no provider is available and 40% that no drugs are available at the facilities. Public facilities are preferred for delivery services (62%).

Interventions aimed at facilitating access to health services require a multipronged approach that should address both supply-side and demand-side barriers. The supply-side interventions that work include improving the knowledge and skills of care providers, provision of emergency transport with a communication system, and Improving management supervision and feedback mechanisms. Similarly, Counselling and consumer information on health services and improving community participation are some of the non–monetary interventions to address demand-side barriers.[13] A combination of interventions customized as per the context appears to produce optimum results. The SAMARTH project interventions attempt to address both supply-side and demand-side interventions.

Intervention 1 - Skill building of health workers: improving capacity through comprehensive training and supportive supervision

The ground-level service providers of KMC like Accredited Social Health Activists (ASHAs), Honorary Health Workers (HHWs), Auxiliary Nurse and Midwives (ANMs), and other health workers including project staff were trained on how to strengthen the services delivery, counselling of the beneficiaries, motivating the family members and the community for adopting appropriate behaviours.

- Adequate knowledge and skills, and their application to support, create and sustain a breastfeeding-friendly environment for families and home-based newborn care. This would play a major role in adopting the right behaviours.
- Training helped improve the joint working of FLWs and project teams and provided additional opportunities for handholding of FLWs.

Learnings - What works?

- Training of the frontline workers through project SAMARTH is a valuable addition to the existing efforts to improve outreach services. Since the ASHAs and AWWs were often the first lines of contact with the health system for the community members, their communication skills and

[13] Bart Jacobs, Por Ir, Maryam Bigdeli, Peter Leslie Annear, Wim Van Damme, Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries, Health Policy and Planning, Volume 27, Issue 4, July 2012, Pages 288–300, https://doi.org/10.1093/heapol/czr038

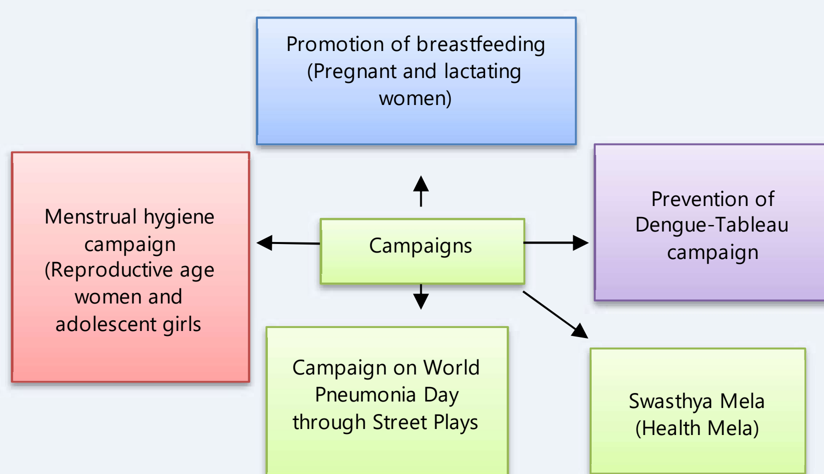
technical knowledge is critical to delivering the messages and are key to building trust and confidence in the community.

- The skill-building sessions for ASHAs and ANMs helped them to confidently engage with the community using the IEC material and other counselling tools.

Intervention 2 - Community Mobilization

Community mobilization was a major focus of the project. Intensive community mobilization process focused on improving awareness and knowledge-building of the community, individuals, and specific groups through participatory processes.

2.1 Health Campaigns



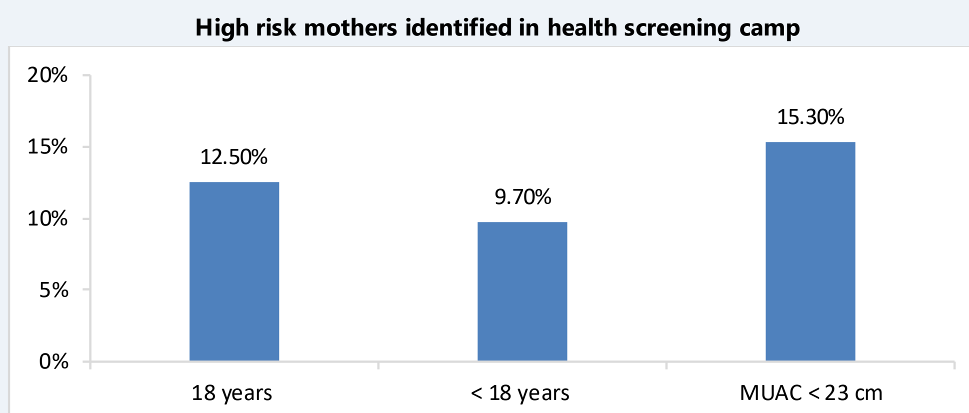
Campaign activities

- Identify the target audience
- Choose information/ messages dissemination strategy and campaign method
- Identify an area or places
- Reach out to the target groups

2.2 Health Camps for Pregnant Mothers

- The screening activity was taken up to reach out to pregnant mothers and identify nutritionally vulnerable and high-risk mothers.
- The planning for the health campsite plan, activities, follow-ups were done closely by FLWs and the project field team.
- The field mobilizers identified the pregnant mothers through the home visits and shared the details with Honorary Health Workers (HHWs) and Anganwadi Workers (AWWs) so they can take further initiatives and put them on their follow-up list.

High risk mothers identified in health screening camp



"Immunization coverage and Antenatal Check-ups are increasing as Field Mobilizers are mobilizing and issuing the referral slip" *...... A frontline worker.*

2.3 Group Sessions with Mothers and family members

- Group sessions are important for the dissemination of key messages and initiating community dialogue on critical issues of mothers and child health and nutrition.
- Series of group sessions were organized by the project team in collaboration with KMC and ICDS field workers to engage with mothers such as growth monitoring and promotion of food groups and diversified diet, Home Based Diarrhoea Management, breastfeeding and prevention of Pneumonia and home-based management of Pneumonia.

Topic
Home-Based Diarrhoea Management
Advantages of breastfeeding and exclusive breastfeeding and complementary feeding
Diversified diet and minimizing the nutrient loss
Growth monitoring
Prevention of pneumonia and home-based management of pneumonia
Infant and young child feeding practices
Group session of the caregivers on teenage married girls on adverse effects of early pregnancy

A medical officer from UPHC shared, ***"PPHF is not only generating sensitization, rather they have provided different kinds of awareness messages at the doorsteps of the people which is very good. counselling for the reproductive age group is also a very important component."***

Case Study

Sonu Biswas is a single mother of two and lives with her mother and children. Both Sonu and her mother are ragpickers and support their family together. The absence of a proper livelihood makes it difficult for her to take good care of her son and daughter. Her son Tanmoy is four years old, and his sister Tushi aged 9, is a student of class III who gets a Mid-Day Meal from her school. Though Tanmoy is registered at AWC, his mothers and grandmother are unable to take him to AWC. A Field Mobilizer working with the SAMARTH project spotted the Tanmoy in the locality and visited the house. She identified that child was severely undernourished with a 10.5 kg weight and MUAC 11.4 cm. She discussed the condition of the child with the local AWW and HHW. The family was living under extremely difficult conditions with a lack of basic hygiene and sanitation facilities, poverty and lack of feeding. With efforts of the field mobilizer and AWW, the child was referred to Ward Health Unit and on the same day, he was further referred to NRC. Tanmoy's mother and grandmother did not agree initially to admit Tanmoy to NRC but gradually field mobilizers along with the health and ICDS team were able to convince him, and Tanmoy reached the NRC with his mother and grandmother. After about a month with the support of treatment and supervision, he was discharged from the NRC his weight was 11.5 kgs. and his MUAC 12.0 cm. During this time Sonu's neighbours played an important role in taking care of Tanmoy's elder sister Tushi. Field Mobilizers and the health / ICDS team regularly visited Tanmoy's house to look after his sister and updated the neighbours about his health condition. Now Tanmoy's mother is practicing home-based care that she learned from NRC. Tanmoy's story highlights how an appropriate and timely initiative and follow-ups can be a big factor to overcome health risk factors.

Learnings – What works?

- The community mobilization efforts provided an opportunity to directly engage with the mothers and family members and address their concerns and misconceptions and provided an opportunity to build up the knowledge and health-care-seeking behaviour of families.
- Community mobilization reached a large community and helped in the dissemination of uniform messages and improving the visibility of FLWs in the area. The community started recognizing them and finding benefits through their interactions.
- The health camp approach was particularly useful in reaching out to unregistered pregnancies and identification of high-risk pregnancies. They were referred and listed for additional home visits by FLWs and regular follow-ups by ANM. This is a one-stop point to receive a complete package of services at the community level.
- Referral slips issued during the outreach sessions made it easy for beneficiaries to access health facilities and linked beneficiaries to the programs such as Pradhan Mantri Surakshit Matritva Abhiyan and ICDS AWC services.

Learnings – How it works?

- The community dialogues help understand the barriers to adopting healthy practices and opportunity for the project team to address some of the barriers by referrals and connecting them to the health system.
- Meticulous planning of each event by the project team and FLWs with the support of KMC and ICDS officials helped reach the objective of each activity.

- The various campaigns organized throughout the years helped in continued engagement with the community and FLWs.
- Intensive outreach by field mobilizers and FLWs helped in reaching the unreached population.
- Collaborative efforts of FLWs and the project team also helped in skill building to communicate, disseminate messages and reach out to mothers and families.

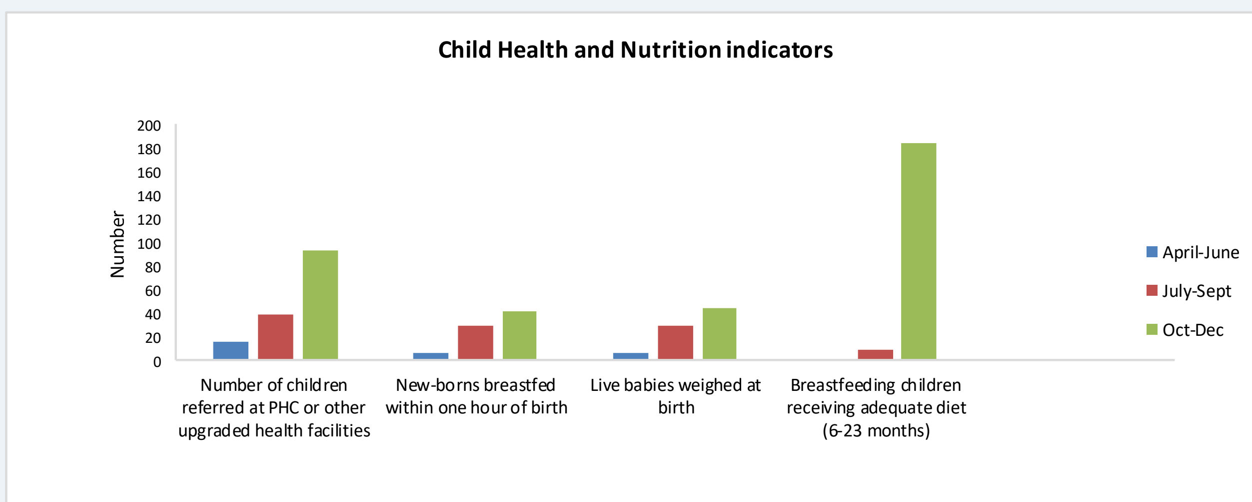
Intervention 3 - Digital platform for monitoring and facilitating timely service response

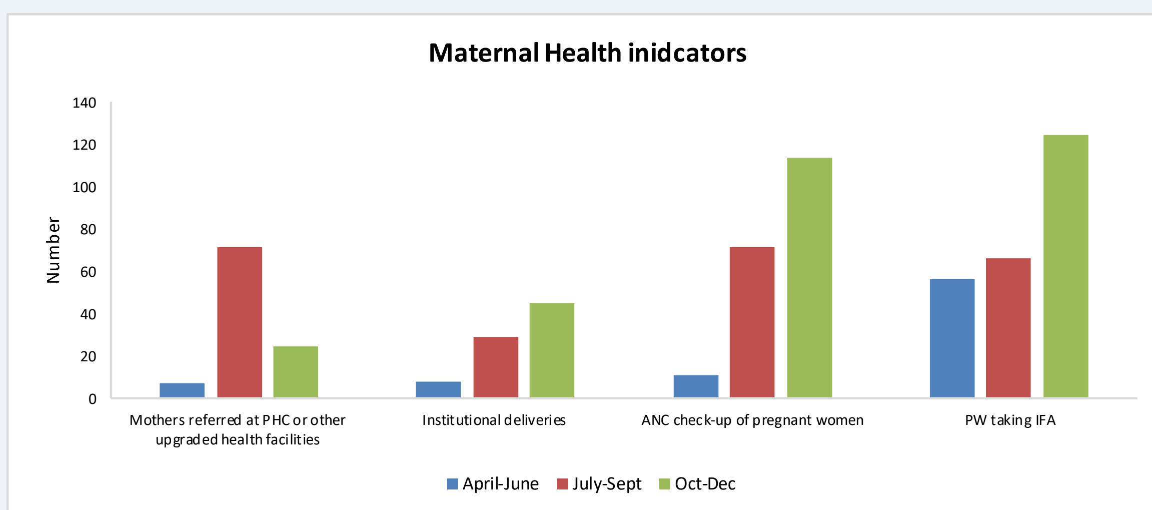
- An Android phone-supported digital MIS application is developed to create a beneficiary database and tracking of beneficiaries and monitoring activities.
- Digital platform is used for-
  - Collection of mandatory information during household surveys like name, age, gender, household number, address and category of the focused group.
  - Health-related information on families.
  - Learning modules and videos have been uploaded to the application. These learning materials are used by field mobilizers and frontline health workers to conduct counselling during home visits and group sessions.
  - The application is used for monitoring the daily activities of field mobilizers. Their login and logout information used for calculating duty hours of their daily work.

SAMARTH Project – Year 1 Highlights

- Consistent increase in service coverage through outreach activities. Number of mothers and children receiving health and nutrition services in the community have increased consistently.
- The critical services such as referral, weighing babies at birth and children receiving adequate diet have increased considerably. Similarly, maternal indicators have also shown consistent progress.
- The progress in several indicators remain slow and action on those indicators need to be prioritized such as promotion of ORS and Zinc for diarrhea and referral of MAM and SAM children, identification of high-risk mothers and their referrals and tracking of pre-tern and low birth weight babies.

Source- SAMARTH project MIS data





Context and Recommendations

The SAMARTH Project executed community-based interventions to improve the service delivery on maternal and child health and nutrition. The project efforts are complementing the ongoing efforts of the government to improve maternal and child health and nutrition indicators.

Context 1: Living conditions and health of urban poor

- Living conditions in slums continue to pose big challenges for the health and nutritional status of mothers and children. Overcrowding, poor sanitation and poor environmental hygienic conditions due to non-clearance of garbage disposal create huge barriers to practice and maintaining hygiene and sanitation.
- A filthy and shabby physical milieu also brews up several respiratory, gastro-intestinal, and viral diseases that often affect the entire slum community. Most of the slum dwellers reported suffering from such diseases nearly every week or so. Moreover, seasonal outbreaks of fatal viral diseases like dengue, influenza and other disease outbreaks are most common in this setting which further worsens the health of mothers and children.

Improving environmental conditions and providing clean surroundings perhaps is the key to improving health and nutritional status of mothers and children in urban poor settings.

Recommendation 1: Community Engagement for improved hygiene and sanitation practices

- Need to focus on inter-sectoral actions to improve living conditions and environment in slum areas. The project team should focus on engaging the community in improving hygiene practices and advocate with the public works department and other agencies to accelerate sanitation improvement activities in the area.
- Mapping of households and points which need special attention to improve the hygiene and sanitation aspects.
- Engage community champions and volunteers for community-level hygiene and sanitation drives.

- Special events can be organized by them, for example, to prevent the outbreak of seasonal diseases a session needs to be organized during May-June to plan key action points for the prevention of diarrhoea and vector-borne diseases.
- The community meetings and sessions with male members can serve as an opportunity to identify the community change makers. The project team can have continued engagement with the identified community champions to track the follow-up of actions and behaviour adopted by the community and prioritize follow-up actions.
- The project team can target to develop community stewardship with measurable monitoring indicators for example- % of parents who correctly highlight the importance of child faeces disposal, handwashing at critical times by all family members, etc.
- WASH should be included in all community campaigns and mobilization activities.

Context 2: Gaps in community outreach and less access to primary health care services.

- Project experience demonstrated that outreach services are crucial to increase coverage and sensitization.
- Formal referral linkages through referral slips helped connect beneficiaries with health services.
- A substantial gap remains in the availability of FLWs workers as per the population norms. Therefore, a substantial proportion of the population remains uncovered and remains unserved by the public health care system.
- Accessibility and quality of primary care facilities continue to be an important issue. Primary health facilities are distributed unequally and not accessible equally. The available facilities fail to attract users because of delays in receiving reports and lack of time and attention given to patients during consultation and follow-up. The primary care service package is limited and often not able to address all issues.

Outreach services need strengthening to increase coverage of health services in urban slums. A substantial proportion of the population remains uncovered and not able to access public health services in the slum. Concentrated outreach efforts can help in reaching out to this unreached population.

Recommendations 2: Bridging the gap in outreach and linking households for improved access to primary health care services

- Outreach services should be expanded by increasing the number of ASHAs to reach out population. Project team can run a volunteer program to fill the gaps and trained volunteers can reach out to these communities and collaboratively work with frontline health and nutrition providers.
- The visibility of primary care facilities should be improved by clear messaging through various channels for example display of signage at various places of the community, promoting package of services available at the facilities through ASHA and AWWs, and newer technological channels such as use of WhatsApp groups, mobile applications can be used to spread the message.
- Awareness of the community about services available in the UPHCs can improve utilization.
- Organizing community outreach activities.
- Strengthening UPHCs by providing support using planning and management tools can help improve quality of services.

Context 3: Capacity of service providers to deliver

- Technical skills of frontline workers (ANMs, AWW and ASHAs) is a continuous process for enhanced performance and effectiveness.
- Innovative pedagogy and training with user-friendly communication materials and clarities on the use of job aids are vital to attaining expected training outcomes.
- Training needs to be focused on improving specific skills such as communication with mothers, weight and height measurement, use of counselling aids, conducting mothers meeting, and organizing food demonstrations, etc.

Continuous handholding and supportive supervision of FLWs can help in the translation of knowledge and skills into effective program delivery.

Recommendation 3: Enhance the capacity of service providers to deliver essential health and nutrition services must focus on skill based

- Recognizing that a single training is not sufficient; More frequent practical demonstrations and 'on-the-job' support are necessary so that FLWs get the opportunity to practice and refine their skills.
- Small skill-oriented training packages with an aim at specific skills are feasible to implement. The training sessions should be on-the-job in field settings with practical examples and handholding for correct practices.
- Handholding and supportive supervision need to be strengthened.

Context 4: Health seeking behaviour of the community

- Health and nutrition of mothers are not a priority in most families.
- Care seeking is delayed considerably due to financial issues or lack of awareness among family and community.
- Men often stay away during discussions on mothers and childcare and nutrition. These discussions are limited to women groups mostly. Despite improved knowledge, it does not translate into improved actions fully and further behaviours because women often do not have control over resources including their time and they have limited decision-making powers.
- Though various channels were used to create awareness but change in practices remains a challenge that needs support from family and community.

Community mobilization is a major strength of the SAMARTH project. Robust planning, intensive engagement with the community and attention to promoting behaviour change in the population are important investments.

sRecommendation 4: Invest more in influencing health seeking behaviour of the community and create an enabling environment

- 'Nutrition and health must be communicated as a 'family benefit', something that can benefit the entire family but also requires the involvement of the entire family.' The messages should be tailored for the family by specifying the role of both parents and other family members and decision-makers in the family.
- Special attention needs to be paid to the messages that engage not only people's minds (as rational, health-related messages often do) but also their 'hearts', such as those related to the

pride of being a good parent or positive aspirations for children's futures. For example, communicating to them that parents are giving their children the best but what more they can do and how better it can be done in fact can motivate them further.

- The messages should not be generic. It must focus on addressing one or more identified and highly prevalent barriers and provide solutions to address those barriers.
- Nudging to change the behaviour is required; the messages should reach to community repeatedly through various channels and reminders through WhatsApp or messages through visually appealing messages important.
- Project team can work to engage with community volunteers and train them as community champions and use their support for outreach activities and messaging.

Context 5: Monitoring and documentation of processes are essential

- mHealth-based android application was developed to capture the SAMARTH project data. Digital data capturing ensured the accuracy and quality of data.
- The data collected through the M&E system provide valuable insight into the extent to which people participate in various activities and the extent to which they adopt the behaviours.
- Although, quantitative data remains limited to the coverage of the services.
- They should be supplemented with qualitative data for better programming.

Recommendation 5: Establish a strong project monitoring system and document processes

- Both quantitative and qualitative data should be used to make an implementation plan and identify the challenges in implementation.
- The use of data for programming purposes is required, e.g., identification of households where pregnant mothers are not registered or children are not vaccinated or children with disability should be collected systematically and this information can be useful to plan the strategy how to reach out to them or identify specific barriers and share the information with UPHC for necessary action.

Way Forward

1. Strengthening outreach services is the first step to addressing barriers to seeking health care. The program should increase outreach efforts by involving community volunteers and mentoring community champions.
2. Skill-building efforts for volunteers should be continued to develop communication and soft skills.
3. There is a need to map the areas through GPS and identify the population that still remains uncovered by existing services. The project team can concentrate their efforts to improve healthcare services and health-seeking behaviour in these areas and support health systems in reaching the unreached population.
4. Health system strengthening efforts can complement the outreach by making health services more accessible, and visible through active engagement with UPHC functionaries.

5. Evidence generated through this project indicates that systematic implementation of intensive community mobilization activities is feasible. However, efforts need to focus on specific messaging with intensified nudging targeting to behaviour change with additional participatory and learning approaches. Strategy to engage peer-to-peer, support groups as an effective intervention and use of modern communication strategies (social media platforms) with innovative methods can be useful for intensified communication.

Conclusion

The health status of the urban poor in India is not only worse compared to the urban affluent, but often even worse than those who live in the countryside. The National Health Mission provides an opportunity for the country to

- Move towards the development of health systems in urban locations
- Bring in uniformity for service delivery mechanisms; and use additional resources clearly earmarked for urban health.

But several program implementation challenges still exist especially for the urban poor. The municipality corporations are putting their best efforts to address the challenge; however, more actions are needed on building awareness of the health nutrition aspects of vulnerable populations in the slums, improving the response of the health system, building the capacity of Municipal Corporations, health workers and the need for a solid database for evaluating progress remain important challenges.

SAMARTH Project has been implemented in the slums areas of Kolkata which are working towards increasing the service uptake and bringing the community closer to health facilities. The year-1 field experience has provided insight into focus areas to prioritize for providing sustainable community engagement processes to improve access and use of MNCHN and WASH services and as a secondary approach to link the women with livelihood programs and government entitlements. The SAMARTH Project envisioned its role to be a "process facilitator" or "linking organization", to support the government program implementation and mobilization of community for service uptake. This important role includes the following functions

- Identifying the program implementation and service uptake gaps
- Contributing to knowledge enhancement of the community and mobilizing them for availing timely health and nutrition services
- Promoting health seeking behaviours of the target audience
- Coordinating actions between the key department and organizations
- Performance monitoring. This position paper guides to refining intervention strategies of the project

ABOUT PPHF

We are a global health non-profit organization working towards transforming lives for improved health and well-being through locally-driven solutions. We have worked in more than 20 states of India with an aim to build the skills of healthcare providers, strengthen management capacity and help create sustainable systems to improve access to quality health services.

We work closely with communities and key actors on sustainable solutions for public health challenges:

- Non-Communicable Diseases
- Women, Adolescent and Child health
- Nutrition
- Infectious diseases
- Environmental Health
- Emergency Health and Disaster Response

We focus on building public health capacity and community actions for better health outcomes. We work collaboratively with stakeholders, leveraging partnerships and influencing policies and practices. Drawing on our experiences and recognizing the unique needs of each region in India, we work in partnership with key stakeholders to design and deliver targeted responses.

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