CHORUS
RESEARCH ON URBAN HEALTH

CHORUS: and introduction and initial findings from needs assessment in Nepal and Nigeria

(Community-Led Responsive and Effective Urban Health Systems)

Agenda

1. Introduction to CHORUS (Helen Elsey)
2. Early results from Nepal: *Understanding the mechanism to strengthen the service delivery of non-communicable disease programs for urban poor at the primary health care setting in Pokhara (Sushil Baral)*
3. Early results from Nigeria: *Trajectories of health seeking in urban slums, their drivers and implications for primary health care (Chinyere Mbachu & Prince Agwu)*
4. Global Actors in Urban Health (Irene Agyepong)
5. *Q&A*

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Introduction to CHORUS

Helen Elsey

SUSTAINABLE DEVELOPMENT GOAL 11

Make cities and human settlements inclusive, safe, resilient and sustainable

Megacities account for 9.9% in 2011 will rise to 13.6% in 2025 of urban population. 50%+ of urban population live in smaller cities of <500,000

By 2050 70% will live in cities globally. Africa and Asia are urbanising the fastest. By 2050 56% will be urban in Africa and 64 % in Asia.

2000 to 2014 slum population dropped 28.4%-22.8%
Actual number of people living in slums increased from 807 million to 883 million.

Surveys can mask urban inequities:

Under 5 Mortality rate: Nairobi slums 79.8 v rural 56/1000lb
Infant mortality rate: Bangladesh slums 49 v 40 rural v 34 non-slum urban

Urban Health issues

- Lack of accessible quality primary care and outreach: Plurality of health service providers: private, NGO, informal, public, specialist hospitala
- Wider determinants – e.g transport, housing, water, sanitation high influence on health
- Changing norms and commercial determinants – increasing health risk factors
- Invisibility of urban poor – poor representation in data and governance
- Complex and multiple government actors – local government low capacity but central role

A consortium based in five countries

Nigeria Prof Obinna Onwujekwe

University of Nigeria
to restore the dignity of man

Bangladesh Prof Rumana Huque

ark foundation
advancement through research and knowledge

BRAC JAMES P GRANT SCHOOL OF PUBLIC HEALTH

Prof Zahidul Quayyum

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Ghana Dr Genevieve Aryeetey

UNIVERSITY OF GHANA

Prof Irene Agyepong (CEO)

Nepal Dr Sushil Baral

HERD International

United Kingdom

Prof Tim Ensor (Co RD)

Polly Spooner (Coord)

UNIVERSITY OF LEEDS

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

UNIVERSITY of York

Prof Tolib Mirzoev

Prof Helen Elsey (Co RD)

www.chorusurbanhealth.org @ChorusUrban

We aim to strengthen health systems in urban areas, by:

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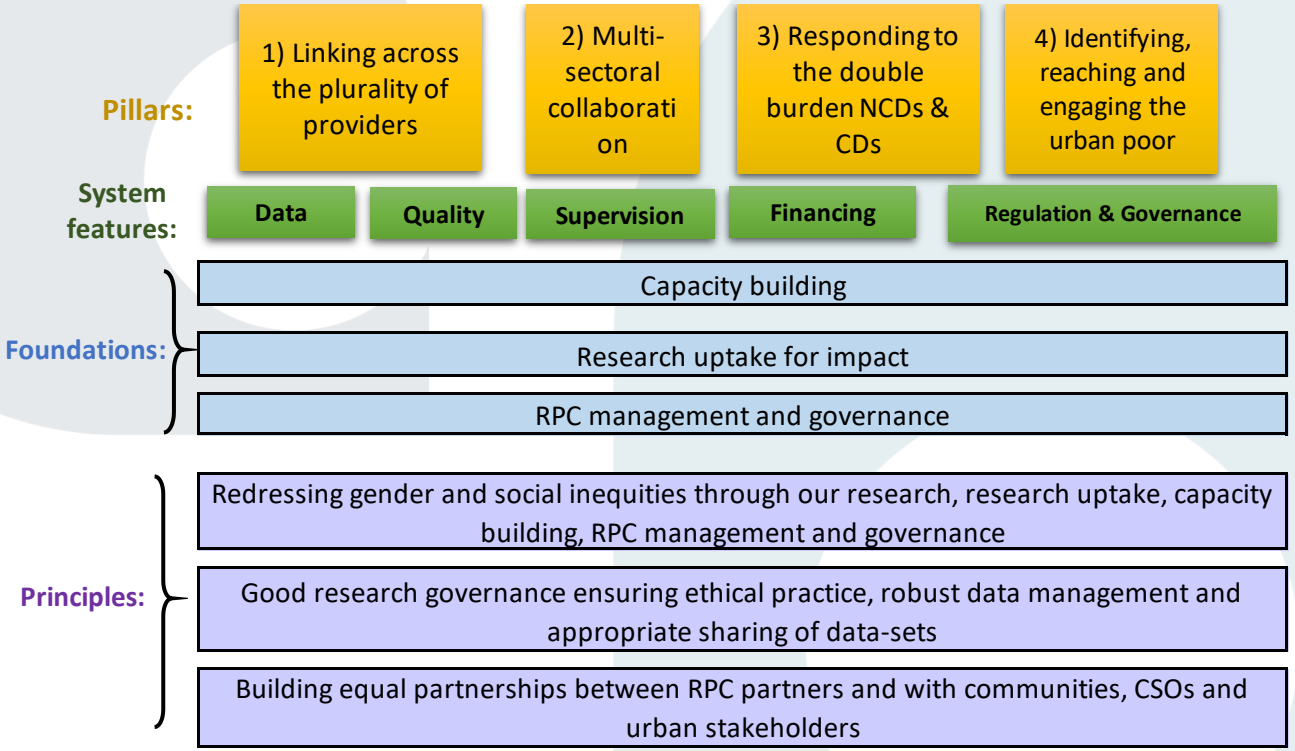
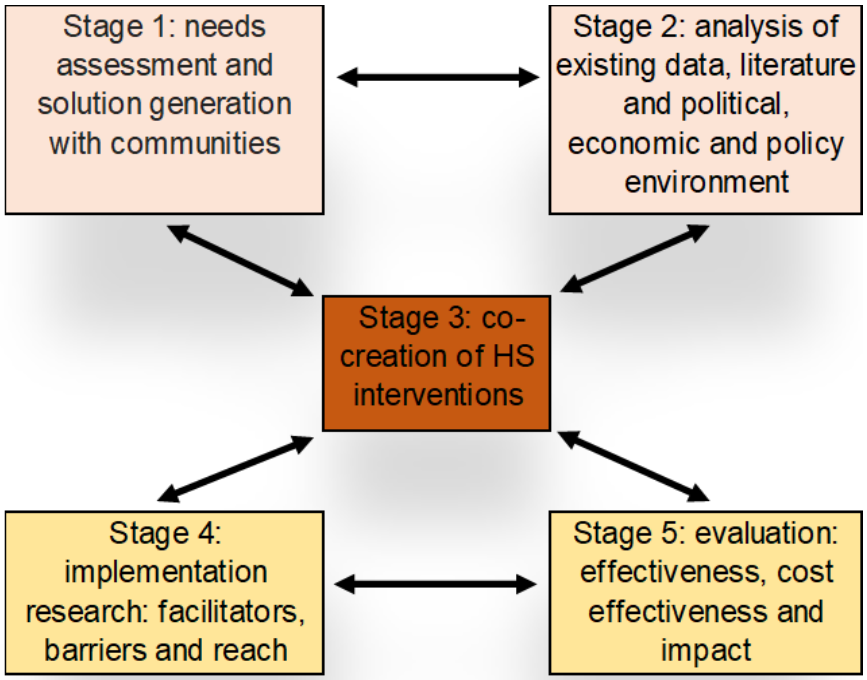


CHORUS seeks to:

"Enhance capability to generate and use high quality research evidence to inform and influence multisectoral health system interventions, policy and programme decisions and implementation at local, national and international levels to improve the health of the urban poor and slum dwellers" (outcome)

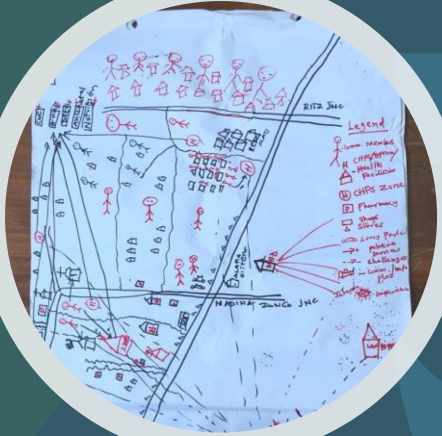
- One large and one medium-sized city, **two projects** Nigeria, Ghana, Bangladesh and Nepal
- **Innovation Fund**: £50,000 or less for early/mid career researchers to lead projects.
- **Capacity strengthening:** assessments, action learning groups, training, webinars, mentors, secondments and 2 PhDs
- **Research uptake**: city, national, regional, global

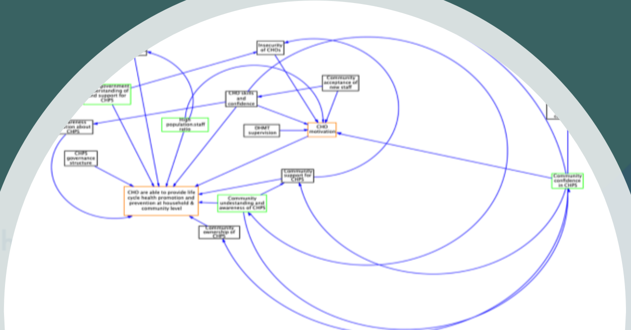


UNIVERSITY OF GHANA

To design, implement and evaluate an intervention to provide and support life cycle health promotion and prevention at the household and community level in cities

- 1) Series of engagement workshops 2021
- 2) Orientation workshops in 4 sites in Madina and Ashaiman, Greater Accra 2022:
- 3) Transect walks : detailed discussions with communities in Madina West, Madina Zongo, Fitter line and Taifa
- 4) Qualitative interviews with policy makers, community health teams, district officers.
- 5) Systematic review of CHPS effectiveness , facilitators and barriers jointly with Ghana College of Physicians Surgeons
- **Issues:** functionality of CHPS (primary care/outreach), substance abuse, NCDs, volunteerism, role of district assemblies/health, vulnerable groups: elderly, young people, new migrants, refugees, environment.





ark foundation
advancement through research and knowledge

Project 1: Strengthening urban primary health care for Non Communicable Disease (NCD) care in Dhaka

- engaging with city leaders and public primary healthcare providers to co-design e.g. improved digital records and management of NCDs
- Analysis of DHS survey data urban NCDs
- Policy review, interviews and analysis
- Qualitative phase: patients, communities (including transgender), health providers and city corporations
- Health facility assessment for NCD care delivery and systems

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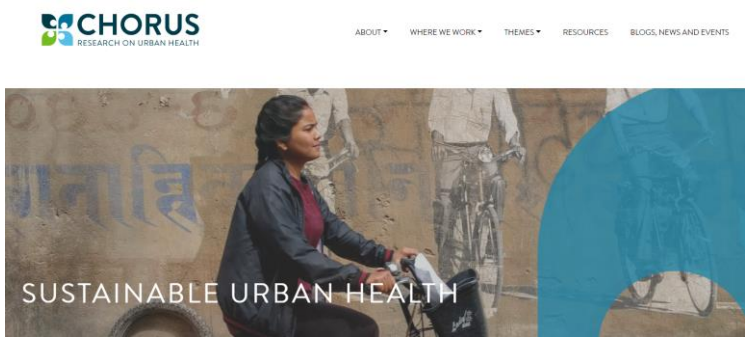
Project 2: Urban primary care models (starting 2023)

- Engagement with city corporation and primary care in Khulna
- Ethics
- Scoping review
- Qualitative and participatory methods

Current cross-CHORUS activities

- Systematic review of Public Private Partnership models on the utilisation of urban primary health care services and their role on urban health system strengthening in LMICs
- Panel session at ICUH 2022 on gender and intersectionality across CHORUS, 2 presentations on needs assessments
- Panel session at HSR2022 on co-design process and from needs assessment, Community of Practice on urban health with ARISE and Africa Cities
- Covid-19 and cities reports and blogs available on CHORUS website
- Blogs on emerging issues from needs assessment available on CHORUS website
- Safeguarding focal point training, systems and SOPs



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CHORUS Nepal Project 1:

Understanding the mechanism to strengthen the service delivery of non-communicable disease programs for urban poor at the primary health care setting in Pokhara

Sushil Baral

22 Sep 2022

Context

Federal Nepal

- While federalism is progressive with defined core functions, clarity on roles and implementation modality – slow and patchy implementation
- Three types of government: federal, provincial, local - not hierarchical tiers
- Legally autonomous: own elected leadership, organisation, funds, staff and functions

NCDs

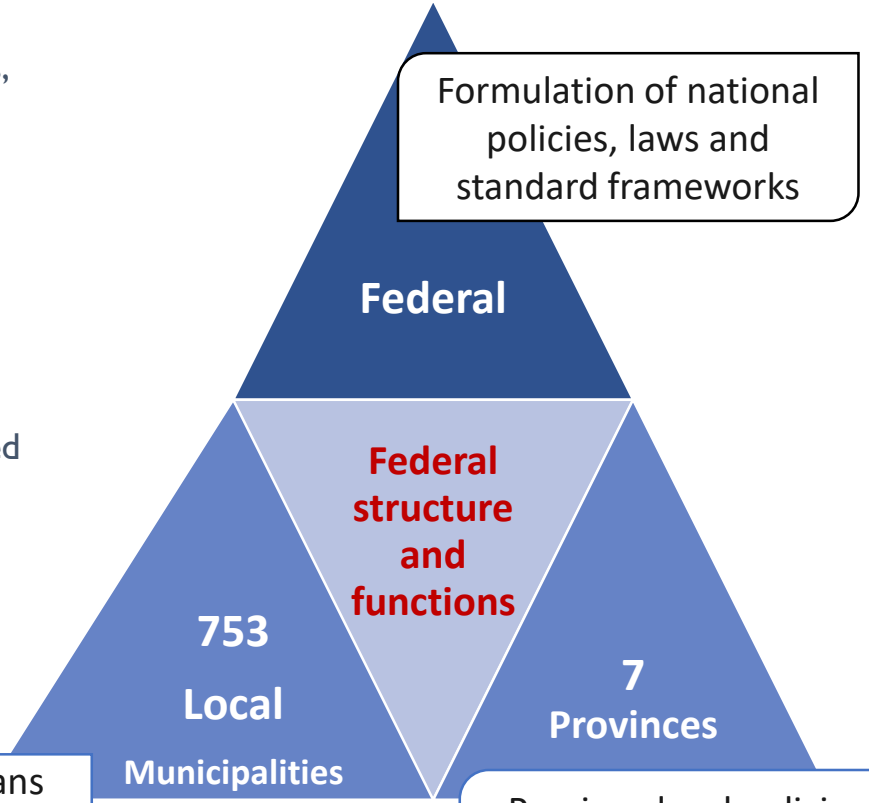
- Accounts for two thirds of total deaths; and Nepal adopted WHO package for essential Non communicable disease

Urban poor

- Masked by urban rich and middle class

Private health care providers

- Major service provider with pharmacy as most common
- Limited service and data linkage
- Weak regulations



HERD International

Objectives and methods – Participatory Action Research

Overall objective: understand the approaches to strengthen local (municipal/urban) health system that engages private health providers in delivering quality health services with focus on NCD prevention and care, to urban poor and marginalized.

Context analysis

Assessing gaps and needs of municipal health system

-Documents review,
-Qualitative interviews
-Secondary data analysis
-Health facility readiness assessment (all public and private)
- *Community mapping*
- *Identification of urban poor*

Prioritization and co-creation

Co-creation of interventions

-Discuss gaps and possible solutions
-Develop and prioritize low cost and high impact interventions

Implementation, evaluation and learning

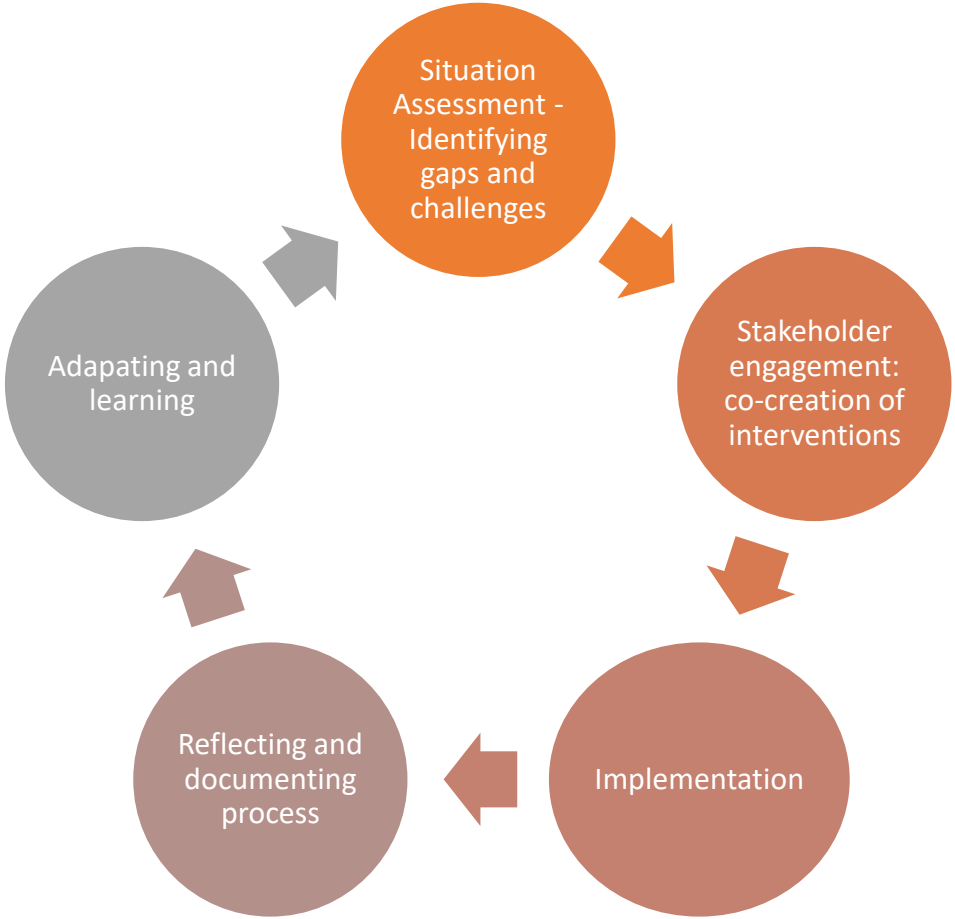
Implement, reflect, adapt and evaluate

-Provide technical assistance to enhance capacity
-Support institutionalization of learnings and document Process documentation and adaptation of intervention

HERD International

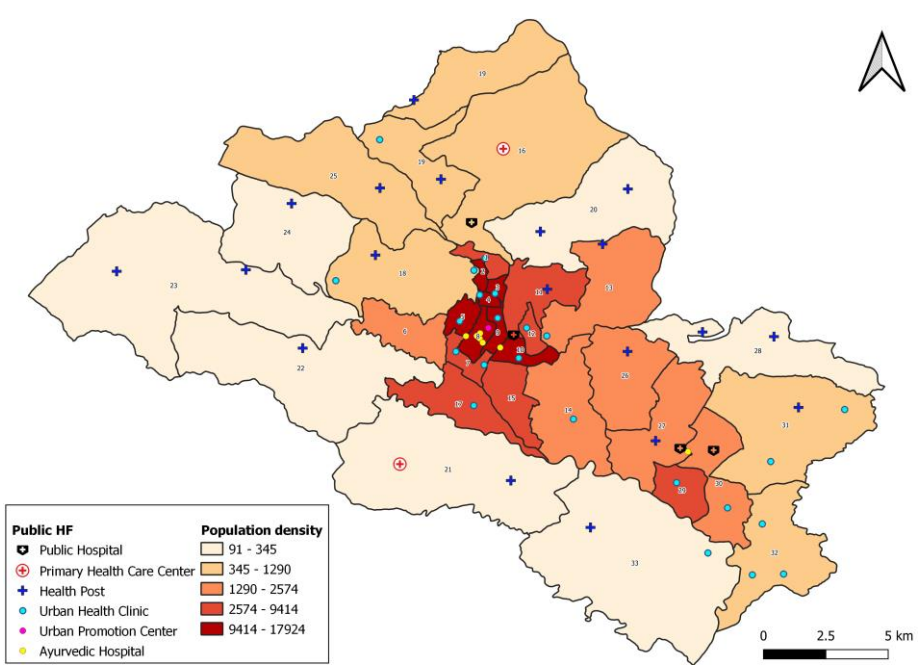
Process

- Engage with local stakeholders - strong and trusting relationships
- Embedded researchers within the municipal health system
- Locally tailored co-creation approach
- Policy influence and scale up – linkage between sub-national and federal policy and learning

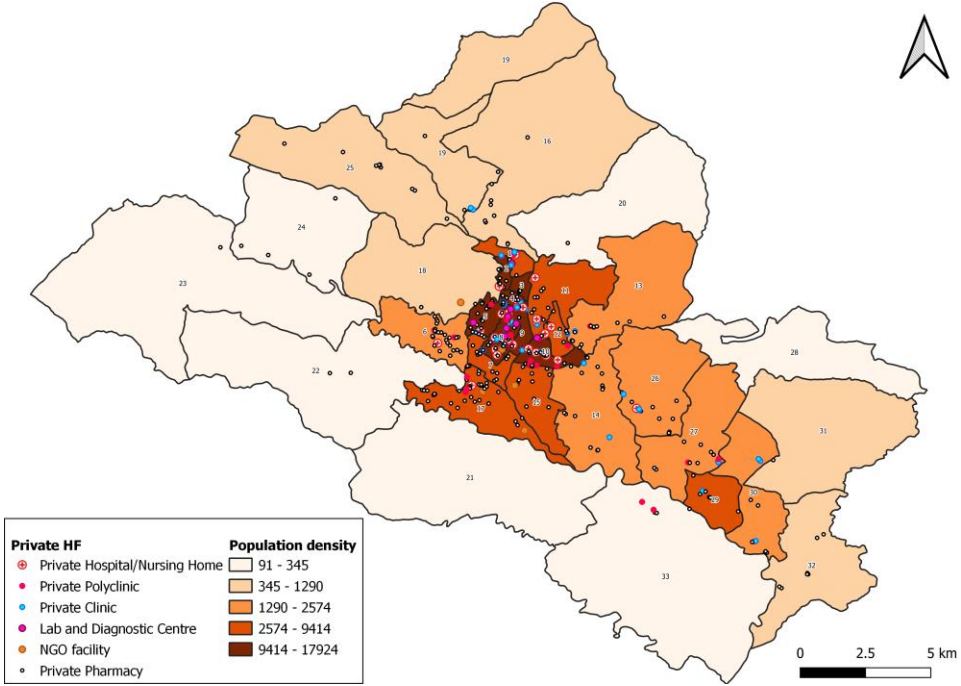


Health Facility Assessment Findings

Distribution of public health facilities



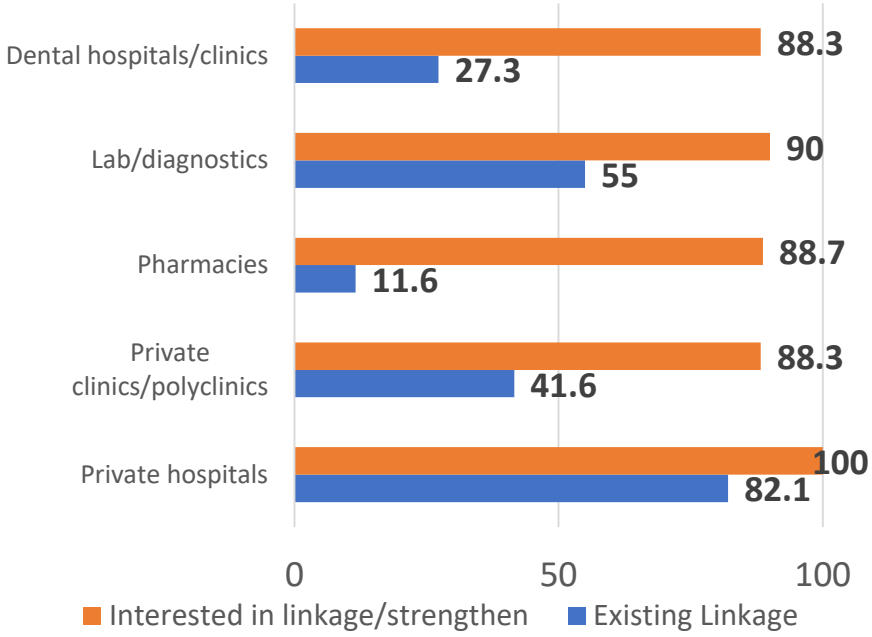
Distribution of private health facilities



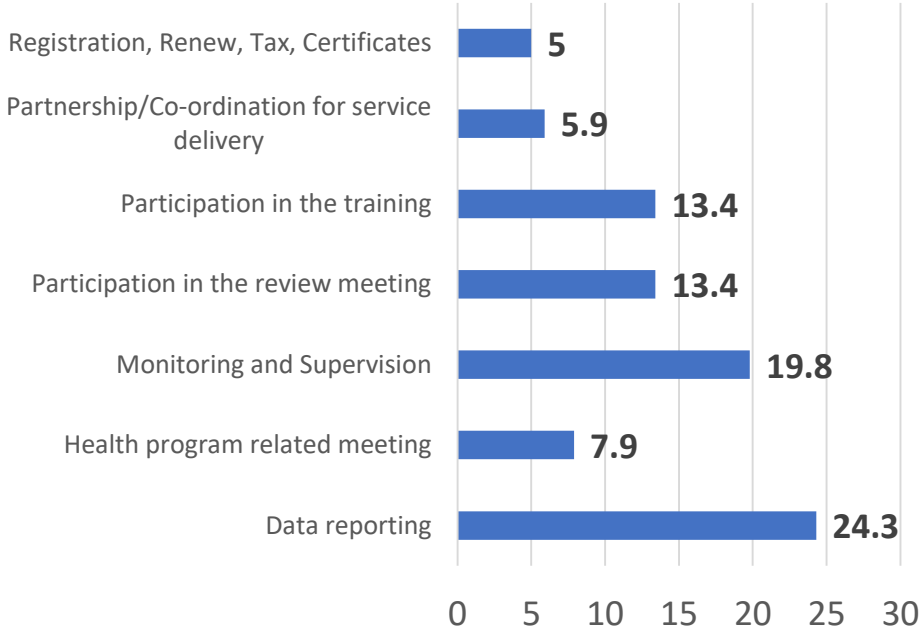
Private health facilities are more concentrated towards densely populated areas; PH services less accessible to people

Health Facility Assessment Findings

Linkage with PMC and interest to develop by types of private health facilities (%)

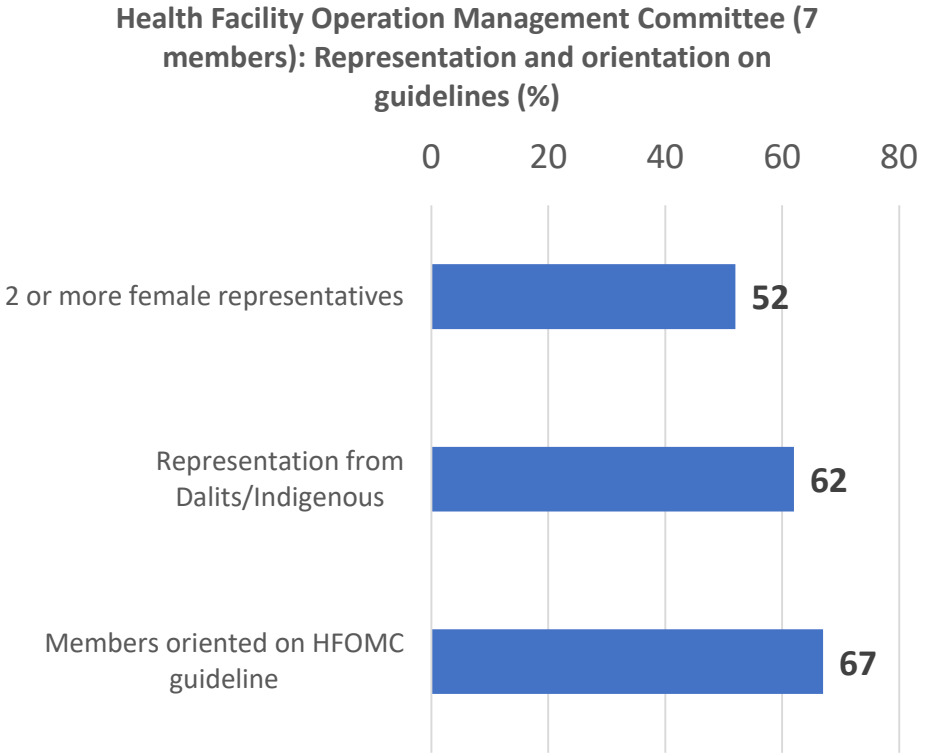


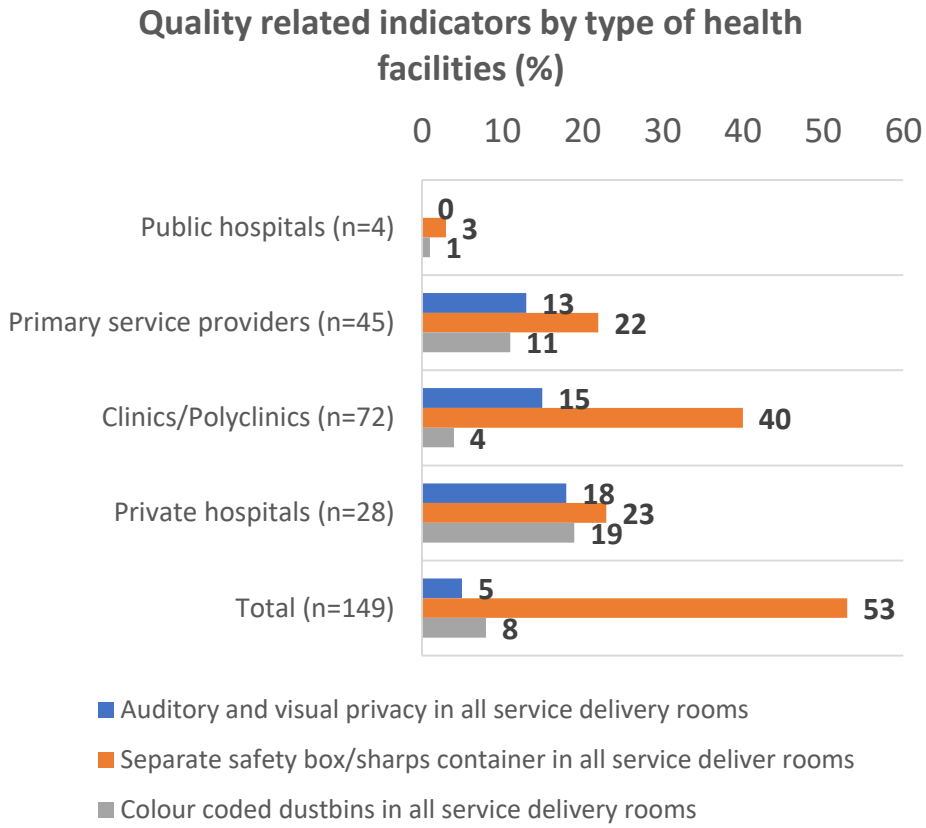
Types of existing linkages with PMC excluding Pharmacies (%)



Considerable gap in existing linkage despite private sectors showing interest in partnership

Health Facility Assessment Findings

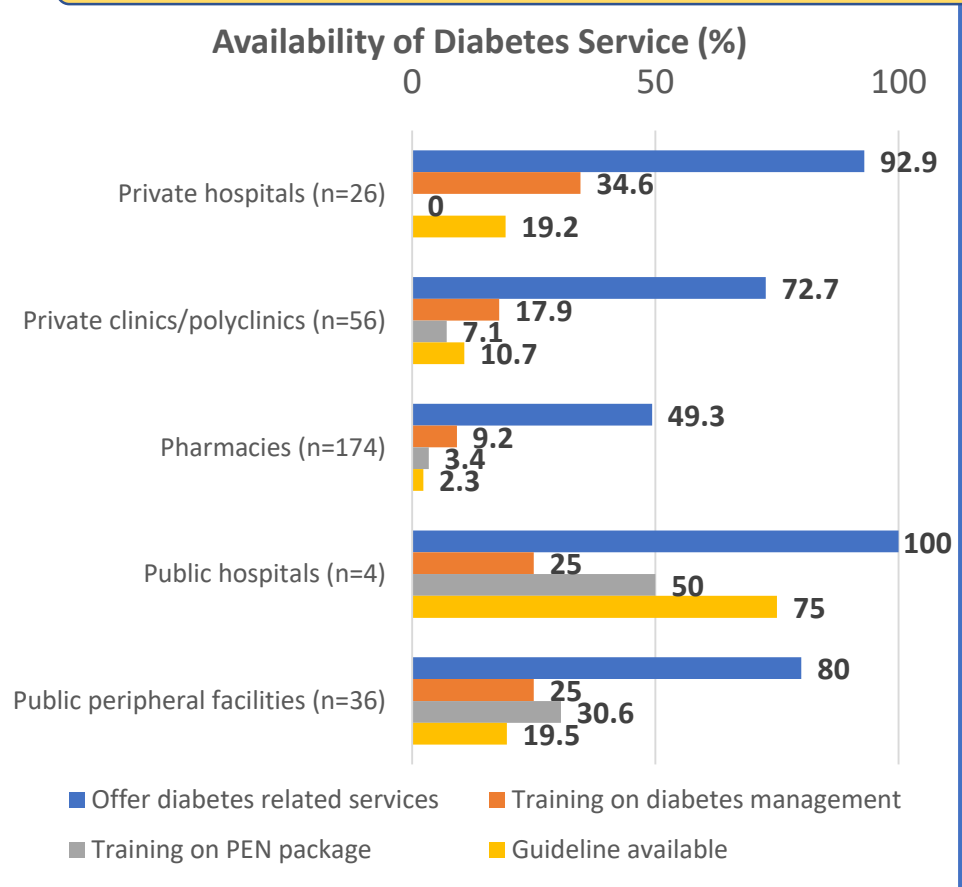


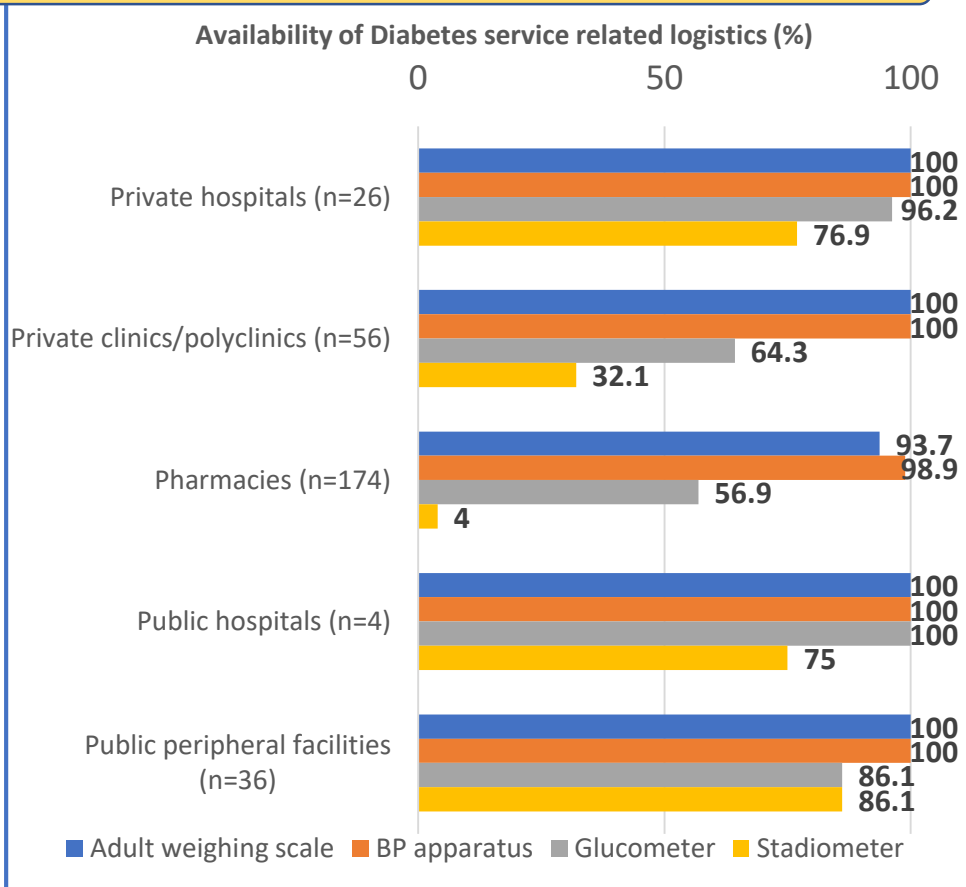


Guideline ensures at least 2 female but only 52% public HFs adhered to that. Likewise, HFOMC quality of care was compromised where not more than 18% of HFs had auditory and visual privacy in all service rooms

Health Facility Assessment Findings

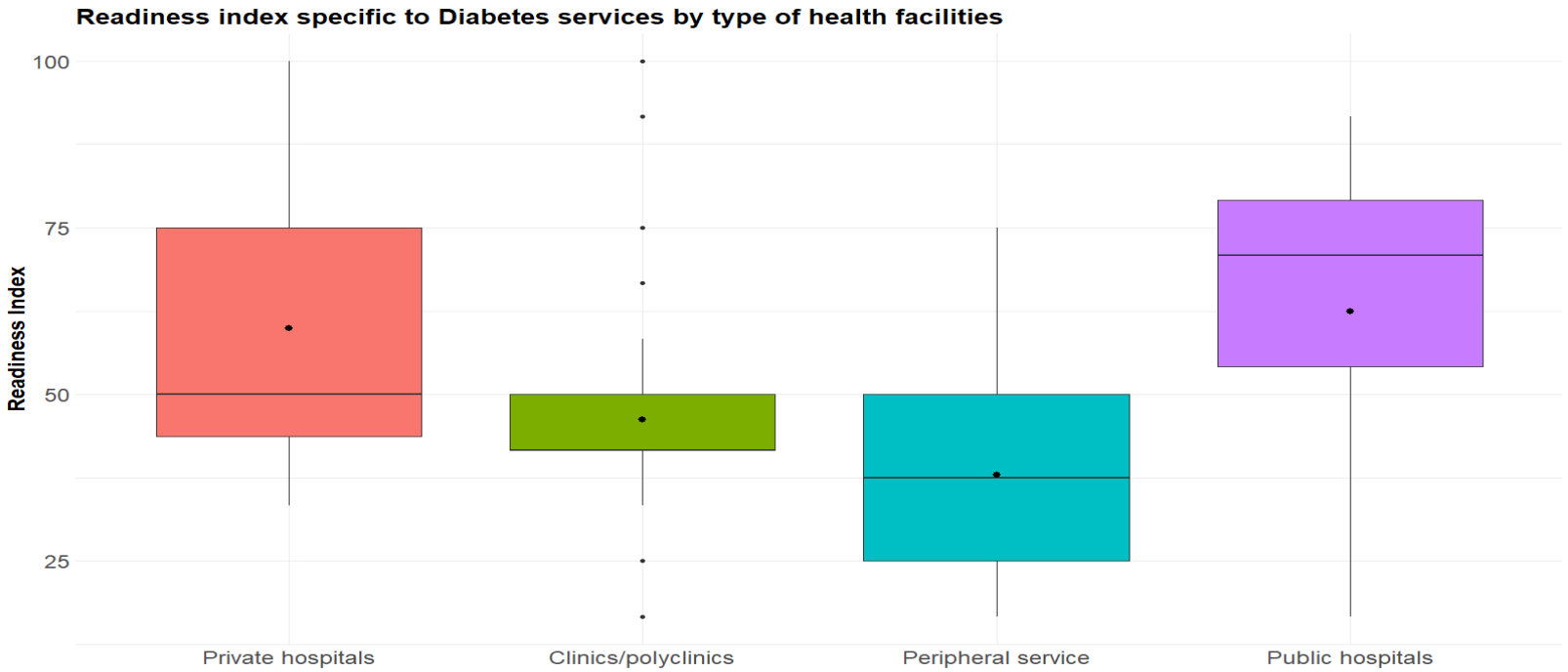
Limited health facilities had required equipment, trained HR and guideline to deliver diabetes related services





Health Facility Assessment Findings

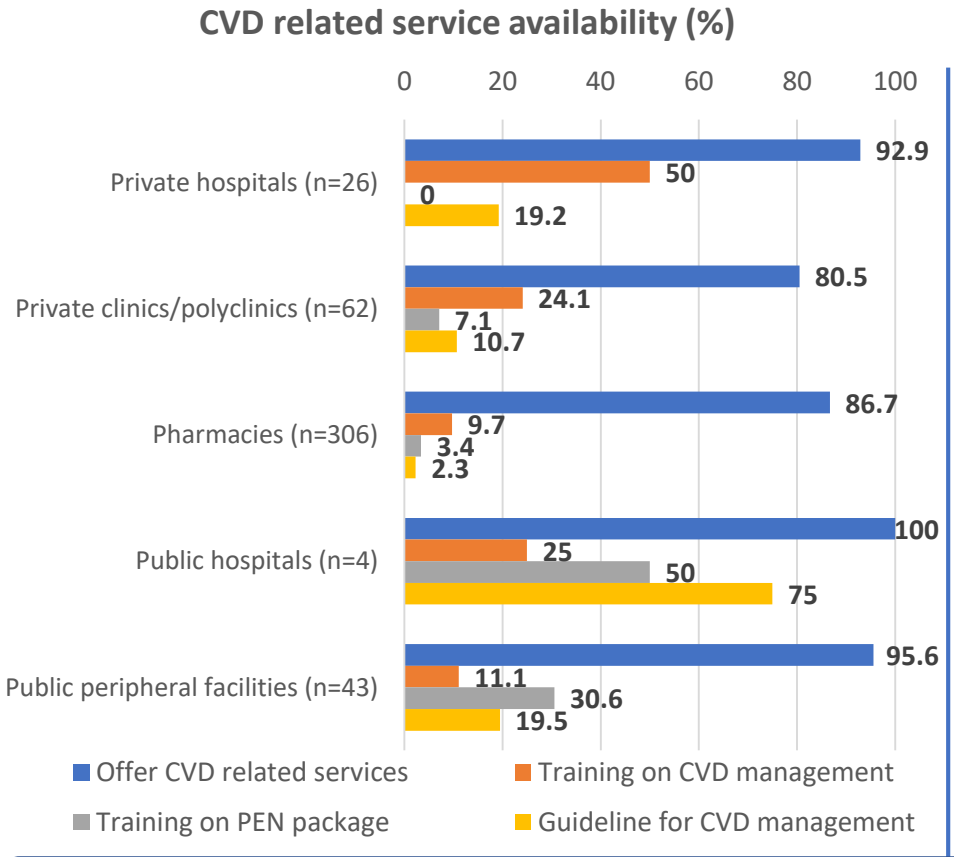
Service Readiness for Diabetes related services

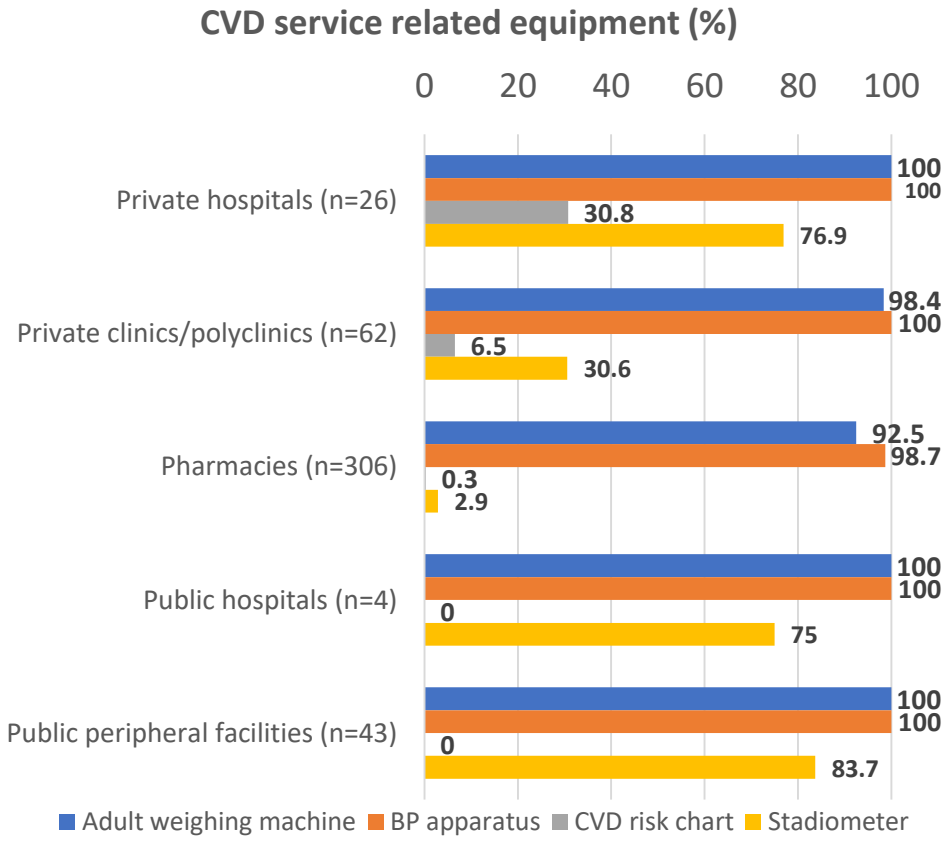


Readiness score is calculated referring to WHO SARA and include HR, Guideline, Equipment and Drug related to diabetes

Public hospitals have better readiness for diabetes care services, where public primary facilities had the lowest

Health Facility Assessment Findings

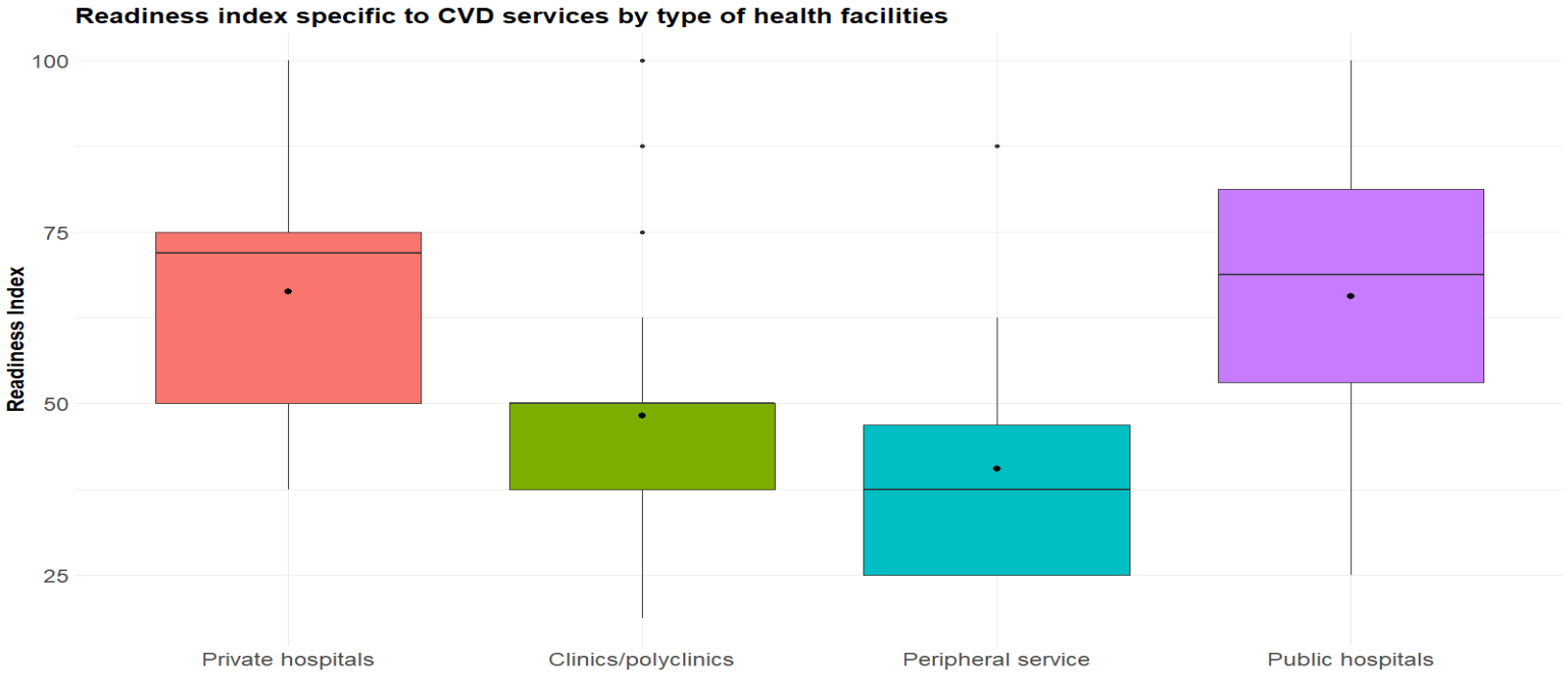




Similar observation was for CVD service that lacked required equipment, trained HR and guideline to deliver CVD related services

Health Facility Assessment Findings

Service Readiness for CVD related services

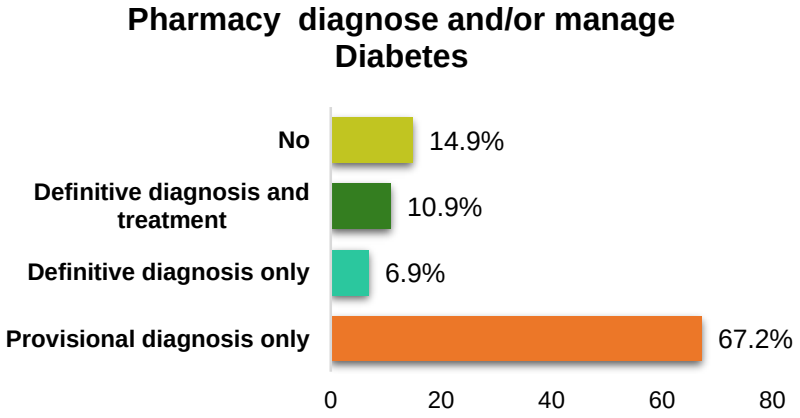


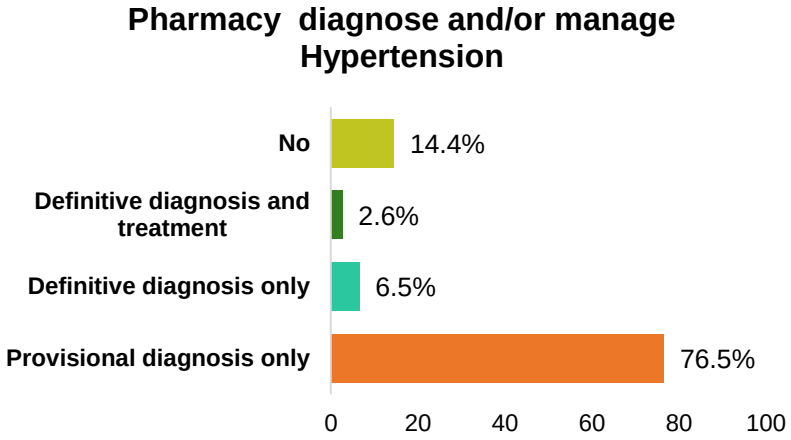
Readiness score is calculated referring to WHO SARA and include HR, Guideline, Equipment and Drug related to diabetes

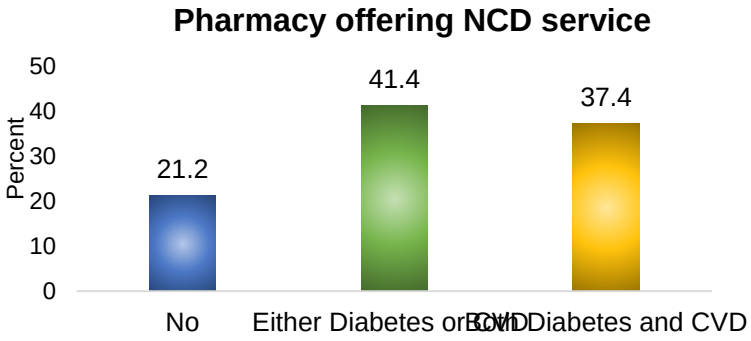
Private hospitals have better readiness for CVD care services, where public peripheral level facilities had the lowest

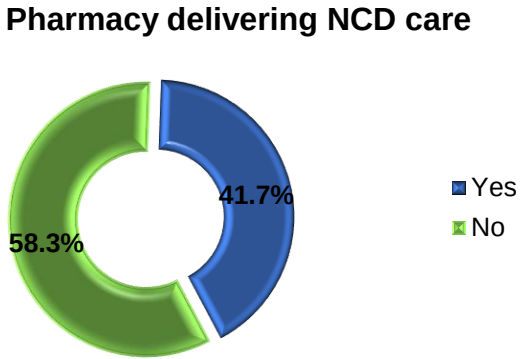
Health Facility Assessment Findings

Pharmacies are delivering the NCD care services beyond drug dispensing, and 40% of them have at least one paramedics

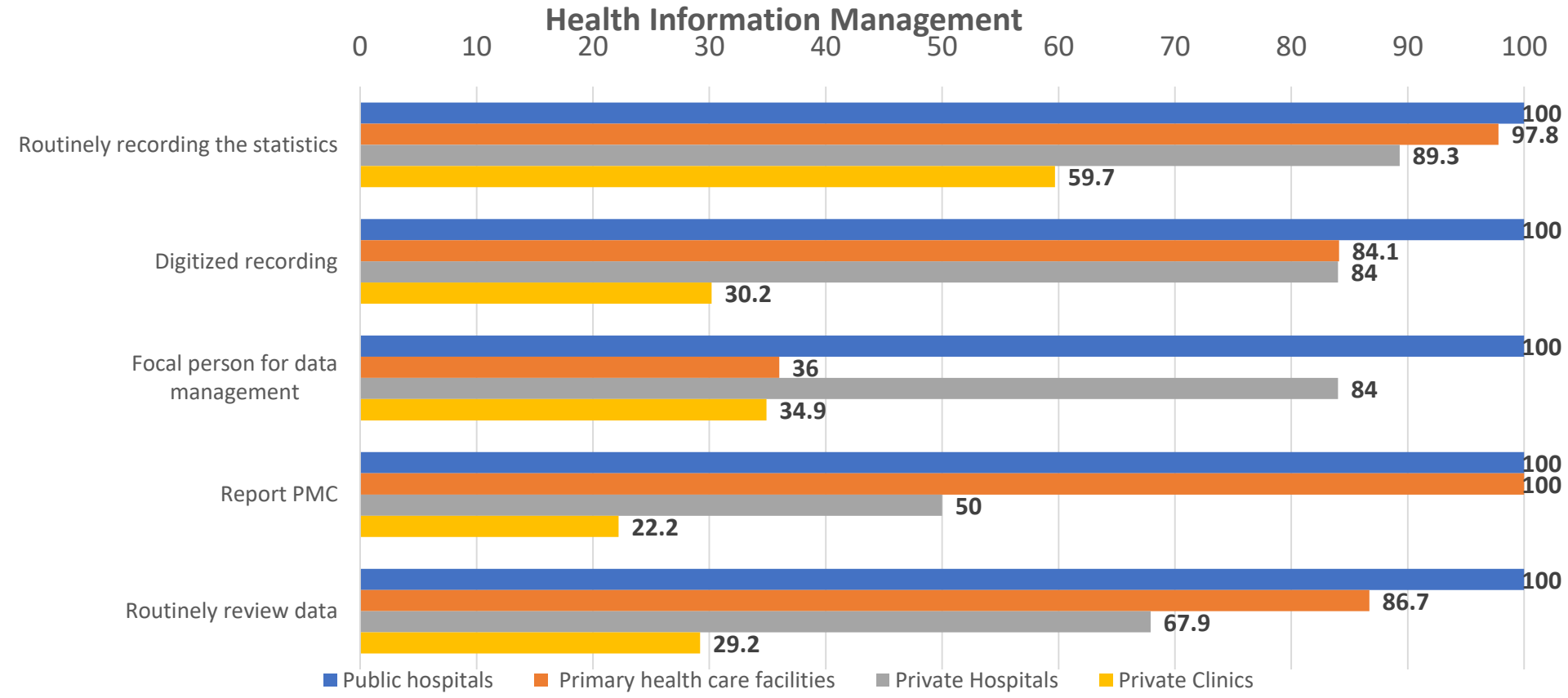






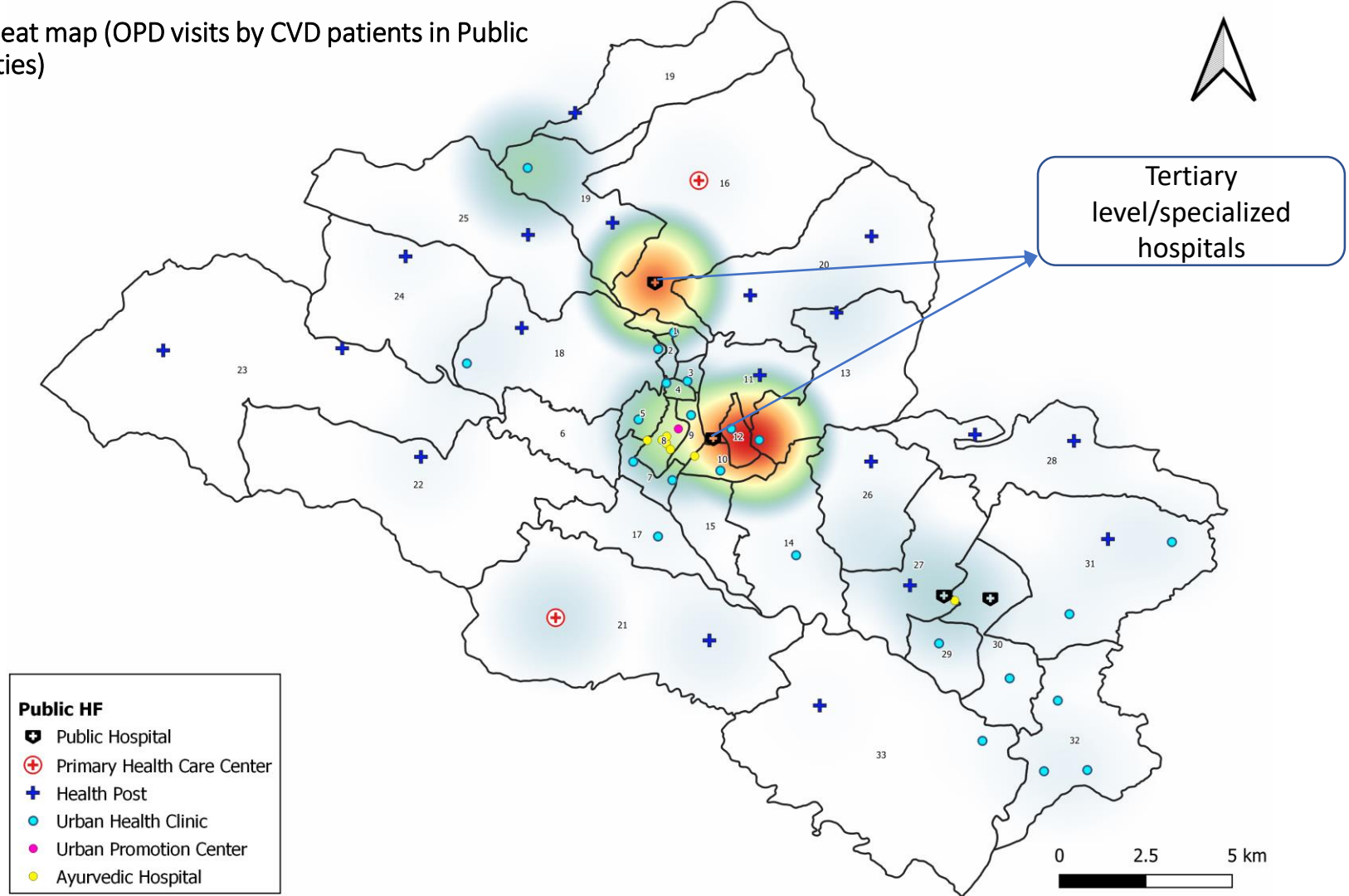


Health Facility Assessment Findings

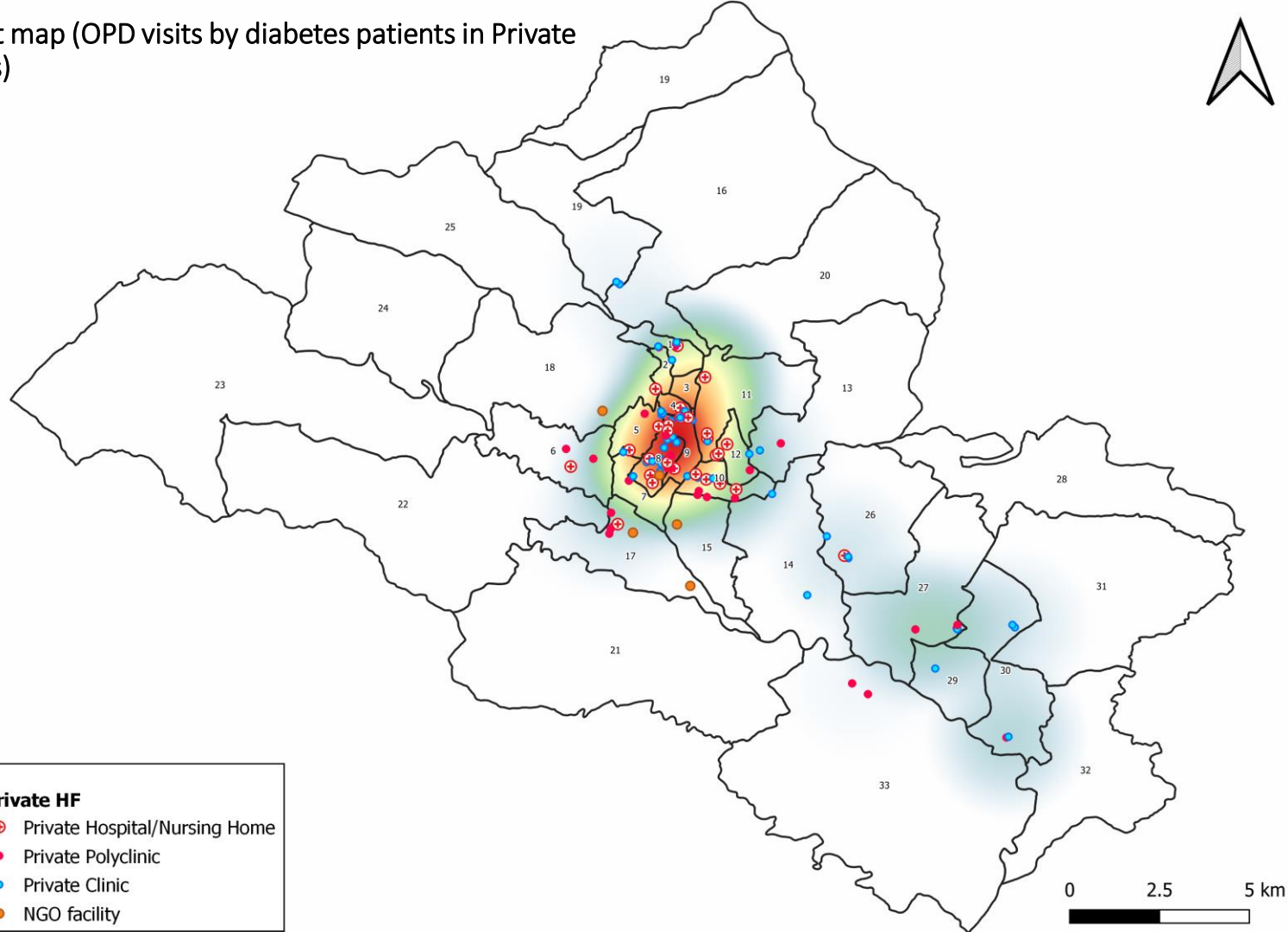


Most of the private health facilities have recording system but not shared with HMIS

Pokhara – Heat map (OPD visits by CVD patients in Public health facilities)



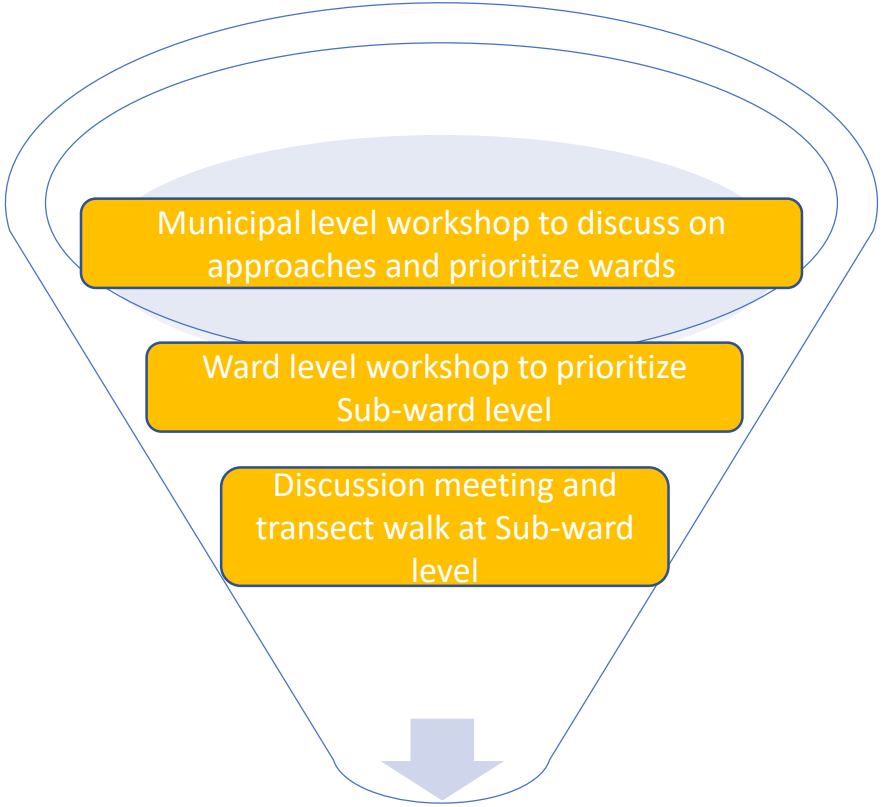
Pokhara – Heat map (OPD visits by diabetes patients in Private health facilities)



Qualitative findings

System level

- *Minimal political attention in health issue; e.g. management committee not focused in quality assurance and efficient health service delivery*
- *Clarity in role and effective coordination lacks in supply of essential medicine among province, district and metropolitan city*
- *NCD not in the priority despite in top five disease (hypertension is #1) of the city*
- *Lack intersectoral coordination in identifying urban poor households*
- *Struggling governance to mainstream private sectors*
- *Contractual HR potential threat to resilient health system;*



Urban Poor Identification

Qualitative Study Findings

Institutional level

- *Lack trained human resources (HR) on NCD/PEN*
- *Despite of receiving NCD care training, lack necessary medicine and equipment*
- *Limited HR to deliver the comprehensive health service*
- *Lack of uniform understanding on recording;*
- *Private providers not mainstreamed in terms of adhering to the government guidelines*

Focus group discussion with adult female

Community level

- *Misconception towards hypertension and diabetes; high prevalence considered as common but not severe*
- *Commonly exposed to risk factors like alcohol, tobacco use, and stressed working environment*
- *Difficulty to access and utilize social health insurance*
- *Extended service hours and proximity to access pharmacies*
- *Difference according to age and gender in seeking care*
- *Dissatisfaction towards behavior of public health providers*

Social Mapping with Key Informants

Conclusion

System level

- Weak coordination across three tiers of government and among municipal stakeholders
- Absence of appropriate mechanisms to identify urban poor and their health needs
- Weak formal mechanisms to engage with private sectors delivering NCD care services
- Weak capacity of municipal health system in policy, planning and supervisions support

Institutional level

- Poor readiness of NCD care services (CVD and diabetes) highlights the need to strengthen basic NCD care services
- Pharmacies were providing the NCD care services beyond drug dispensing but without formal linkages

Community level

- Lack trust towards public health providers
- Bypassing/underutilization of public primary health facilities, use of private providers

Challenges and Lesson Learned

Challenges

- Understaffed health coordination division with high-workload, leading to delays in many fronts
- Weak linkages across different units/departments in municipality leading to disjoined efforts, silos, lack of information sharing
- Reluctant private sector to share information despite efforts
- COVID-19 risks to researchers and participants, impacting field work

Lesson learnt

- Social mapping found effective to identify poor households using funnel approach
- Use of COVID-19 protocol under safeguarding policy demands more time and resources
- Ownership of research works by municipal leadership leading to effective implementation
- Leadership transition in municipality required more efforts in coordination
- Effective implementation of safeguarding measures by field researchers and stakeholders vary

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Project 1 Title: Developing and institutionalising health system linkages between the public and informal sectors for improving the equitable provision and use of appropriate essential health services in urban slums in Nigeria

First reconnaissance output: Trajectories of health seeking in urban slums, their drivers and implications for primary health care

By

Health Policy Research Group, University of Nigeria

UNIVERSITY OF NIGERIA
NSUKKA

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Research questions for project 1

- How can the links between informal health service providers and formal health system (MoH, formal public and private providers) be strengthened to ensure delivery of essential and quality health services in urban slums and for the urban poor?

- How can the capacity of selected non-formal health service providers be strengthened to deliver quality health services within the limits of their capacity and practice?

- What will be the roles of various institutional structures in ensuring the formalisation and successful creation of linkages between the informal providers and formal health system in urban slums and for the benefit of the urban poor?

- What governance, monitoring and supervision mechanisms are effective in managing the created linkages of the informal providers within the public health system?

- How can the various health system building blocks be optimised to ensure effective and sustained linkage between the informal and formal health system for overall optimal health system performance in urban slums and for the urban poor?

Some images of the slums

1

2

3

4

1 – Onitsha
2 – Enugu
3 – Onitsha
4 – Basic bone setting equipment in a slum

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Study Areas – Slums in Enugu and Onitsha Cities

Qual/Quant Research

1.Stakeholders' townhall meetings/workshops

Mapping of potential stakeholders and strategic areas in the urban slums to visit

1.Advocacy visits to key decision makers

1.Reconnaissance in the study areas

Follow-up interviews, focus group discussions, and surveys with key stakeholders and households

Why and how reconnaissance?

- Reconnaissance is regaining grounds in research uptake, especially in exploratory studies. It entails conducting detailed espionage on subject matters and areas that have never been researched or under-researched.

- Informal settings for conversations is the aim of reconnaissance. Respondents feel relaxed and attend to conversations without feeling that their voices are being taped or are compelled to stick to the formality of interviews.

- The reconnaissance approach is justified as a good research approach to break into communities, understand complex and nuanced behaviours, and explore paradigms (Lloyd, 1965; Nix & Seerley, 1971).

- We spoke to 104 persons across 8 slums in 8 weeks

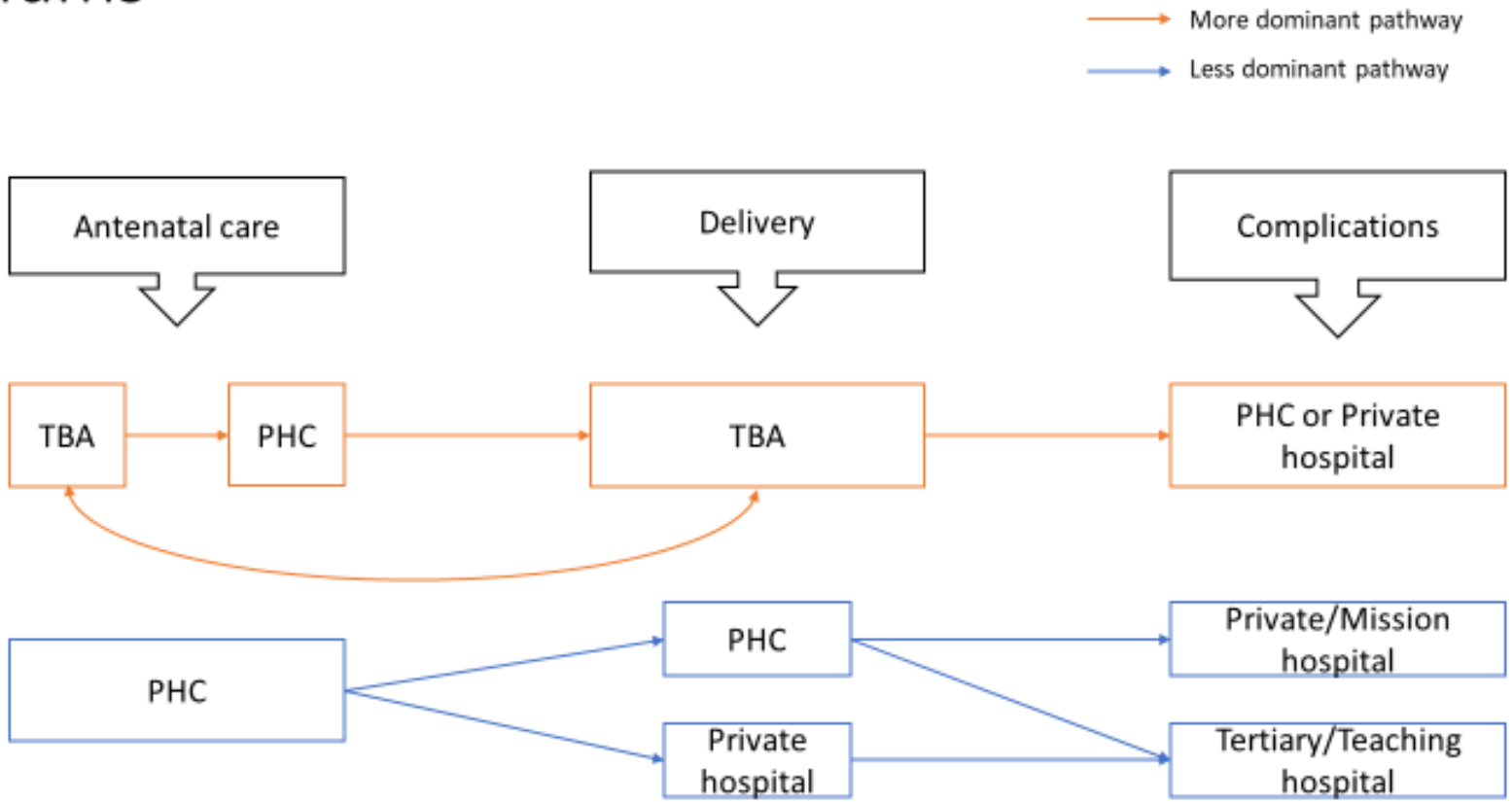
Explored paradigms during the reconnaissance

Paradigms	Methods
Health seeking trajectories of community members	• Identified key contact from the list of contacts during the mapping • Random conversations with community members on locations of specific informal and formal providers • Visited informal and formal providers and soliciting referrals • Random conversations with community members on health seeking history, patterns, and current/future options • Triangulated the above with information from formal and informal providers • Identified thought patterns and trust level through explanations about health seeking behaviours by users and providers • Identified different shades of community support to informal and formal providers

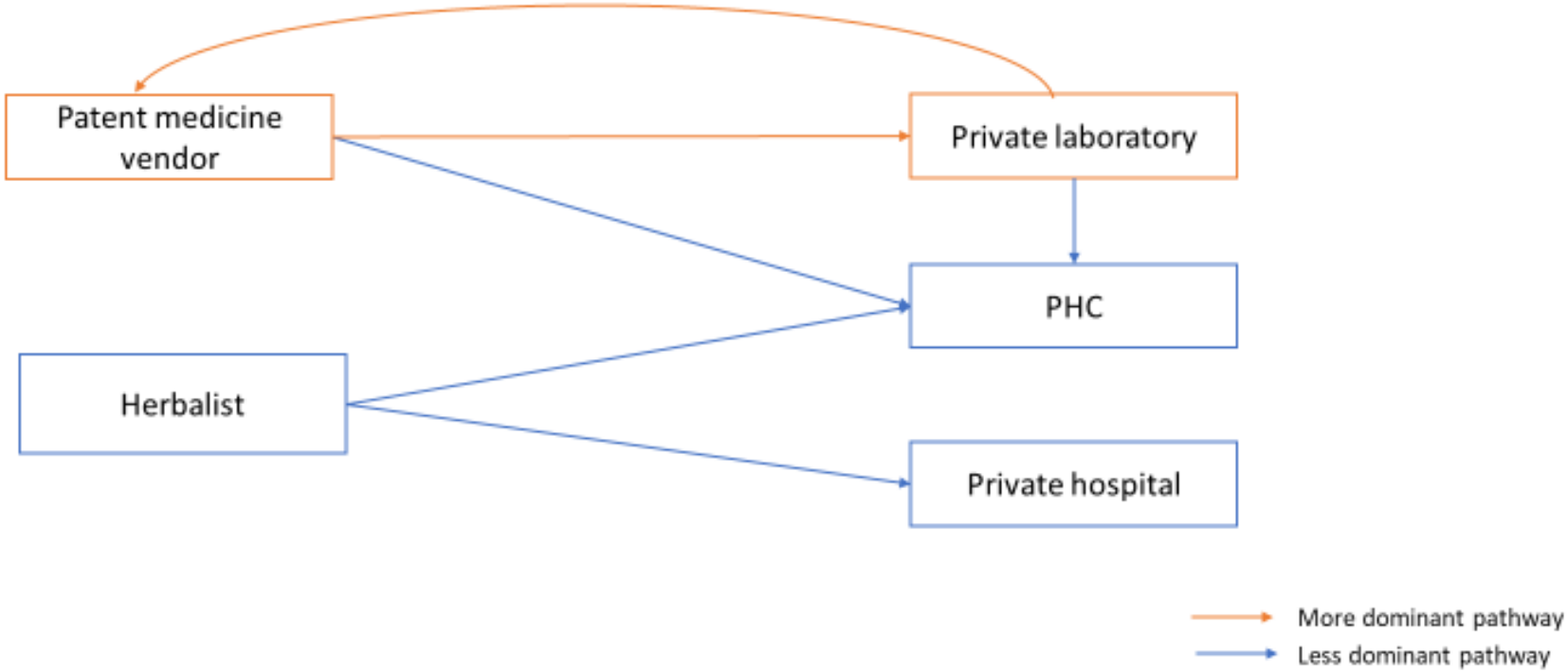
Other explored paradigms during the reconnaissance

Paradigms	Methods
Scope of services of informal providers and dynamics of patronage, referrals, and protection	• Had conversations with informal providers on (a) training (b) supplies (c) securing and sustenance of patronage, and (d) understanding of service limits and regards for safety of users (e) the roles of unions
Relationship between informal and formal providers	• Explored the nature of referrals • Explored CSOs' and NGOs' efforts in scaling up the health of slum residents and reactions of informal providers and the residents • Looked out for collaborative and conflictual instances between both providers
Improving relationship between formal and informal providers	Tried to discover: • Readiness for linkage • Concerns about linkage • Possibility of linkage

Pathways for maternal healthcare seeking in urban slums



Pathways for other healthcare seeking in urban slums



Important lessons for us

- Primary healthcare centres are not considered optimal by slum residents, and this has affected trust
- Slums without PHC facilities within quick reach rely on informal providers
- Informal providers are supported and respected by community residents, and some attribute their crafts to divinity
- Informal providers may (not) be expensive compared to primary healthcare facilities, but they are flexible with credit facilities – it's an attraction
- Informal providers are poorly regulated or supervised
- Dearth of information among slum residents on primary healthcare services
- There are potentials for linkages

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Global Actors in Urban Health: Summary of desk search as at 18/Sep/22

Delali Kumapley & Irene Agyepong

Methods

- Google Search done over the period April to Aug 2022
- Search Terms
  - Urban + Global + Health
  - Urban global health actors
  - Urban health individuals
  - Urban + global + Health + Powers
  - Urban + global + health + policy actors
  - Urban + global + health + actors

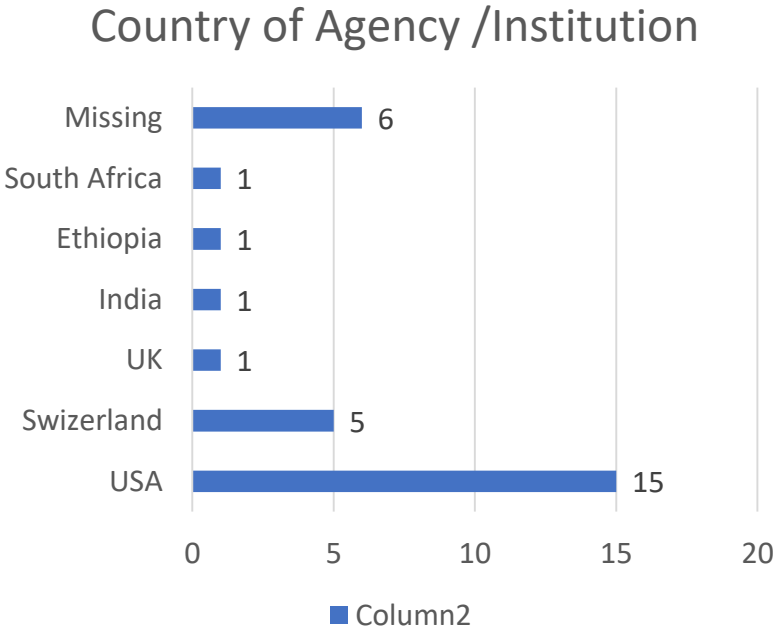
- Extraction template with key variables
  - Category
  - HQ country
  - Description /role in urban health
  - Geographic area of work including whether active in CHORUS countries
  - Contact information
  - Any already existing links with CHORUS

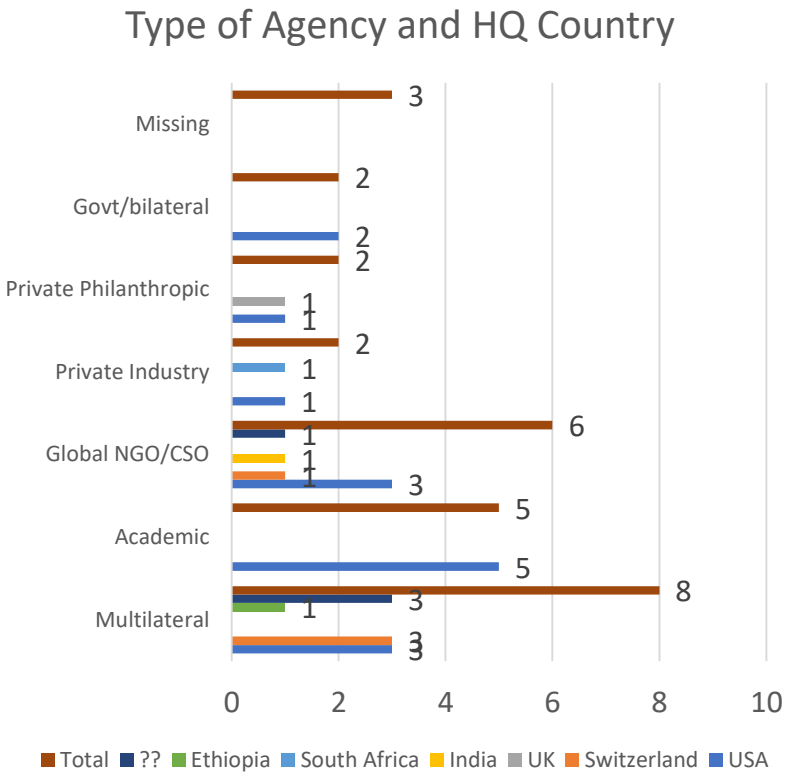
Results

- 30 agencies / institutions
  - 8 multilateral
  - 6 global CSO /NGO
  - 5 Academic
  - 4 private industry
  - 2 national government /bilateral
  - 2 private philantropic
  - 3 unclassified*
    - go back to websites to try and classify
- Roles in urban health – See Excel sheet
- Countries of operation – See Excel sheet

- Country of agency HQ
  - HIC (21)
    - USA 15 (50%)
    - Switzerland 5
    - UK 1
  - LMIC (4)
    - India 1
    - South Africa 1
    - Ethiopia 1
- Missing data (6)
  - *go back to websites to try and classify

Global Actors in Urban Health





Next steps

- Check
  - which actors have areas of work that has synergies with the CHORUS pillars
  - Check actors are active in Ghana, Nigeria, Bangladesh, Nepal
- Do an indepth study of what these actors do in relation to the CHORUS pillars and in the CHORUS countries
- Look for potential synergies and possibilities for strategic alliances

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RESEARCH ON URBAN HEALTH

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