Society for Nutrition, Education and Health Action (SNEHA): An Ethos of Care

Abstract

This case study engages with the journey of SNEHA (Society for Nutrition, Education and Health Action), a public health non-profit organisation founded in Mumbai in 1999. India has the distinction of being witness to a long history of efforts by public-spirited healthcare professionals. Alongside treatment, their work in public health has consistently involved giving due emphasis to prevention, reducing the excessive reliance on institutional-led public health delivery, moving towards community-based approaches and giving considerable attention to maternal and child health, the bedrock of any sound public health system.

The efforts of SNEHA (which means "love" or "affection") in developing, expanding and adapting this approach amongst some of the world's largest and dense poor and low-income urban settlements in India constitutes an important part of this history. Started with little funding, in a little over two decades, it now oversees over Rs. 29 crores of funds; and its programmes, which started as small pilot projects to gather evidence, have evolved into large interventions drawing in many individuals and institutions along the way.

Public health, unlike many other spaces of developmental interventions, demands balancing affordability, quality care and credibility with little margin for error. The case engages with the ways in which intentional evolutions to its practice have allowed SNEHA to grow, in full public glare, in a rapidly urbanising agglomeration. The case also offers an opportunity for learners to reflect on how SNEHA's organisational culture of appreciative inquiry and its adoption of technology have enabled it to hold together a team of 500 staff and over 6,000 volunteers; and how community-based models can overcome the shortage of full-time medical professionals in a resource-constrained to deliver consistently high standards of care.

Keywords: Public Health; Urban Community-based Healthcare; Maternal and Child Health; Appreciative Inquiry; Strategic Talent Management

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Origins

Dr Armida Fernandez (Dr Fernandez) and her team of neonatologists and other medical colleagues together as collaborators had traversed a long journey in scripting SNEHA (Society for Nutrition, Education and Health Action) together. This medical team had spent time in Mumbai's low-income settlements, learning about the challenges of the lack of information, resources and access to quality health services. Supported by philanthropist friends, Dr Fernandez and the team founded SNEHA in 1999, which emphasised care and responsibility at all levels of its healthcare delivery; and grappled with the constant, on-going need to sustain a motivated cadre to fulfil its community-based public health mandate. Those who comprised the early SNEHA team were not restricted to qualified medical professionals: the team had clinical psychologists, developmental scientists, anthropologists and social workers, which added strength to community-based healthcare. Qualified doctors were not involved in the daily field work. SNEHA had groomed, trained and developed a cadre of para-health professionals that delivered healthcare related services, an act of great responsibility with little room for error and negligence.

Through its work, it has aspired to demonstrate that the ultimate benefit and quality of a public health intervention depends on the last-mile individuals delivering the intervention with intense focus and perseverance. Set-up at the close of the first decade of a liberalising India (1999), SNEHA grew to a team of 500, two decades into the new millennium. As liberalisation unfolded, modernity swept many parts of urban India, but its public health infrastructure was not one of its immediate beneficiaries. Indeed, if anything, a rapid rise in urbanisation further compounded a stubbornly entrenched challenge: public disinterest and inadequate investment in public health.

Setting up the core

In the early 1990's, Dr Fernandez (neonatologist and Dean of Lokmanya Tilak Municipal General Hospital), and her team were routinely caring for underweight and premature infants born into low-income households. These households often faced issues of poor nutrition and health, especially among mothers

and children. This team, which included the present Executive Director of Programs, Dr Shanti Pantvaidya (Dr Shanti), wanted to go beyond and do more to improve the lives of women and children in these settlements.

They had seen some gruelling cases at Sion hospital (Lokmanya Tilak Municipal General Hospital) that touched them very deeply. Dr Shanti recounts that right at the beginning of this work, there was a case of a child who had been raped by the father; and the grandmother, trying to save her son, did not want anything to be done legally for the child. In another moving case, while then Dean Dr Fernandez was doing rounds of the emergency ward of the hospital at night, she came across a woman who was being discharged, with a plaster on her arm and leg. The woman told Dr Fernandez that she didn't know where to go as she couldn't go back home: "I was thrown out of the house because my husband turned HIV positive and I was blamed. They broke my arm, hands and legs and they threw me out."

Confronting cases like these frequently, Dr Shanti recalled their daily routine of Dr Fernandez, herself and a few other medical experts getting together at evening tea-time at the hospital to reflect on what they were experiencing and the way forward. Recounting in 2021, Dr Shanti reminisces:

> So, these kinds of cases which we saw actually led to a lot of discussions. Every day at about 6:30-7:00 pm in the evening, I used to walk into the Dean's office. She (Dr Fernandez) was the dean. She would finish her day's work, I would finish my day's work. We would sit and the other colleagues would drop in and we would all have tea and *shevpuri* and we'd be discussing our cases, and what we needed to do. That's where these stories emerged. So altogether, we said that you know, we've always been managing treatment and managing illnesses. We said it should be the other aspect that we should really start looking at, that is, prevention of issues or promotion of health so that people don't have to land up in our hospital. Like that woman, the husband turns HIV positive, her arms and legs are broken, fractured, she is sent to the hospital, and she has nowhere to go. So, it was about addressing these attitudes of violence as well.
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> Hence,one of the first things established in SNEHA was a crisis centre. But we were very lucky: a clinical psychologist came to meet us. Today, she's heading our prevention of violence programme: Dr Nayreen Daruwalla. When she joined us she had recently finished her PhD and came in as a clinical psychologist. Because she joined we were able to start the crisis centre. That is where it (SNEHA) started: our attempt at prevention of all this violence and the crises associated with it.

It was thus, in 1999, that Dr Fernandez established SNEHA with support from a core group of colleagues from the hospital and philanthropist friends (refer to Exhibit 1). Their first initiative was the Centre for Violence against Women and Children, located in the Dharavi slum area in Mumbai (a location famous for its manufactured goods and infamous for its dense and for a long time squalid living conditions). The centre was run by Dr Nayreen Daruwalla (currently program director– Prevention of Violence against Women and Children). The crisis centre provided counselling services, and engaged in direct interventions and outreach in the community to prevent instances of violence against women and children (refer to Exhibit 3).

Prior to 2001, when Dr Nayreen joined SNEHA, she worked as a counsellor in a school in South Africa, then moving on to working with survivors of rape and violence in a non-profit there. On her return to India, she started working at Tata Institute of Social Sciences, heading an HIV/AIDS project, where a

Professor connected her with Dr Fernandez, who asked her to join SNEHA. Dr Nayreen recounts her early days at SNEHA, after accepting Dr Fernandez's invitation to join the nascent organisation:

> I think when I started, there was only one social worker working on the (crisis centre) project. Dr Fernandez gave me a sheet of paper, which laid out the goals of SNEHA. And then she said, "Okay, now you start the work." So then, I asked her if I could have one person to work with me because I could not do everything on my own: run a counselling centre, do networking, do community intervention. But we had no money at that time. And she said, "I will give you Rs. 5,000 honorarium. If funding comes in from Dorabji TATA trust then I will increase your payment. But we will write proposals to get more funding". I said okay. We wrote up our project proposal and we got the seed money from Dorabji Tata Trust. That is how we started the work. Initially, there were no formal systems in the organisation. We did not have appointment letters, and we were still based in a public hospital. So, actually, in my 20-21 years at SNEHA, I have done all kinds of jobs because there was a need to do all kinds of jobs.

Gradually, SNEHA grew as more professionals and paramedics along with a diverse set of people joined. The next program that took shape at SNEHA was on maternal and newborn health (refer to Exhibit 4) . Dr Shanti canvasses the whole gamut of ideas and interventions in those early years:

> Along with that (the crisis centre), we were discussing maternal health because we had all known from experience when we were working in these hospitals that sometimes pregnant women would be sent very late from different hospitals, and we would be managing these very late referrals. Sometimes it used to be so late that the mothers died, or newborn mortality or foetal loss would happen. So, we said that this is another aspect that we have to really work on, and that is how SNEHA's next programme took shape: maternal and newborn health.
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> After that, we were thinking about what all needed to be done (at the newly-established SNEHA). Since I had worked in the municipal hospital system for a long time, Dr Fernandez asked me to look into developing and establishing a formal referral system. The other thing was to strengthen primary care and give good primary care to pregnant women. These were the areas we initially thought of. Dr Wasundara Joshi, a paediatrician turned behavioural scientist brought in the value of appreciative inquiry in behavioural change. The team wanted to incorporate this mechanism for behaviour changes in the community and in the facilities. So, this is how the whole process started. And when we put in some work on this, funding began to come in. It was almost like coincidences, almost like miracles, but it did happen. Initially, we were all doing it with no money, nothing. As Dr Fernandez would often say, the people who were trustees of SNEHA at that time were people whom we could trust. They were not specifically chosen because they had particular professional qualifications or they were experts. It was just because we could trust them. By the way, they are all still there. So, that is how we started. It was the crisis centre first, then it grew into the maternal and newborn health programme (launched in 2003), and then we got funding for our programmes.

Choosing to take upon the issue of maternal and newborn health into its fold brought an addition to the SNEHA family with Sushma Shende, currently the program director for the Maternal and Child Health program. Sushma initially joined Dr Fernandez at Sion Hospital in 1997, prior to the birth of SNEHA, as an anthropologist with a great deal of experience in public, rural and tribal health. She recollects:

> One day, she (Dr Fernandez) said, "Sushma, when I'm going to start my NGO, please join me. I don't know what kind of salary I'll be able to give you because I don't have funds currently. Will you join me?" I said of course. Then sometime after that, I went on maternity leave for two years, and during that time, 1999-2000, she started SNEHA. She called me back again after two years. My daughter was actually very small at that time and had some kind of bronchial asthma problem. She was in the hospital, so every time Dr Fernandez called I would tell her that I could not join because I needed to take care of my daughter. But she persistently called me back. She must have called me three times actually. She could have hired anyone else, but because of the persistence, I came back to her but told her I could not work full-time. She told me I could work part-time and then she made all the adjustments to make sure that we could work together again, and I started working with her. Back then, we were a team of four people at SNEHA.

The joining of Nayreen and Sushma completed the nucleus of the core team of an incipient SNEHA. The team firmly believed that together they could bring about a substantial change in the health status of the most vulnerable communities in the informal urban settlements of Mumbai.

Over a period of time the team at SNEHA grew to include several volunteers, counsellors, and front-line field workers led by the four-strong group of program directors. While providing them with mentoring, Dr Fernandez also gave them enough autonomy to build their own teams and bodies of work. Under Dr Fernandez's watchful eye, these early programme verticals bloomed into islands of excellence within the organisation, and continue till today to form the core of SNEHA's work.

SNEHA Today

Today (2022), SNEHA is closely involved with the public health system and other relevant public systems and officials. Working with all levels of government—from public health officials to police officers and community-level workers, it looks to strengthen the capacity of the chronically under-invested public healthcare system and ensure delivery of quality services. In addition, SNEHA provides technical, programme and policy support to implement prevailing public health models in other regions. It also partners with corporate businesses, domestic and international donor agencies, family foundations, small businesses and high net-worth individuals to deliver specialised public health programmes in and around Mumbai.

It also collects and studies data for patterns and trends to improve interventions and inform public health policy and practice. Its research has been published in national and international academic journals.

SNEHA's team today comprises individuals from a wide range of backgrounds, committed to public health. It has over 500 staff associated with the organisation in various ways: as full-time staff, consultants, part-time staff and volunteers. At the executive level, SNEHA is managed by CEO Vanessa D'Souza and

Executive Director Dr Shanti. The leadership team consists of 12 people (10 of whom are women), with a further 12 forming its second line of associate directors, all of whom are women. It is governed by nine trustees and an advisory board of four (refer to Exhibit 2).

While its work in Mumbai still defines SNEHA and forms its fulcrum, its presence has grown from one city to seven cities. Within Mumbai itself, it has spread from two slum settlements to eight and from 56 public health facilities to 184 health facilities, and from two police stations to 91 police stations of Mumbai (Yatin, 2021). To understand SNEHA's journey in the sphere of urban public health—from a sapling conceptualised by Dr Fernandez and Dr Shanti to a fully grown tree with a team of hundreds of dedicated staff—it is important to understand the context of public healthcare in India, and equally the context of one of its most iconic cities: Mumbai.

Public healthcare in India

The Indian public healthcare scenario presents a spectrum of contrasting landscapes. At one end of the spectrum are glitzy steel-and-glass structures delivering cutting edge healthcare to well-heeled, mostly urban India. At the other end are rural and remote areas and the low-income settlements of urban India where even basic primary healthcare is lacking. There is an increasingly visible disparity in the provision of affordable healthcare to the socially disadvantaged, the economically challenged and the marginalised. Healthcare provision in underserved urban settlements areas like slums is particularly vulnerable where, for instance, cases of malnutrition, bacterial and viral infections, psychosocial trauma, reproductive health issues and gender violence are highly prevalent and are amplified by living conditions.

The overall lack of physical, institutional healthcare infrastructure and resultant overcrowding, vacant posts,[1] ill-equipped health professionals, limited range of specialist services and paucity of funds has dogged the Indian public health sector for decades. In turn, the private healthcare sector has grown considerably as more and more people turn to it for better access and higher quality of care, even if the out-of-pocket expenditures are considerably higher. Out-of-pocket spending on healthcare in India is one of the highest in the world, with over 60% of patients spending on health at the point of care. Nearly 300 million people in India spent 10% or more of the annual income on healthcare, a level noted by a NITI Aayog report as "catastrophic." Beyond absolute expenses, the high out-of-pocket component of this overall expenditure is considered responsible for pushing several millions into poverty annually (Sarwal et. al, 2020). Despite a high-level expert group convened by the Planning Commission reporting in 2011 on possible pathways to Universal Health Coverage by 2022, India has as yet not achieved this milestone. In turn, this has exacerbated its entire spectrum of existing public health issues. Achievement of Universal Health Coverage was identified by the 65th World Health Assembly in Geneva as the key global imperative for countries to consolidate their advances in public healthcare (Singh, 2013).

These shortcomings were some of the main reasons 2020-21 was a litmus test for India's health infrastructure, as it was for many other countries worldwide with the onset of the COVID-19 pandemic: laying bare not just the chinks in the armour, but the glaring gaps in its health delivery system. The second wave of the COVID-19 infection in 2021 revealed just how unprepared the country was to tackle the dizzying number of hospitalisations, or provide basic oxygen support to patients with severe infection. However, on the flip side, healthcare remains one of India's largest sectors, both in terms of revenue and employment (Sarwal et al., 2021).

[1] In 2021, 21.8% of rural Primary Health Centres did not have a doctor at all; 68% of rural Community Health Centres had no available specialists (Ministry of Health and Family Welfare, 2021).

In 2021-22, the Government of India's public expenditure on healthcare stood at 2.1% of GDP[2] (IBEF, 2022). By 2022, the private spend on healthcare was expected to reach Rs. 26.7 lakh crores ($372 billion)[3] (Sarwal et al., 2021), primarily because of rising incomes, an increase in the awareness of health issues and increasing adoption and distribution of health insurance. In 2021, the Indian healthcare sector was one of the country's largest employers, employing a total of 4.7 crore people (IBEF, 2022). The World Health Organisation (WHO) has prescribed a 1:1,000 doctor patient ratio, but this ratio in India is about 1:1,456 (PIB Delhi, 2019). Further, around 70% of India's population live in rural areas, but the distribution of doctors is heavily skewed towards urban areas, with only around 34% of doctors located in rural areas (Zadey et al., 2021).

The public healthcare set-up in India is three-tiered, comprising primary, secondary and tertiary healthcare facilities. The primary tier has three types of healthcare institutions, namely, a Sub-Centre (SC) for a population of 3,000-5,000, a Primary Health Centre (PHC) for 20,000 to 30,000 people and a Community Health Centre (CHC) as a referral centre for every four PHCs covering a population of 80,000 to 1.2 lakh (Ministry of Health and Family Welfare, 2021). District hospitals and CHCs function as the secondary tier for rural healthcare, catering to more specialised needs and as referral units for the primary tier. Tertiary care services are provided by medical colleges, specialist hospitals and state-level medical institutions, and tend to be concentrated around urban areas.

With public health institutions facing a perennial shortage of capacity relative to demand for services in India, historically, a significant proportion of the responsibility of ensuring public health outcomes has been taken up by civil society organisations and initiatives. Landmark public health schemes have emerged from collaboration and consultation with civil society. For instance, the ASHA (Accredited Social Health Activist) programme is an internationally recognised, large-scale governmental effort launched as part of the National Rural Health Mission to improve health outcomes amongst the poorest and in the most underserved regions of India. The programme was itself inspired by the *Mitanin* initiative in Chhattisgarh, in which a healthcare volunteer was assigned to look after the basic health needs of every 250 people (Lahariya, 2022). The *Mitanin* programme was designed in close consultation with regional civil society actors. Similarly, the success of implementation of the ASHA programme depends critically on the support provided by the ASHA Mentoring Group—comprising community health organisations and NGOs, who support, select and train ASHA workers with presence at central, state, and even district and block level in some cases (NRHM, 2012).

SNEHA is born of and continues this tradition of civil society-led, community-based healthcare by extending it to find its footing in a city like Mumbai. Mumbai (erstwhile Bombay), which from a public health stand-point is an inquisitive researcher's delight and an administrator's nightmare, is also a city likely to test the endurance of the most dogged of public-health workers. The story of Mumbai in its full preempts the story of many cities in India.

Living conditions in urban Indian slum settlements

The urban landscape post-liberalisation is only a faint echo of the past: it has expanded with a vengeance beyond what the eye can behold, yet in some sense it has only magnified the issues that always lay alive and kicking in the urban underbelly. Unplanned and hurried urbanisation in India has significantly dented the quality of water, air, land, and accentuated lack of sewage and drainage facilities. This has been compounded by extreme weather events which result in seasonal flooding and sharp heat and cold waves. The folklore of Indian cities was full of written and unwritten tales of many families in search of a house, as

[2]India's GDP in 2021 was estimated at USD 3.1 trillion (USD 3.1 lakh crores).
[3] The exchange rate used in the 2021 report was $1 = Rs. 71.875.

lack of adequate, affordable and quality housing forced many migrants, vulnerable and the poor to put together make-shift shelters. With greater thrust on housing for the poor over the years, this has seen some respite. Yet affordable housing stock continues to lag demand for it, due to scarcity of land, regulations which do not resolve the ambiguity of title to land in informal urban settlements and conflicts between private and public interest.

Further, each city has followed its own unique history of urbanisation. As a result, many informal urban settlements (slum or slum-like) are characterised by the poor quality of habitat in general. Of this, sanitation and water remain a sore point, and a drain on the wallets of the inhabitants of these settlements due to high incidence of water-borne and communicable diseases. These settlements, often constructed without any formal planning and with materials unsuitable for housing, can be overcrowded and unsafe to dwell, especially during severe weather events (Nolan, 2015). Against such a context, lack of preventive and curative medical health services puts the issue of public health into sharp focus in urban India.

The urban setting of Mumbai

It is perhaps in the city of Mumbai[4], the largest urban agglomeration in India after Delhi NCR (PIB, 2011), that these threads all come together into their own. It is a city which has historically suffered from poor public health and a densely packed population; it also attracts huge numbers of immigrants from other parts of the country. The city is a dichotomy of sorts: the rich and famous living alongside the dwellers of its slums, some of which are large enough to be a city within a city. Urban planning in India, and more so in an overcrowded city like Mumbai, is not uniform with entrenched and embattled economic and political interests at play that result in great development of some areas and total neglect of others.

The 2011 census estimated that 42% of Mumbai's population (around 1.8 crore people at the time) lived in its slums, rising to 57% including other categories of low-income "one-room homes" (Chandrashekhar et al., 2020). With these two contrasting faces of Mumbai's development trajectory, challenges to public health are varied and civil society organisations like SNEHA who work in this context face a myriad of different and difficult situations to cope with. In addition, closely packed and overcrowded slum areas are particularly vulnerable to events such as epidemics, extreme weather or riots and thus represent high-risk areas from a public health perspective. Recovering from the trauma caused by such events can span generations.

Dharavi, an area which SNEHA works extensively in, has long been infamous as one of the world's largest slums. The maze of narrow lanes, open sewers and cramped huts sprawls over 535 acres of government-owned land (Malik, 2022). The houses themselves, however, are maintained by individuals. An estimated 6 lakh to 10 lakh people live in Dharavi, drawn by its affordability. In a city where housing rents in the most-developed areas are some of the highest in the world and rising all the time, rents in Dharavi are as low as Rs 185 per month (Bernstein, 2016).

The slum, like many others, lacks provisions for sanitation, drains, safe drinking water, roads or other basic services. Residents in "non-notified"[5] slums are not able to legally access the city's water supply and so must often tap into the central water pipes illegally using makeshift methods. Further, lack of electricity or gas supplies mean this water may not be boiled before drinking. Typically, in such settlements, small, narrow gutters which are open or partially covered are found between rows of dwellings that serves as drainage including sewage. Since these drains are not part of formal urban planning and design, they often get clogged and contaminated water can spill over onto streets.

[4] Including the Mumbai Metropolitan Region (Greater Mumbai).
[5] Areas notified as slums by the concerned municipalities, corporations, local bodies or development authorities.

Mumbai is also a city with torrential rain that lashes during the monsoon months. Lowland areas like Dharavi often flood, leading to extreme sanitation problems. The makeshift toilets required to meet emergency needs of the habitants of the area are a natural breeding ground for communicable diseases in and around the vicinity. As a result of all these factors, each year, 30-60% of households get affected by water-related diseases and two thirds of these are children. Unclean water is especially dangerous for children and can increase their mortality rate (Papadimitriou, 2019).

When SNEHA was launched, it set out to equip women in its areas of field work in Mumbai with the tools and information they desperately needed to build healthier families. The level of need was extraordinary, and Dr Fernandez had witnessed it first-hand, working for more than three decades at Sion hospital, Mumbai's busiest public hospital, where it was a daily struggle to save underweight and premature infants born to poor mothers with little or no basic health knowledge. Although SNEHA started formally in 1999, Dr Fernandez's experience of the health of the public located around Sion hospital—situated on the periphery of the Dharavi slum area—stretched back more than 20 years prior, when she was a young paediatrician working at the hospital. She recalls that in the 1970s, the hospital treated an average of 3,000 cases per day. Urban development professional Carlin Carr, in an interview with Dr Fernandez in 2015, writes:

> A turning point for the young doctor came after giving a presentation at a conference in the northern part of India (in 1977). She spoke about what they were dealing with at the hospital–reading out numbers that were shocking, but, she thought, likely what the others in the room were dealing with in their own corners of the country. At Sion, she told them, 77% of sick newborns died. The room was aghast (Carr, 2015).

"Even for India, it was shocking," said Dr Fernandez.

The mother and her child: The "public" in Public Health

Indeed, it is the clear effect on the health of mothers and children that converts this situation into a public health crisis. It is an inescapable truth that the health of a mother and child determines the future quality of well-being of a society. In India—a rapidly urbanising economy—a critical number of mothers and children remain at severe risk of suffering from poor health and lack the resources to access remedial measures. The issue is not one just of public health, but has wider socio-economic ramifications. As Vanessa D'Souza (CEO of SNEHA since 2013) highlights, addressing this forms the very foundation of SNEHA's work:

> We aim to break the intergenerational cycle of poor health, which means that we have to work at every critical point in the reproductive life cycle of the woman, child and adolescent. Therefore, we work on pre-conception care and prenatal care during pregnancy, which is what we call maternal health. Then, we work on child health and nutrition for the first five years of their lives, and then we work on adolescent health, which is from 11 to 19. Further, across all ages, we work on gender-based violence.
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> The reason we have this approach is that research shows that if you work on all these critical points in the woman's life cycle—and in some cases, we also work with men but the focus really is the woman and the child—you can actually break this intergenerational cycle of poor health. So, for example, if you can work with a woman prior to conception and you can make sure that

> she has, for example, good iron levels before she gets pregnant. Then there's a much better chance of her delivering a full-term baby that is healthy, and therefore, the child has a chance to start healthy. If you miss that period, for whatever reason, or you're unable to improve her health indicators during pregnancy, then at least if you work with the child, then you can make sure the child doesn't slip into malnutrition. Now, what often happens is we see the woman healthy, but the child slipping into malnutrition. So, therefore, the need to work on all these.

The size and scope of the issue means that an under-funded public health system cannot meet these challenges, unless they depend on other non-institutional care approaches. While outlays towards social welfare have increased, it has not yet resulted in commensurate investments in public health gains. Meanwhile, the visible privatisation, while providing greater quality access, has put a dent on affordability. As a result, providing quality and affordable care always remains a project for the future.

This sets the context for primary and secondary healthcare interventions that go beyond the institutional approach, and instead focus on community-centric models. They lay stress not just on cure but are concerned with prevention. They give a central impetus to the health of children, adolescent girls and mothers, and are confined not just to physical measures but account for psycho-social ones as well. They are also highly contextual as they realise the particular conditions in a given locality must also be studied and properly accounted for; it is what makes such interventions relevant and meaningful.

Underlying them is a straightforward principle: rather than call people to healthcare service providers, take healthcare to the people. SNEHA has over the years become an important part of the healthcare system in Mumbai. Dr Fernandez reflects on its early days as a young organisation venturing into this complex context:

> We started as a group of doctors going into the Dharavi slum, where up to a million people squeeze into tiny makeshift homes and lack even the most basic services. We were there to offer basic advice and guidance to women and families about maternal and newborn health. The fact that we were doctors lent us credibility. And our timing was right, because not many NGOs working in urban slums were focusing on this niche. We focused on it because that's what we knew (Fernandez and D'Souza, 2017).

Building a solid foundation: a focus on evidence

In those early days, with insufficient funds to run large-scale programmes, SNEHA began running pilot projects in Dharavi. For the young organisation, a strong base of research was the preferred method of developing a foundational understanding of the communities it worked with. It was also a crucial part of building credibility as a public health practice with donors and other important stakeholders such as local and state government health officials. As Dr Fernandez shares, this period categorically highlighted to the team at SNEHA that to attract quality funding, evidence was a must:

> It [running pilot projects] was an approach we had experience with in the medical field. Not that we had a choice; one could also say that we were forced to do pilots because we didn't have enough funds to run a bigger program. And we were used to learning as much as possible, as quickly as possible before taking action. Before launching a pilot, we would do a

> baseline survey. For one nutrition program, for example, we wanted to know about adult and infant eating patterns to get at the larger question of why people in Dharavi were malnourished. The pilot that followed involved a few hundred babies and received funding from a women's organisation in the United Kingdom. We learned from that program and that gave us the courage to plan a bigger one for the community.
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> We realise now that our efforts to grow have been greatly helped by the fact that whatever we do starts with knowledge built on a solid research base. We were accumulating evidence from the start, but our initial funders didn't ask us for it. Then, our evidence was suddenly more important to funders, even critical. We were seeking larger grants, but we were finding that very few people in India understood that health and nutrition were important stepping-stones out of poverty. So it was quite a battle for us to prove the linkage. And initially, no one was interested in funding our program to prevent violence against women and children. We spent five or six years developing model programs and collecting evidence that they worked before major grants started coming our way. Fortunately, those battles are behind us.
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> Today, of course, evidence is a must to get quality funding. The 2013 law (Companies Act, 2013) requiring India's largest companies to contribute two percent of earnings to corporate social responsibility had a lot to do with elevating the role of evidence in securing funding. So we're fortunate that monitoring and evaluation are part of SNEHA's DNA. When a prospective corporate donor realises that we have a baseline study and that we feed data back into our work, they say, "Okay, these people are not just randomly doing activities; there is some thought going into what they are doing" (Fernandez and D'Souza, 2017).

Data collection and analysis have grown into a core element of SNEHA's research-based approach to public health interventions. Today (2022), the organisation manages a database of 290 data points for over 50,000 low-income households in Mumbai (Research, 2021). On the field, this quantitative and qualitative data is collected and updated by a trained team, using mobile applications to facilitate the process and reduce errors. SNEHA's Monitoring and Evaluation team comprises public health researchers who monitor and track programme performance against key indicators. They are responsible for administering baseline, midline and endline surveys to evaluate the impact of their programmes.

The focus on evidence also paved their way to work with government health agencies. These agencies operated on large scales, but in many cases they lacked the capacity to fully meet their mandate. According to Dr Fernandez, these agencies were often looking for proven ways to improve services, and SNEHA started sharing its evidence-based model with many of these in the hope that they would be adopted for use. Nearly 10 years after the launch of one of SNEHA's first formally designed and funded programme—the Maternal and Newborn Health programme in 2003—its slow and painstaking evidence-based approach led to a partnership with the Municipal Corporation of Greater Mumbai (MCGM) and the subsequent adoption of this programme by Mumbai's public health department (one of the largest in the country, covering a city of more than 18 million people as of 2012) and the health departments of six smaller nearby cities. In addition, SNEHA also started working with the government's Integrated Child Development Services programme (Fernandez and D'Souza, 2017).

Evidence mattered but did not define SNEHA. SNEHA was always, and is, defined by its ability to translate this know-how into real health outcomes for the communities it worked with. And it has always preferred to do this by binding more of those who are part of the public health system and hence have a share in its responsibility. Its partnership with local governments was one route, the other was to make its existing clinical practices more responsive to the needs that its own evidence-gathering was making clear. Over the years, it learnt to develop service standards and protocols that could operate in urban slum settlements, as well as rigorous monitoring and evaluation to ensure that those standards were being correctly followed and were having positive effects on health outcomes for the communities it worked in. Dr Shanti recounts:

> When I was establishing SNEHA's referral system, the thing that really came forth was that for years, doctors from maternity homes—level one of the public health tiers—were referring to a tertiary hospital or a second level general hospital without ever visiting or meeting the person. They had not met or had any contact. It all used to be through case papers, small chits or no communication at all. Is the referral system bringing them together? Are these efforts benefitting the mother and the baby? And as we progressed, we wondered: we are working, giving messages, but are they [people from our communities] really responding to those messages? We had to assess and see how they were responding, whether it was having the impact that we wanted. So, at this stage what we developed quite a lot is the aspect of monitoring evaluation and research. That was an important phase of our growth. The research collaborations with University College London (UCL) are continuing to contribute immensely to this side of our growth.
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> For example, the first year I spent was to create the protocols of the clinical services for the maternity homes (level one of the public health system), the second level general hospitals and the tertiary hospitals. And all facilities are required to give that kind of clinical service. So, developing standards, then implementing those standards, then monitoring and evaluating whether these standards are working and producing the necessary maternal child health or newborn health results and giving feedback based on these. So, along with adding programs, this whole system of nesting in quality improvement cycles formed the soul of our work.

The model matures

SNEHA's evidence-led approach was not a common one for civil society organisations at the time (prior to the changes triggered by the Companies Act, 2013). However, its credible core of staff, its ability to provide donors with baseline data and to design and launch rigorous pilot projects quickly generated a lot of interest from stakeholders in the public health system and from funders keen to contribute to the domain (refer to Exhibit 7). Starting from no funding at all in the year 2000, by 2007 it had an income of Rs. 32 lakhs (SNEHA, 2007). Five years later in 2012-13, when it had secured a partnership with MCGM, it was managing funds of Rs. 5.6 crores (SNEHA, 2012), a remarkable increase of nearly 18-fold. Most recently in the year 2021-22, its total available funds had grown to Rs. 29.9 crores (refer to Exhibit 8). Clearly, SNEHA's approach and its credibility as a public health practice had struck a chord.

However, its founders were doctors and while their passion, medical expertise and scientific approach were being channelled through the structure and form of an NGO, the nitty-gritty of running such an organisation—deciding where to spend incoming funds, building an internal team of the right

composition and addressing the increasing interest from donors to "scale" their operations—represented a steep learning curve, as Dr Fernandez reflects: "I didn't know what an NGO was. We were all professors, and when I got the first money I said, 'What shall I do with it?'" (Jenkins, 2013)

The idea of achieving scale was in particular a foreign idea to SNEHA's leadership team of health professionals. While they wanted to reach more people through their programmes and in a cost-effective manner, it took several years of thinking through different options and scenarios:for instance, the degree to which to grow SNEHA itself, or possible models through which other organisations could be trained in implementing SNEHA's approach, before a decision was arrived at regarding scale. Dr Fernandez elaborates:

> We decided in favour of partnerships, in large part because we don't understand the local situations in states like Jharkhand or Bihar. So we partner with NGOs that are already working in other states because they understand the local context, and they work with us to adapt our models to their specific context. We contextualise the models, share the protocols, provide the technical training, and monitor the implementation with them.
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> For example, two partner NGOs have taken our program to prevent violence against women and children to seven Indian states. [One of them] is implementing our maternal health program in Pune. [And the other] is implementing our child health and nutrition program in Gujarat. Many organisations have recently come to SNEHA and asked how they can borrow our models or elements of our models. For us, it's a low-cost way to extend our impact; it's far more efficient than having to hire and manage staff members across India. NGOs want to partner with us because they don't have to reinvent the wheel: they can use our model, after adapting it to their local context. This partnership model reduces implementation time and lowers costs, and so it is a way to efficiently scale up (Fernandez and D'Souza, 2017).

With time, SNEHA settled on partnerships with: government, civil society actors, donors, and other research institutions (for instance, sharing data with national and international academic institutions as well as hosting and mentoring young graduate volunteers at SNEHA). This approach was not planned for: it materialised through evolution in SNEHA's own practice and with hindsight, which perhaps best suits the need to grow in an urban public health context. As work and associations grew, SNEHA itself needed to grow as an organisation to ensure that it could implement fully-staffed programmes that would make optimal use of its increasing levels of available resources.

Recognising "leverage": direct *and* indirect

Not surprisingly, with a broad-based intervention, with multitudes of partnerships and associations, SNEHA had gathered a gamut of people under its roof: from those directly working with households in settlements to those advocating and engaging with the government. The size of its team grew five-fold in a little over two decades.

Much of this spurt happened over just three months in 2012, when SNEHA was just over a decade old. In 2012, SNEHA had 100 people working with it. Then, with the aid of three large tranches of funding for programmes on maternal health, child health, as well as an integrated model encompassing maternal

child health and gender-based violence (refer to Exhibit 5), it grew from 100 to 300 in team size in an astonishingly short three-month span.

After that, from 2012 to 2021, they grew steadily—but at a much slower rate—from 300 to about 500, with the latter threshold crossed in 2021: a result of expanding to new areas, in particular to interventions on prevention of violence against children and early childhood development. This expansion was joined at the hip by a refusal to compromise the high standards SNEHA had become known for. It required recruitment of specialised personnel (matching the skill sets and expertise that the new areas of work demanded), and these comprised much of the incremental hires over the years as SNEHA expanded. But it was clear that there were limits to this.

In early 2021, SNEHA received a large grant from the multilateral development agency USAID to further scale-up their operations. This time, a conscious decision was made to cap the size of the organisation at around the figure of 500 staff on payroll (refer to Exhibit 6). There was of course the "psychological" realisation of having attained a significant size and not wanting to exceed it. But there was also the case of "practice evolution" at work.

SNEHA's practice started with small pilots to generate evidence. This in turn allowed others to join hands in larger interventions. This practice yielded a particularly rich crop as the practice really expanded. Thus, while a fivefold increase in staff levels since 2012 seemed substantial, it hid an even larger footprint of other individuals it has been able to connect together with its interventions. The work grew at an even faster pace than the expansion in its own size, or the sum of the direct and indirect benefits managed to outstrip the physical investments made into it. SNEHA's realisation of this levering effect, along with a natural desire to be prudent and economical, played a part in how it chose to respond to the large USAID grant.

This "nonlinearity" is a result of an evolution it has brought to its approach. It was a decision driven by a blend of factors: the "psychological" aspect of having attained a particular size, but also a mixture of strategic thinking and prudence in the use of resources, which although SNEHA did not lack, it still looked to stretch as far as possible to increase its community-level impact. Vanessa lays out:

> Despite that [large funding from USAID to scale up], this time, what we did was to keep our staff levels the same for two reasons: to sustain our work, as well as to control our staff strength. So, we've moved from what we call a direct to an indirect model. This means, in any area we work in, we enter into with three stages of intervention. The first is what we call the direct intervention stage, which means as soon as we enter an area, we work intensively with SNEHA field teams there. You will see large field teams because we do the work ourselves. And we take support from volunteers, we take support from the government frontline workers, but the core work is done by SNEHA frontline workers. After that, we finish the endline (survey: the complement to a baseline survey) after three years, and then we move to what we call an indirect intervention, where we will reduce our staff strength by about 50%, if not more. And then we will depend on volunteers and government frontline workers. So the change of model from direct to indirect has allowed us to expand so much more and yet keep our staffing under control.
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> There are two important things in the indirect model. One is the sustainability of the work itself (SNEHA being able to transition and hand-off an intervention to other stakeholders at the end of its project lifecycle). And

> therefore, in stage two of the indirect model, we need to make sure that volunteers come in, they take over a lot of the roles of the frontline staff and also the government frontline workers take on greater responsibility. But simultaneously, we're reducing our staff. And that's how we have been able to increase our budget. So, just to give you a sense, in 2012, our budget was five crores. Today, it's 30 crores but our staff is not increasing at the same rate because our model has been changing like this. So there's a lot of focus on using more technology, using more volunteers, government frontline workers, Community Action Groups and less and less SNEHA staff.

Volunteers who have come to be an important part of SNEHA's "indirect" model are primarily women and adolescents (and to a lesser extent, men) from the communities in which they work. In 2020-21, SNEHA had a volunteer base of almost 6,000 individuals. As Vanessa explains, the volunteer pool, far from being a random group of people, is consciously selected to help contextualise the interventions as deeply as possible:

> It's not easy to use volunteers. We say that 25% to 30% of the population (of our communities) is always migrating. So, what we do is we have a strategy when we choose volunteers in any community, we ensure 70% of our volunteers have houses on ownership, which means the chance of them staying in that community is much higher, whereas 30% would be renting.
>
> We learned this through experience. Initially, when we started working with volunteers like this (in 2016) we didn't even look at ownership and rental, but we've seen again and again that (volunteers on) rental have a much higher attrition rate. So now we have a proper screening process to identify this. The reason we do this is because a volunteer who is on rental understands the problems of somebody from the community who is on rental. So, these volunteers will be assigned to somebody who has moved recently from a village into an urban area. They would be able to understand the challenges of a woman who has moved to the city recently. Remember, most of these women come in newly married from UP (Uttar Pradesh), Bihar, wherever, all across India. They've never stepped outside their villages and now suddenly they're thrown into this urban area, they don't know anyone, they don't even know their neighbours. The practices are different, they've joined a family whom they don't know. So, the support system we put in place needs to be able to understand these women, and therefore, we very strategically divide our volunteers. And to that extent, we've been able to reduce the attrition, but yes, I would still say 10 to 15% of volunteers still move on (each year).

The foundation of community care arises when such relationships emerge and take hold. It ceases to be a pure health intervention dependent exclusively upon the skill and competency of fully qualified doctors, but a complementary effort. SNEHA, as a non-profit, could anyway scarce afford to rely exclusively on a professional medical cadre alone. A model around which a diverse group of medical and non-medical staff are able to come together and deliver health outcomes in urban communities is practical, scalable and in true public interest. SNEHA cites the words of American author and physician Dr Mark Hyman in summarising the importance of this community approach: "The power of communities to create health is far greater than any physician, clinic or hospital."

The "frontline"

For SNEHA, composing and holding together such diversity with due consideration to the specific outcomes it is working towards is an indispensable skill. Vanessa elaborates:

> So, if for example I'm working on maternal health, and in that maternal health program, I need medical inputs on a protocol for high-risk pregnant women or if I am working with children, I need a protocol for addressing malnourished children, then, I need to necessarily have medical expertise; a social worker can't give me their expertise. Now, for medical expertise, I have two options: I can either hire a full-time doctor or I can get a consultant doctor. We usually have consultant doctors for these highly skilled, highly specialised roles. They're not full-time workers because, actually, while we would love to have them full-time, it's very hard to get doctors who want to work full-time in an NGO. Therefore, we're usually constrained to get them as part-time consultants. Similarly, for counsellors, etc. That's in terms of medical expertise.
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> There is another reason why we have diversity in terms of our talent. So, if I, for example, want to enter a new area and if I want to create a new model whether it's in maternal health, malnutrition, etc., we start off with a lot of desk research to understand what are the practices that are currently available and how we adapt these to the model that we want to set about accomplishing. And therefore, we need to hire researchers, both quantitative and qualitative researchers, we need to hire people who are good at statistics, and therefore you will see a lot of that core expertise in monitoring, evaluation and research.

Within a single programme then, SNEHA can utilise the services of "super-specialist" medical professionals (often highly reputed doctors who can contribute anything from a few hours a week to an hour or more a day of their time), qualified researchers and statisticians, trained nurses, as well as teams of trained volunteers connected directly to the communities in which the programme would be implemented.

Its exacting standards and attention to detail requires SNEHA to go to great lengths to seek and mould individuals for specific roles required to deliver a programme, even if that programme is a small fraction of its work. Vanessa cites examples:

> We have two programmes where, as part of the service delivery model itself, we need competent medical nursing. One is the palliative care programme and the other is nurse aide training. But both are extremely small parts of the overall work of SNEHA. However, because the delivery model is highly intensive on the number of medical folk required, it may seem like these are much larger programmes. But in terms of beneficiary coverage, in terms of total budget, they are very small compared to the larger programmes.

The makeup of talent at SNEHA is thus an intricate picture. Through great attention to detail, multiple disciplines and specialisations are woven together with public spiritedness, adaptability and a willingness to work long hours in a difficult context. However, filling the available programme roles for work

in the field is not without challenges, as Nayreen highlights using the example of SNEHA's programme addressing violence against women:

> There are four components of our work. One is counselling and trying to make connections; second is community mobilisation and preventing violence from happening in the community; third is working with the system—the existing health system and the legal system; and fourth is research. Now, if I take the first component, counselling, to give you a specific example from my experience of 21 years: I think the biggest problem I have faced in counselling is that generally, counsellors on violence are all social workers. And because they are social workers, they do not have technical knowledge of psychology. It has been so difficult to provide counselling interventions along with mental health interventions. If a woman comes in with a violence problem, as a social worker, they will take her to the police, they will intervene with the family, they will do everything that is supposed to be done. But if you ask them about mental health interventions, which are softer skills: of making a plan with the woman, of making her comfortable, and of dealing with her emotions, I think that is where we are still struggling after these 20 years. But, alternatively, professional clinical psychologists and counselling psychologists don't want to do this job because the pay is less. Although our counsellors are paid pretty well, the pay is still less, and second, they are reluctant to do a police visit and then a home visit because of paucity of time and resources and all of that. So, getting that balance is extremely difficult. And I think I have faced that problem all along. Now the programme has developed GARiMA: a web-based package of care for counsellors and social workers to integrate gender-based violence and mental health interventions in their work adequately.
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> The second is community mobilisation. Community mobilisation is one aspect where social workers fit very well. There, I have had fewer problems because their whole background of social work helps a lot in community mobilisation projects. Of course, I think the only challenge I feel, especially when they come with degrees from reputed social work institutions, is that they don't like to do community mobilisation. They want to do higher-level jobs; they don't like community jobs. So, if there are three or four posts available, a social worker may not apply for community projects. They will apply for communication, they will apply for a coordinator position. You can't do anything about it. The social work field on the one hand, teaches a lot of groundwork; but on the other hand, it attracts them to seek management jobs. I think it is an inherent contradiction for them to be more in the field as per their discipline versus opportunities that have opened up in the NGO sector. So, that is where difficulties are, but more or less fewer difficulties as compared to the counselling field.

Since multiple interventions are done by the SNEHA team in a given location, nurturing a talent pool is an evolving exercise which needs constant and dynamic calibration. Besides, SNEHA's frontline team is expected to work within established medical frameworks, systems, processes and techniques, despite not always understanding the full scope of these as they may not be certified medical professionals. Nonetheless, it is through them that the underlying medical science has to be integrated at a community

level. This requirement to blend social work with public health expertise at a community level on one side, with technical expertise on the other, has made the frontline personnel at SNEHA into an indispensable cadre of its own standing and in a sense, a strategic consideration for SNEHA.

An organisation with two or more strategically critical yet different cadres always runs the risk of having the division of roles leading to a division of people within the organisation. Organisationally, then, constant thought and efforts have to be channelled in the direction of holding the balance together. Perhaps the most important piece of this effort is to really understand why someone would want to sign up for such roles, what really motivates them and where to search for this motivation and sustain it within the organisation. According to Vanessa:

> Typically, I think what we try and determine from people is what motivates that person. And often, we find that in the course of maybe a situational example, or an interview, that the motivation may be more pecuniary. It may be salary, it may be recognition or maybe just having, for example, a large team reporting to you. So, those are things that we watch for. Because for us, the biggest motivation has to be that you want to make a real change on the ground.

She continues:

> I feel at a senior level, we actually walk the talk when it comes to the organisation's values and behaviours that we want to reinforce in the organisation. While hiring talent at SNEHA, if we have more than one candidate who is more or less the same, I will always choose a candidate with the right attitudes and values. And we've seen that actually works much better. One, because the right attitudes and values get percolated down in the organisation, and two, the person is a better fit. We did this program of investing in future leaders, with Bridgespan in 2018. It was a nine-month program with the senior leadership. And the idea was to identify six core competencies and six leadership competencies that we wanted, to cascade across the organisation in order for people to be able to achieve the strategy. So things like innovation, critical thinking, communication, workload management, etc., are all part of these competencies, and of our capability development.

Appreciative inquiry: a cultural cornerstone

What then, are the attitudes and values that fit a workplace located in difficult and dense urban settings, that deals with the day-to-day details of a variety of people (chiefly mothers and children), must cover many aspects of their lives, and must combine medical expertise with the know-how of communities?

It is also work which is front and centre in the public domain: health, unlike many other concerns, is immediate and intimate to everyone. Actions that any health practitioner takes has direct bearing for the person at the other end. This “answerability” puts greater onus on the care-giver. Seen against this, it is quite an accomplishment for SNEHA that despite the expansion and new recruits flowing in they have still retained most of the team right from when they started. This perhaps signifies that, preoccupied though it has been with its work outside, it has nurtured an environment that attracts a critical pool of

publicly-minded and motivated individuals. Even after all these years, this culture and the underlying spirit is well and alive amongst its original guard. Dr Shanti says:

> It's a very friendly place, and we have not had great attrition. It's because of the basic principle of working through the strengths of people. The appreciative participatory method which was there from the beginning added a lot of value in developing further talents and managing talent. You'd be surprised, the programme directors who joined us in 1999, many of them all still there. So, it's a very nurturing atmosphere and therefore, people acquire talents. But it is time-consuming. It takes time and it requires patience. I didn't know anything except medicine, not that I know much now, but I understand the community now, and our community processes. So it allowed me to grow; we have all grown in this organisation. Talents have been acquired and we have been allowed to acquire these.
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> I think there is also a lot to say even about the funders. I think the funders understood the genuineness of the work and so they allowed the talent to develop; they allowed us to falter. And when we faltered, came back, righted ourselves and did the work well, they were there with us. It's an open value system on which these values were established: the values of transparency, integrity, honesty, nurturing. And this appreciative nature of working through strengths and the participatory approach, takes a little longer but it is very helpful in retaining and growing in your position.

She continues:

> Why are the volunteers working with us? They are not given any money. After working for a period of time they see that malnutrition levels (in communities) have come down, complementary feeding has gone up, exclusive breastfeeding has gone up, immunisations have gone up. When they see these results they feel nice. They gain a lot of knowledge and are appreciated when going into their communities. Some people even call them (the volunteers) doctor: "Doctor, *mere bacche ko aisa hua hai toh kya kare*?" (This is what has happened to my child. what is to be done?) So, they feel very respected. The respect and recognition they get keep them going.

SNEHA acquiring appreciative inquiry as an innate trait owes its origins to an early staff member—Dr Wasundhara Joshi—who was an expert in behavioural sciences. Dr Joshi developed a model of appreciative practice using behavioural insights from her work, and piloted these as early as the core team's last year at Sion Hospital in the early 2000s. She was able to demonstrate to the team the effects the appreciative methods had on encouraging behaviour change in people and in developing strong relationships with community members. For that early core team of SNEHA, building a culture of appreciation was also a way to ensure that staff in the organisation they were setting up experienced a culture very different to what the founders had experienced over their many years working at Sion Hospital. Dr Shanti reflects:

> Let me tell you, honestly, I would reach the hospital in the morning around 7:30-8:00 am. I would slog out, let us say, till 7:30-8:00 pm, or I would bring some work back home. Then I would be on call: taking emergency calls at

> midnight, taking calls early in the morning, then I would get ready and get back to the hospital. But in my 35-year career in Municipal hospitals, hardly anybody told me that I had done a good job. How do I know that I'm doing okay? The only time would be when I would suddenly get a call from the Director of Medical Services of Municipal Corporation saying: "please give us your expert opinion on this." That was the only way that appreciation was given. The rest of the time, public hospitals got only *gaalis* (abuses). Sometimes I used to feel that [Sion] hospital should tell people: that in a day we conduct so many deliveries, that in a year we have about one lakh operations going through, that in a day the number of patients transiting through the hospital is in multiples of ten thousands. These are not ordinary numbers for a public hospital. I used to think that the public relations department should at least let it be known how many cases we were managing and how many difficult cases we handled. But those things were never known. And what we got was only: public hospitals are bad. There were only complaints.
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> So, that was the root cause of us saying that this is very disappointing and discouraging. We have all put in hard work, but nobody has said anything. That is why we took up these participatory appreciative methodologies at SNEHA, which work through the strengths of people. Wasu [Dr Wasundhara Joshi] took it up very seriously. So, that was the route to building a culture like this, especially our experience of never having been appreciated.

For an organisation with 500 peoples of different kinds on its rolls and many more associated as volunteers or through the public health system or in other civil society organisations, its finesse in nurturing a culture that stands apart yet accommodates expansion and adheres to excellence will be put to even greater test in years to come. The backdrop is again shifting in remarkable ways: the medical profession is expanding into niches with greater and greater specialisation, the Indian urbanisation story continues its relentless march while confronting risks of climate change, and the motivations to work in civil society are perceptibly shifting.

Harnessing the growth

Dr Shanti admits that SENHA had always had to grapple with drawing in the right kind of non-field-based management talent that could chart the organisation's future direction. From experience, it had found that managing the growth of the various segments of its field teams came naturally to it. But it has had to work hard at putting in place the right group of people at the transition between field management and the senior management (who oversee entire verticals or portfolios of programs). This group needs to be able to support senior management and crucially, interact well with SNEHA's diverse group of partners, both national and international. Dr Shanti elaborates:

> See, the growth of the field staff: the actual field staff, the community organiser to the next supervisor level: the Programmer Officer, and then to the manager level: the Field Manager—that growth is happening very well. Where we are finding difficulties are between the Field Manager to the junior level of the senior management. There are two senior management levels: Associate Programme Director and Programme Director. From the

> Field Manager to the Associate Programme Director level transition, that growth has been quite challenging. We still have to crack it well.
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> The demands of these levels are very different. As a Field Manager you're thinking at, say, the 2,500-3,000 feet level. But at the Associate Programme Director level, you have to start thinking at 10,000. As a Programme Director, you may have to think at 25,000 and as an Executive Director or CEO, we have to think at some 50,000 feet level. That transition in thinking and strategising is significant. So, we are wondering whether we should have somebody in between [Field Manager and Associate Programme Director). And from this in-between level onwards is the senior management, where you have to interact with the rest of the world. You may be queried on talent or you may be queried on what processes you are going to follow. We have to interact with domestic and international donors, experts coming down: consulate council members would visit you, for example. So, those levels of interactions start taking place. It is not the language, it is the ability to interact with clarity. Language is not the only problem.

Nayreen further highlights that while the growth of SNEHA has been crucial to increasing the organisation's reach and impact, it has been equally important to pay close attention to the trade-offs that must be made whilst growing so as not to lose sight of SNEHA's founding philosophy of providing care deeply rooted in the needs of communities. Furthermore, a preoccupation with growth can also impair creativity and the overall agility of the organisation as decisions pass through multiple teams and management levels, all of which takes time and can lead to missed opportunities.

Her own vertical (Prevention of Violence against Women and Children), which started with just herself and a single social worker, today has 130 staff and four second-line leaders. Finding the balance between maintaining its grassroots ethos and developing the right management strategies to sustain its level of scale is an ongoing challenge with no easy answers. The trade-offs Nayreen calls out are a bug-bear for many in civil society today, but for a public health organisation, with the weight of "answerability" and ever growing need for its support, it resonates louder. The onset of COVID-19 pandemic put this into sharp relief.

COVID-19: pivoting through technology

The effects of the COVID-19 pandemic on urban health required SNEHA to quickly pivot into new areas that it had not worked on while ensuring its existing programmes could deal with the greater demands placed upon them. In particular, there was a need to combat the severe psychological trauma brought about by, amongst many other reasons, the huge numbers of deaths in urban slum areas as well as the livelihood losses triggered by months of lockdowns. According to Vanessa:

> I think one thing that we have seen happening is the deepening of interventions a lot post-pandemic, and we think that will continue. When I say deepening, there are new areas that we never worked on before that we've had to forcibly start working on to address community needs. And also when I say deepening I mean the depth of our own interventions. For example, in an area where we might have been only working on maternal health, we are now rolling out a counselling helpline, simply because we

> have seen very high levels of stress and anxiety. So, in many ways, we are also integrating and deepening our own work. The next focus we see going ahead is that while we've always worked very closely with the public health systems, we see that strengthening for many reasons. Urban health has become a priority, which was not the case before. Further, since the government has seen how an organisation like SNEHA works very closely with the most marginalised communities, and the kind of role we can play to be a catalyst between the public systems and the community, they have also started engaging us a lot more. Besides that are the NGO collaboratives. We've started working a lot in partnerships post-pandemic with other NGOs. And that's something we will continue to do.

SNEHA meanwhile had to redesign its programmes for "low-touch" modes of delivery to comply with the constraints of physical distancing and the lockdown. Technology started to play a much bigger role in the delivery of its services in the wake of the pandemic, as Dr Shanti lays out:

> We had to shift to a mode of working with technology. See, we were working through volunteers: we could not physically enter because most of our slums became containment zones. They were completely locked out, but the people who were living there were our volunteers. So, because we knew the volunteers we told them that the work had to be done by them. They told us that what they needed was mobile data; that their phones didn't even have this. The first thing we did was to give them data charges and data packages. We gave it to all volunteers. It was the first facility we gave. And then we started working through them. So quite a lot of those immediate needs were addressed. All our staff were also fully insured. Medical insurance is there for them.
>
> All our people learnt to create and hold meetings through Google Meet. Our beneficiaries often do not have smartphones, they have ordinary phones. So, volunteers would convey the messages from meetings to them over phone calls. Luckily, we had a very strong volunteer system. Because, as an organisation, we were anyway transitioning to using more volunteers, we had created volunteer management systems. So, the volunteers supported us a lot during this pandemic time. It was a low touch, tech-based model we went into at that time. And at the same time, ensuring our other services could still be delivered in some form. In fact, in one area we even started virtual clinic services. It is still continuing because the beneficiaries are finding it so good. They don't want the virtual services to be stopped. So, virtual maternal (antenatal) services have started.

The virtual antenatal clinics were a fortunate by-product of this difficult time. The other was the development of chatbots to quickly respond to cases of stress, anxiety and lack of information. Encouraged, SNEHA also started exploring the use of GIS (Geographic Information System) mapping to better understand the effects of the pandemic on its communities.

However, technology was by no means new to SNEHA, for it had already been using technology for its backend systems as early as 2012 (when it saw a significant spurt of growth). An early affiliation with University College of London for randomised control trials (to test the effects of community mobilisation on

the prevalence of violence against women and girls) helped SNEHA establish and formalise internal systems and protocols for implementing research projects at scale. Its frontline staff have been using smartphones for data collection since 2012, ahead of most peers in the sector. Today, these have been upgraded to tablets. Equally, it has also developed strong internal infrastructure for management: making use of business intelligence systems and cloud servers and services, all of which, according to Vanessa, allowed SNEHA to pivot very fast during the pandemic.

Technology also holds promise as a way for SNEHA to increase contact with full-time doctors, a group whose expertise is in constant demand but remains the most challenging to acquire. Online platforms offer a possible way to connect their teams directly to doctors. Developing a model around which this could work is an area of exploration, with SNEHA taking care that the design of such tech-enabled modes of delivery do not detract from its ethos.

Practising an ethos: public-spiritedness, nurture and excellence

Sushma poignantly compresses SNEHA's journey, which has encompassed care, growth, expertise, excellence, adjustment, trade-offs, evolution and innovation, into the words that animate this ethos:

> There have been many opportunities that have come and gone along the way but somewhere I feel, the cause and the focus on the mission, that is what drives SNEHA. Being true to our mission all the time and sticking to it whatever the circumstances; I think that is what is keeping us alive. I think we are people who work with heart and head together. These are difficult to put together in this situation, but keep your heart and head together despite all that; I think that's the motto.

The future will not be like the past, for today SNEHA starts at 500 instead of four. It has raised the bar for itself and public health in the places it operates. It has learnt much and has much to tell others: a rare organisation in which everyone who laid the founding stones continues to be there. The bug-bear of fissures and fractions was held at bay by the preoccupation with shouldering much public responsibility.

With passing age and maturity come even heavier responsibilities. Chief amongst these, occupying the thoughts of its founders and its leadership, will be that of holding itself together and building upon its past. India's public health challenge will remain daunting for a long time to come and it will have to be dealt with by a new generation: a completely different demographic with different aspirations and different sets of values. The blend SNEHA has managed to craft inside, the struggles it has had in harnessing its growth, the trade-offs that remain front and centre and the possibilities that technology offers, provide much food for thought for those who follow. In navigating these, they could certainly rely on the credibility of what SNEHA has accomplished in the field of public health. But perhaps of even greater value will be its innate trait of practice evolution, or rather, constantly evolving its practice to make its ethos come alive and stay alive. In the vitality of this practice and ethos SNEHA continues to be found, amidst the din and buzz of the city that never sleeps.

Exhibits

Exhibit 1: Overview of SNEHA's vision, mission and values

Fig. 1: SNEHA's vision, mission and values

Source: SNEHA Annual Report (2021-22)

Exhibit 2: SNEHA Board, Governance and Management

Fig. 2: SNEHA Board, Governance and Management

Source: SNEHA Annual Report (2021-22)

Exhibit 3: Prevention of Violence against Women and Children programme overview

Fig. 3: Prevention of Violence against Women and Children programme overview

The **SNEHA** programme on Prevention of Violence Against Women and Children (PVWC) works towards developing and sustaining high-impact strategies for preventing Gender-based Violence (GBV), ensuring survivors' access to protection and justice, empowering women to claim their rights, and mobilising communities around **'zero tolerance for violence'**. The programme is implemented at three levels to address gender-based violence.

Primary prevention includes community mobilisation through campaigns and group education with 172 women's groups, 32 men's groups and 358 women volunteers who identify, intervene and refer cases of violence against women and children.

Secondary prevention is offered via comprehensive services that provide counselling, crisis intervention and coordination with public health facilities, the police and legal aid. The programme runs 7 community-based and 4 hospital-based counselling centres across Mumbai.

Tertiary interventions include extended counselling and legal interventions. The programme partners with the police, health and legal systems through training, support and coordination of cases to reinforce their roles in assuring basic social, civil and economic security to survivors of violence.

The programme has fostered a strong community base of volunteers and an attitudinal change is evident in communities that encourage more surveillance and immediate response in incidences of violence inside or outside the home.

The Prevention of Violence against Children project is aimed at:

- Identification of and response to maltreatment and violence against children
- Working with parents to enable them to gain an understanding of their disciplining practices that may be overt and covert forms of violence

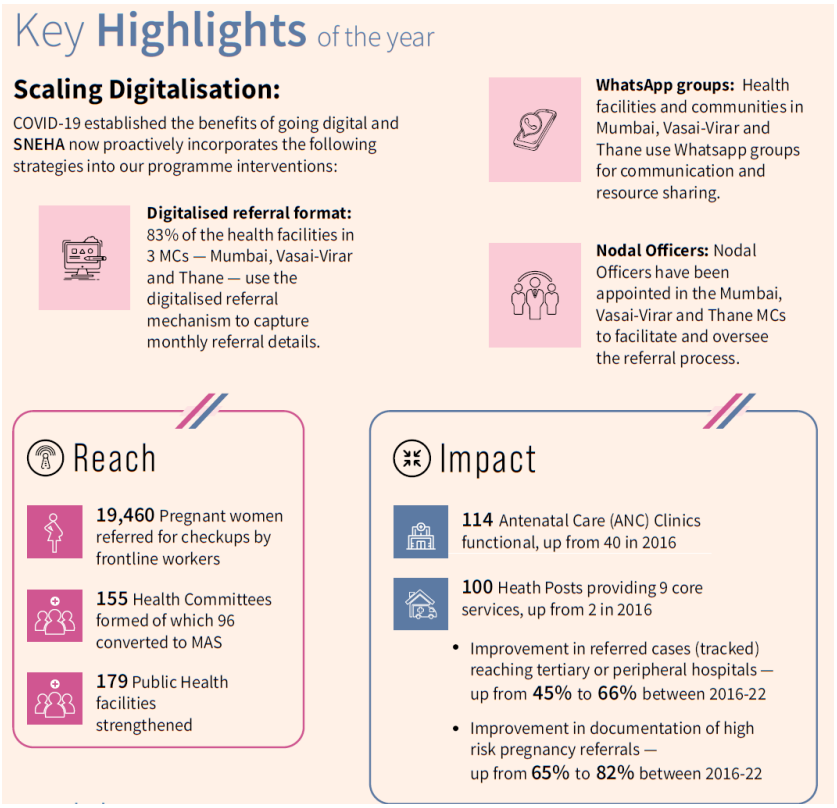
LOCATION

- Across Mumbai

Source: SNEHA Annual Report (2021-22)

Exhibit 4: Maternal and Newborn Health: an overview of SNEHA's flagship programme

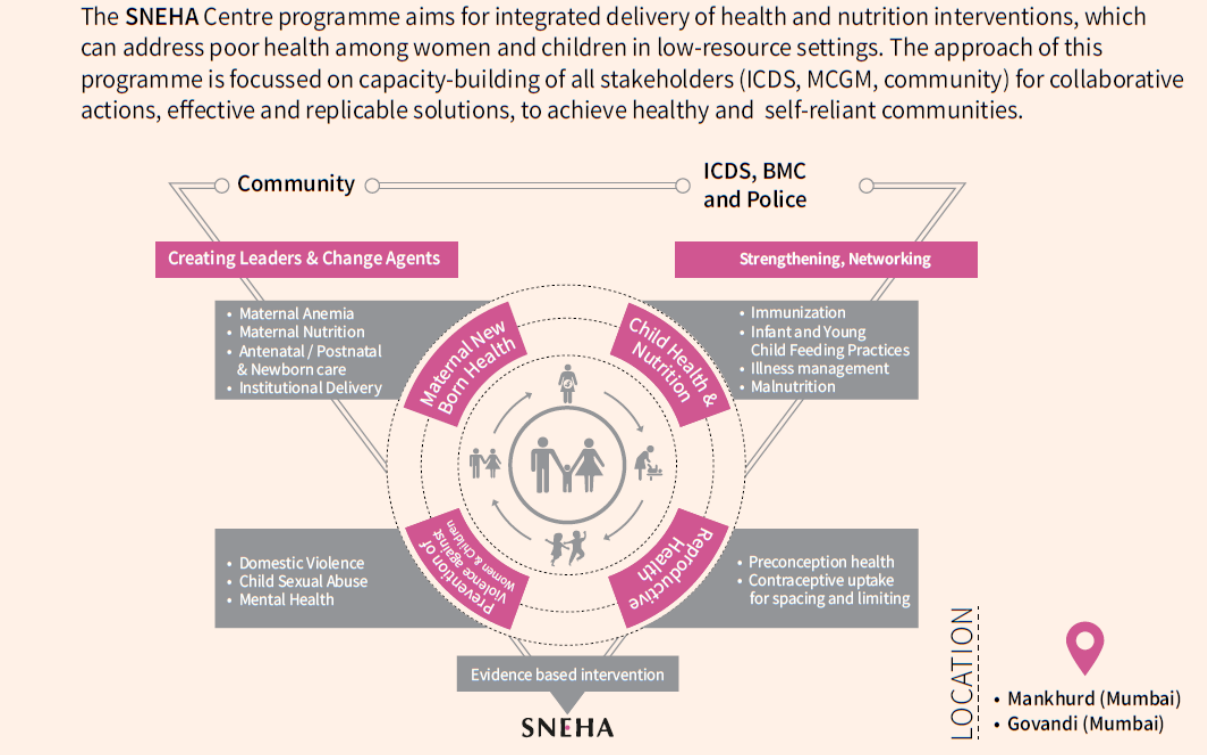
Fig. 4: Maternal and Newborn Health programme overview



Source: SNEHA Annual Report (2021-22)

Exhibit 5: Design of the integrated "SNEHA Centre Programme"

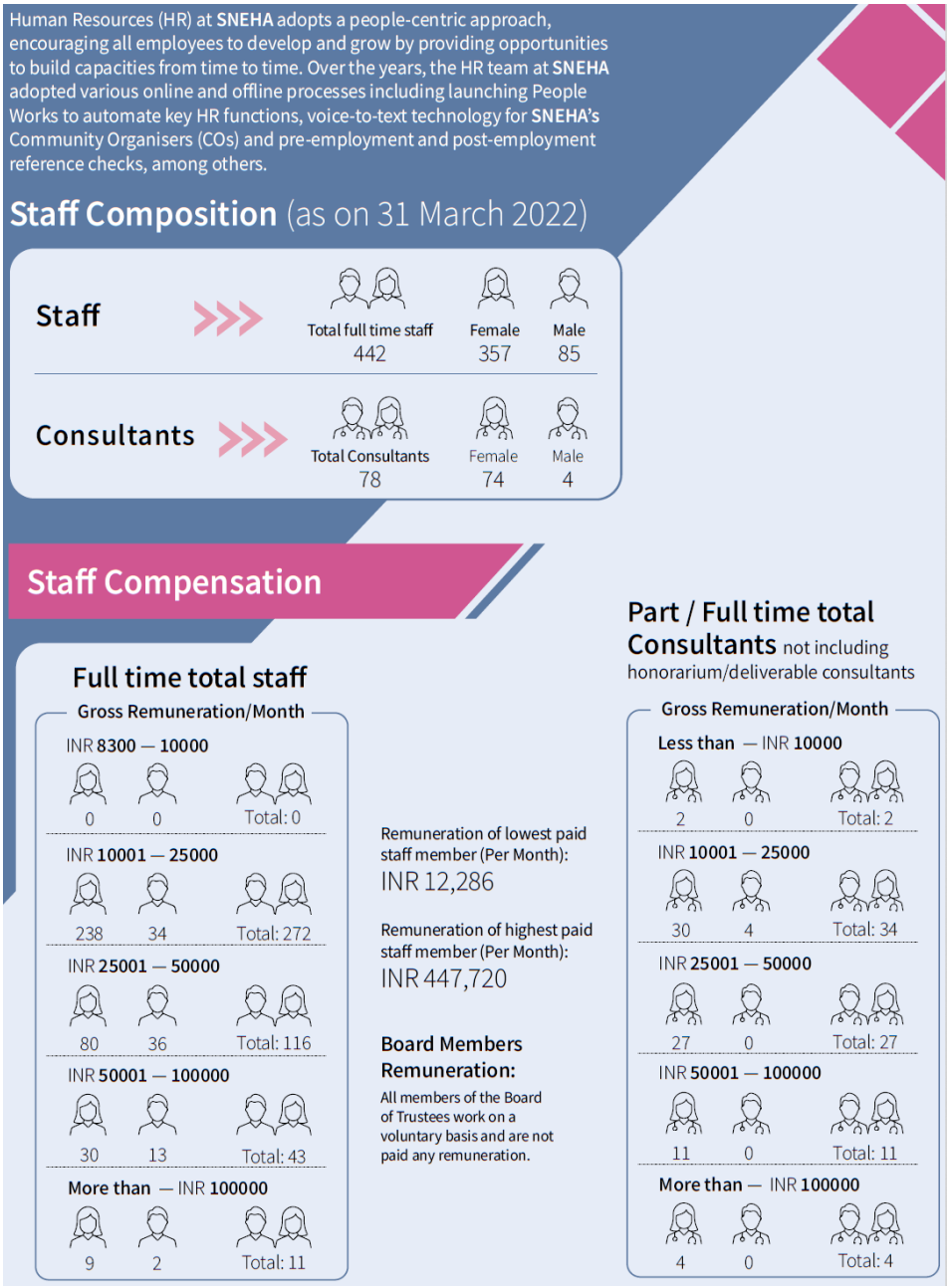
Fig 5: Design of the integrated "SNEHA Centre Programme"



Source: SNEHA Annual Report (2021-22)

Exhibit 6: Breakdown of talent at SNEHA

Fig 6: Breakdown of talent at SNEHA



Source: SNEHA Annual Report (2021-22)

Exhibit 7: Overview of donors

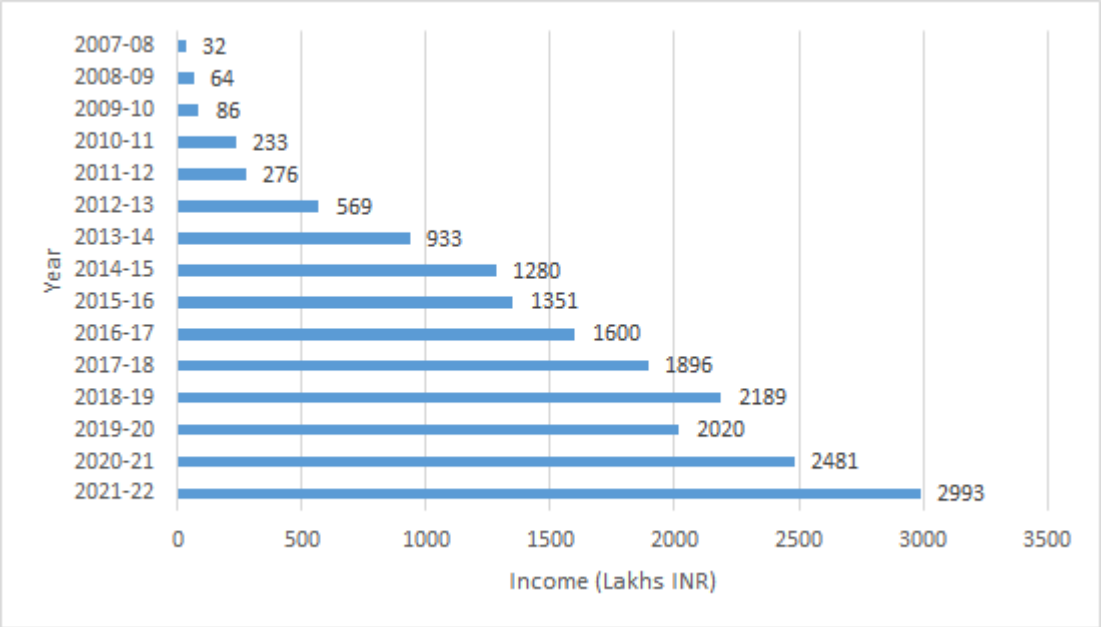
Fig. 7: SNEHA Institutional and programme donors (March 31st 2022)

- ACG Cares Foundation
- Agiliad Technologies Private Limited
- ATE Chandra Foundation
- Atin Kukreja
- Azim Premji Philanthropic Initiatives
- Bajaj Allianz General Insurance Company Limited
- Charities Aid Foundation America, Inc.
- Cipla Foundation
- Dasra
- Department of Women and Child Development, Government of Maharashtra
- Epic Foundation
- Fidelity Asia Pacific Foundation
- First Abu Dhabi Bank PJSC
- Give2Asia
- GlaxoSmithKline Pharmaceuticals Limited
- Global Development Group
- H T Parekh Foundation
- Julius Baer Capital India Private Limited
- Karmatex Apparels Private Limited
- KBF Foundation Canada
- King Baudouin Foundation - Brussels
- Koita Foundation
- Laxmibai Dwarkadas Charity Trust
- Manan Limited
- Mariwala Health Foundation
- Morgan Stanley India Company Private Limited
- Morgan Stanley India Primary Dealer Private Limited
- N K Patni Charitable Foundation
- Nihchal Israni Foundation
- Population Services International
- R G Manudhane Foundation for Excellence
- Rajnish Puri
- Rizwan Koita
- Sahayog Foundation
- Silicon Valley Community Foundation
- The Consulate General of Canada in Mumbai
- The Ford Foundation
- The Hongkong and Shanghai Banking Corporation Limited
- Tides Foundation
- United Way of Mumbai
- University College of London

Source: SNEHA Annual Report (2021-22)

Exhibit 8: SNEHA annual income trends

Fig. 8 SNEHA: annual income trends (2007-2021)



Source: SNEHA Annual Reports (2007-2021)

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