Save the Children

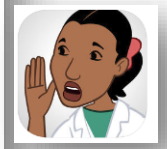
Unfinished Agenda: Equity Gaps

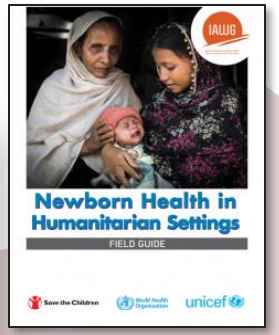
Why are humanitarian settings important?

- Despite improvements globally in newborn health, relatively poor outcomes persist in areas plagued by conflict or political instability.
- Women and newborns are particularly vulnerable, and responses do not match their burden of morbidity and mortality
- Conflict-affected countries report higher NMR and lower coverage of key MNH interventions compared with non–conflict-affected countries
- International standards define EmONC and ENC, yet they remain poorly funded and poorly provided in humanitarian responses
- **Response assessments, supply kits, intervention packages, and indicators have historically largely missed newborn**

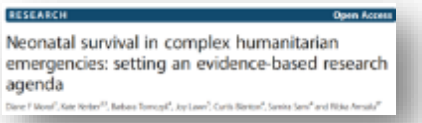
Save the Children

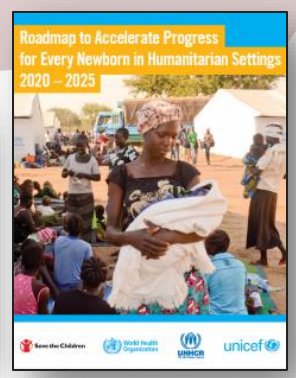
Increasing attention

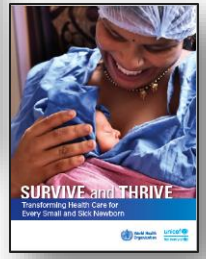


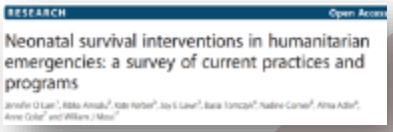


2020





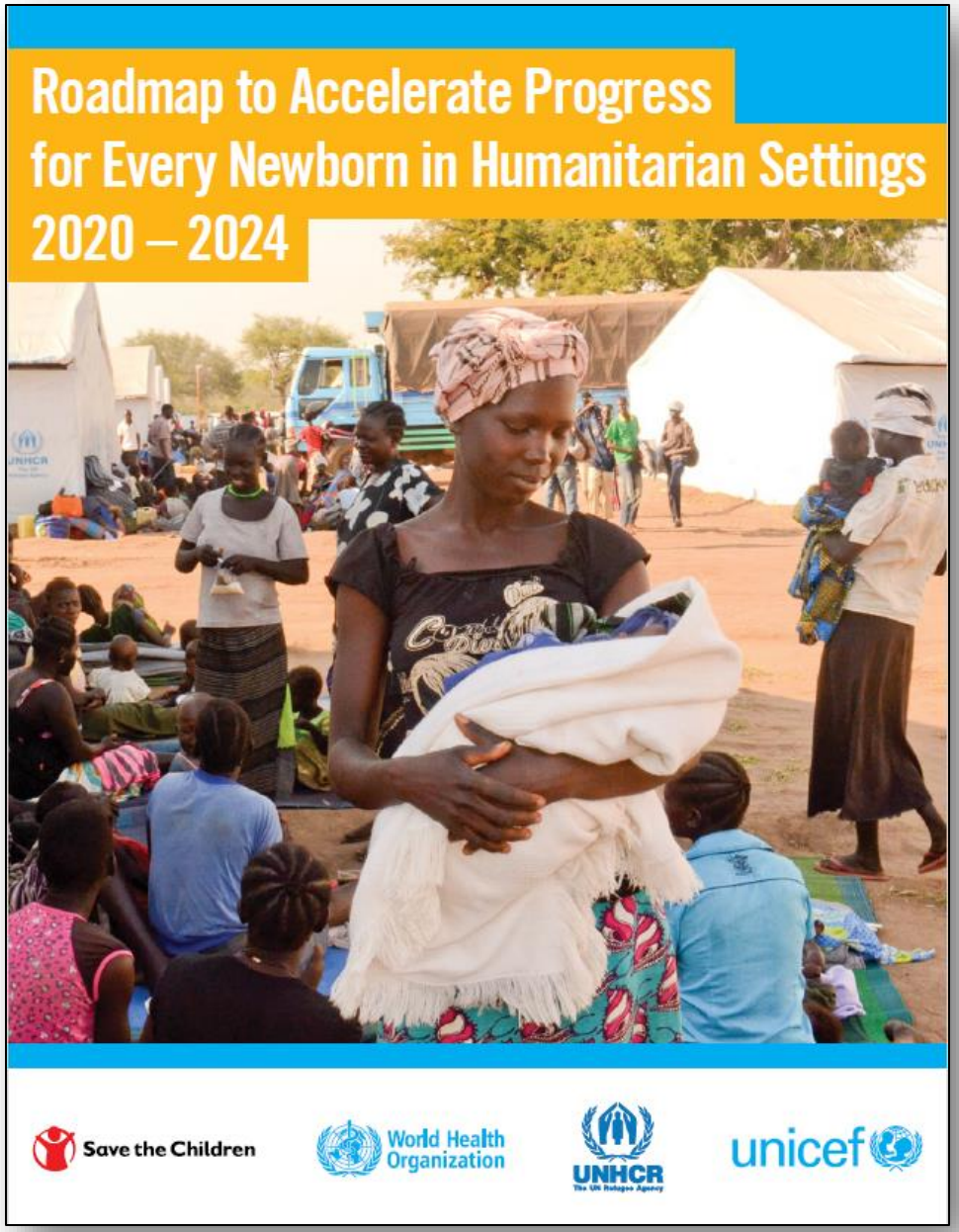




2011

Save the Children

Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings: 2020-2024



healthynewbornnetwork.org/issue/emergencies

Objectives

Survive: End preventable deaths

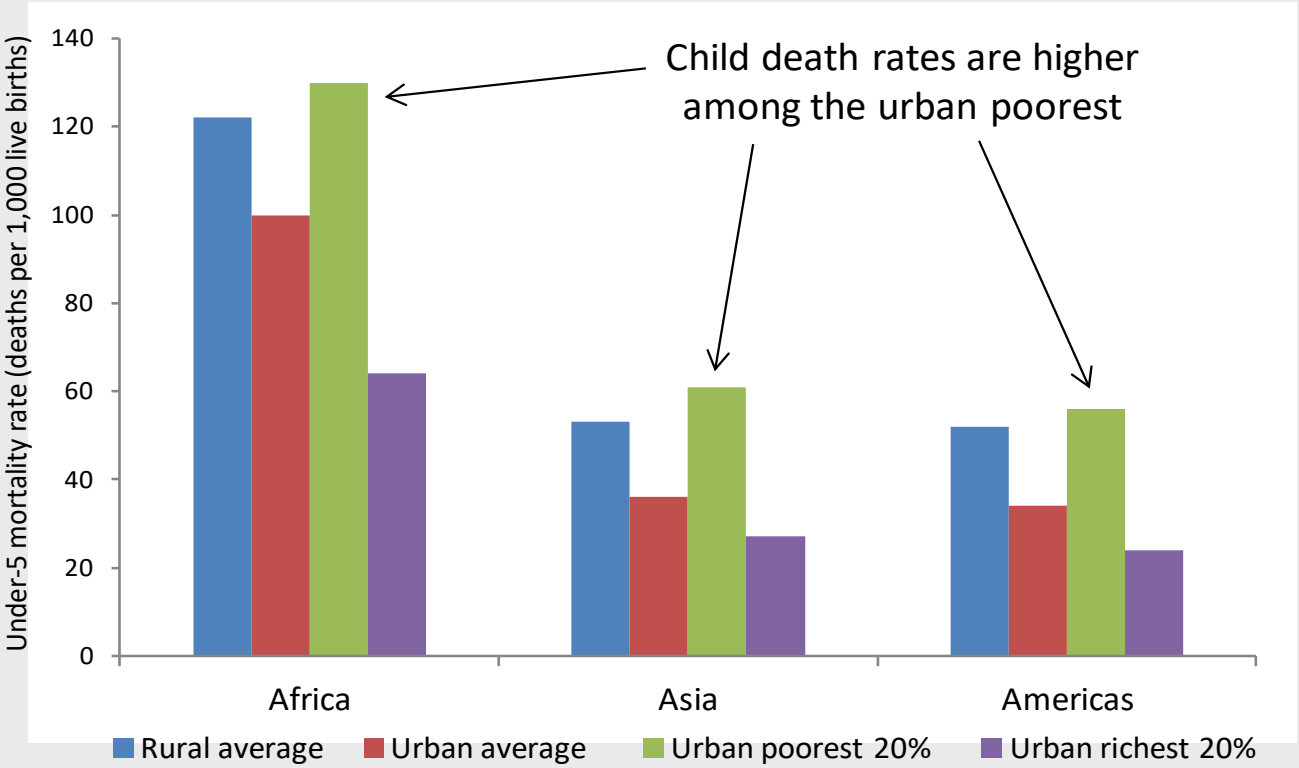
Thrive: Ensure health and wellbeing

Transform: Expand enabling environments

1. Strengthen the mother-newborn dyad in humanitarian crises
2. Expand access to dignified and quality care during pregnancy, delivery, and post-partum
3. Deliver appropriate care for small and sick newborns
4. Register every birth and count every newborn death and stillbirth
5. Strengthen linkages with key humanitarian sectors across the continuum of care
6. Facilitate coordination across the humanitarian-development nexus
7. Empower communities and governments through partnerships that promote innovative and sustainable solutions
8. Explore innovative approaches and conduct research to support service delivery in humanitarian settings
9. Increase the visibility of newborns in humanitarian settings

Rapid Urban Growth

- **54% of global population** live in urban areas
- 61.7% (Africa) / 30% (Asia) of the urban population lives in slums



Huge **coverage gaps** between rich and poor

E.g., Skilled attendance at birth: 99% vs 19% (Delhi), 94% vs 63% (Addis), 94% vs 76% (Lagos), 77% vs 6% (Dhaka)

Urban Health: significant burden, little priority

- Significant Burden…
  - Inequalities in urban areas generally exceed those in rural areas in majority of LMICs (Uthman 2009)
  - Slums in Bangladesh, Ecuador, Brazil, Haiti, and Philippines have higher infant & neonatal mortality rates than those in rural communities (Ezeh et al 2016)
- Little Global Priority…
  - Minimally considered by New Urban Agenda & SDGs
  - Majority of development health funding directed to rural areas (Shetty 2011)
  - Only 2.8% of studies of LMICs are based in a slum area (Ezeh et al 2016)

Study on global priority for urban health

Challenges in each of four areas; issue characteristics shape challenges

- Dominant development agenda that is rural health oriented
- Data gaps on scope
- Insufficient evidence base on solutions
- Powerlessness/invisibility of urban poor

Problem definition. Differences on definition of urban; which urban health issues are most critical to address; extent to which high-income country frameworks can apply to LMICs

Unconvincing position. Pits urban vs. rural health against each other, and the sector faces multiple misperceptions:

1. "Urban advantage" held by all urban dwellers
2. Urban dweller association with illegal/criminal activity
3. Urban = mega cities
4. Urban health problems are developed country problems

Shawar and Crane. Health Policy and Planning, Volume 32, Issue 8, October 2017, Pages 1161–1173, https://doi.org/10.1093/heapol/czx065

Barriers to successful MNH implementation

- Limited availability of data for decision-making
- Unskilled providers (home births high among the poorest)
- Knowledge of public providers was often poor (esp ENC[3])
- Equity gaps remain; programs often did not reach those most in need (e.g., homeless)[5]
- Transient nature of population makes programming difficult[7]
- Traditional door-to-door approach often does not work in slum settings
- Donor structure will not easily accommodate the cross-cutting issues urban slums need

1st Delay

CHW Model:
-Volunteerism does not work ($ is fundamental)
-Women are not at home for door-to-door visits
-Less sense of prestige for CHWs
-Sense of community is fractured/trust is harder to gain

Delay #1 Deciding to seek care

Social Networks:
-Traditional family support is non-existant
-Women rely on people with power (landladies) for information and potential assistance in case of emerg
-Anonymous nature of daily life leaves women alone
-Rely on TBAs for support/comfort

Address Education, Social dynamics

Linkages with health system:
-Health care is viewed as luxury
-Convenient care is with informal/private sector (-
Women are not attending the ANC visits necessary and thus are not linking with the health system
- Opportunity cost of leaving work for ANC is too high

SBCC Messaging
-Unclear how to best communicate messages
-Mixed messages: confusing exposure to urban realities + traditional practices
-Mobility: hard to reach women with consistent, regular messaging

2nd Delay

Delay #2
Reaching a Functional Facility

Referral:
-Women are often not linked with formal health system
-Delays from ill-equipped facilities to tertiary level
-Families rarely trust the referral (lack of trust in system)
-No system for linking/connecting private with public facilities for information sharing or updating on status

Address Referral, Access Transport and Communications

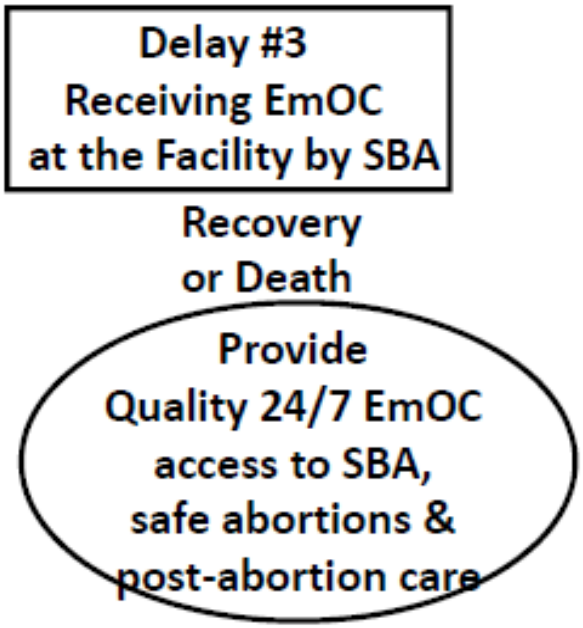
Transportation:
-Access is a myth
-Distance is not far for women to travel
-Price hikes at night
-Cost of transportation is a barrier
-Few slums have wide enough roads for vehicles
-Crime in slums prevent women from traveling at night

3rd Delay

24/7 CEmOC Facilities:
-Very few facilities have the staff necessary to manage the patient load
-Self-referrals overwhelm tertiary hospitals
-Clinicians working in public sector may be ineligible for gov't benefits (Bd)

Quality of Care
-Abysmal quality of care
-No regulation of private sector
-Women fear the care they will receive: 'tongue lashing, rude, bad attitudes, etc. of providers

Subsidized care:
-Despite many programs to help subsidize care for the poor, studies show women are prevented entry without payment, informal fees are ubiquitous
-Lack of reliable data on #'s of women in slums precludes most vulnerable from participating in any program



Programmatic considerations

- 2019 Cochrane review on nutrition interventions in urban slums: concluded there was little evidence on effective interventions in the urban slum context. [1]
- A systematic review on urban CHW programs: most programs appear to be largely copied from rural models, with little innovation and/or tailoring for the realities of urban settings. [2]
- Insufficient evidence on solutions = set a focused learning agenda
- Poor positioning and governance = reframe the demographic argument (avoid reinforcing negative stereotypes about the urban poor; use disaggregated urban data to debunk idea of universal urban advantage)

[1] Goudet SM et al. Cochrane Database of Systematic Reviews 2019, Issue 6. Art. No.: CD011695. DOI: 10.1002/14651858.CD011695.pub2.
[2] Ludwick et al. Health Policy and Planning, 2020, 1–14 doi: 10.1093/heapol/czaa049

Strategic considerations

- Link with existing/emerging global priorities (migration and displacement; climate change and resilience)
- Identifying and tracking pregnancies in slums is challenging. Potential for better reach and intensity with media, technology, social media
- Urban has different social networks, social capital, individual vs group survival strategies. Establishing trust is fundamental
- Programmatic recommendations:
  - Integration: RMNCAH continuum, intersectoral, home-to-hospital
  - Context-sensitive and equity sensitive
  - Flexibility and the ability to adapt quickly
  - Depth rather than breadth
  - Link MNH issues with other health issues and efforts (e.g.WASH)

THANK YOU

Save the Children