Addressing Maternal and Newborn Health Services by General Practitioners for Mumbai’s Urban Poor: A Case of Unregulated Quality

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**SNEHA**

*Society for Nutrition, Education, and Health Action (SNEHA)* was founded November 1999 in Dharavi, Mumbai

**Expertise**
- Women and Child Health in Urban Slums
- Community Based Interventions
- Health System Strengthening
- Replicable Models
- Research and Training

**Approach**
- Working in Partnership
- Using Appreciative Inquiry

**Sure Start**

An initiative to address maternal and neonatal health (MNH) in rural Uttar Pradesh and by piloting models in urban areas of Maharashtra

**Objectives**
1. To significantly increase individual, household and community action that directly and indirectly improves maternal and neonatal health.
2. To enhance systems and institutional capabilities for sustained improvement in maternal and neonatal care & health status.
What is Quality of Care?

Are services...

Available?

Appropriate?

Accessible?

Acceptable?
SNEHA Sure Start

- Location: N-Ward, Mumbai
- Ward Population: 765,325
- Ward Slum Population: 554,319 (72%) \(^1\)
- Target Areas: 4 Vulnerable Slums
- Project Population: 200,000

Source: 1) Municipal Corporation of Greater Mumbai, 2009
Private Health Sector Context

- Public spending on health care in India is among lowest in world
- Large unregulated and urban centric curative private health sector
  - 80% of private health care facilities service the health needs in India\(^1\)
  - 5,000 unqualified medical practitioners and 270 unregistered private dispensaries in Mumbai\(^2\)

Sources:  
1) A. Jilani, G. Azhar, N. Jilani & A. Siddiqui, 2009  
2) Wallia, 2004
Rationale for Working with General Practitioners

• 51.4% pregnant women avail of antenatal care from private sector in Sure Start areas¹

• Preference for private sector²:
  – Accessible beyond the timings of primary public health services
  – Close proximity
  – Affordable
  – Poor behavioral treatment in public health facilities
  – Overcrowded public health facilities

Sources: 1) PATH Sure Start Baseline August 2008; 2) SNEHA Sure Start Situation Analysis Report June 2007
Profile of General Practitioners

Types of Private Providers

1. Qualified Medical Practitioners
   - Modern Medicine (MBBS)

2. Practitioners of Indian System of Medicine
   - Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy (AYUSH)

3. Others
   - No medical qualifications


n=26 GPs in N-Ward
Ethical Questions

**WHY** should we work with private practitioners?
- Have varying qualifications, some unqualified
- Questionable availability of quality care
- Highly accessed

**HOW** do we ensure quality of care?
- Risk of legitimizing clinics through implementation process
- Role of an NGO
Our Position

Rationale
• To improve Maternal and Newborn Health had to address this private sector
• To promote non-therapeutic care by focusing on preventive & promotive aspects

Goals
• To ensure women have the right to quality health care from General Practitioners (GPs)
• To maximize good health outcomes

Objectives
• To standardize practice antenatal, postnatal and newborn care practices
• To encourage appropriate and timely referrals

Approach
• “Do no harm” approach
Methodology

• STANDARDIZE
  - Developing protocols for maternal and newborn health care, including for referrals

• TRAIN
  - Implementing protocols to improve quality of care

• MONITOR
  - Using different techniques to monitor adherence to protocols
  - e.g. Community Survey Tool, Exit Interviews, Clinic Data
Evolution of Strategies

- Survey & Assessment of 126 GPs
- Developed & Finalized Clinical Protocols
- 3 Continuing Medical Education Sessions with Notes for 75 GPs

After Poor Impact
- Partnership Collaborations
- Individual Interactive Module Developed & Trainings Conducted
- Target Narrowed to 26 Most Accessed GPs

After Decreased Attendance
- Trainings with Notes on Documentation & Pregnancy Danger Sign Referrals
- Group Practical Demonstrative Trainings

After Lack of Improvement
Challenges and Ethical Issues

• Thriving clinics
  – Lack of time
  – Lack of motivation
  – Distracted participation

• Coordinating trainings

• Frequent change in GPs and their practices

• No regulations within which to work

• Lack of documentation
  – Questions for monitoring adherence, e.g. referrals
  – Reliable data
Conclusions

- Training trend shows improvement in MNH knowledge
- Behavioral skills are strong
- Clinical skills are inconsistent and below average
- Documentation is weak
- Public Health Post better in adopting protocols & documentation

Lack of Motivation → No Time and Concentration Given to Skill Upgrading → Lack of MNH Standards and Quality of MNH Care → Active Regulation
Future Steps

- **Generate Awareness** in clients to demand quality services from GPs
- **Advocate** for active, functioning regulatory bodies
- **Standardize & Monitor** GPs’ services

**Quality of Care by GPs**
Future Scope of Work

1. Protocols for standardized practices

2. Regular monitoring to include:
   - Medical education sessions / training
   - Documentation
   - Registration of qualified persons

3. Public-Private Partnership by involvement in national health programs, specifically Reproductive & Child Health II (RCH II)

Sources: Duggal and Nandraj, 1991; Birla & Taneja 2010
“Regulation seeks to ensure quality, accountability, protect the consumers and control costs.”

~Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure for the 11th Five-Year Plan (2007-2012)

Thank You!

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