Institute for Healthcare Improvement

International Forum On Quality & Safety in Healthcare

How the European Sanitary Movement Informs Justice-Based Action and Inspired Paul Farmer

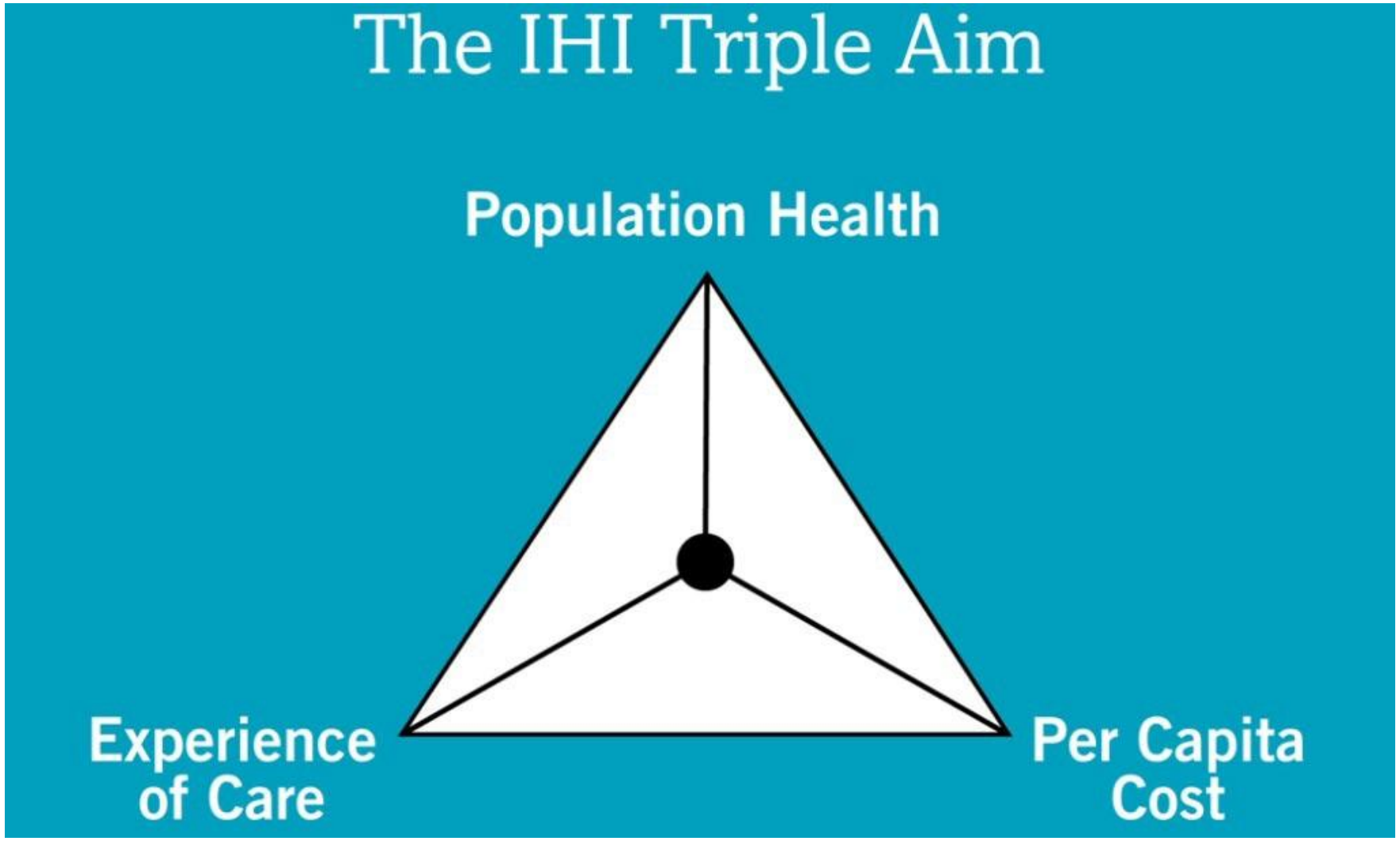
Don Goldmann, MD
Chief Scientific Officer, Emeritus, IHI Professor of Pediatrics. Part-Time Harvard Medical School

Professor of Epidemiology
Harvard TH Chan School of Public Health

Jafet Arrieta, MD, DrPH, MMSc Vice President, IHI Instructor, Harvard Medical School & Harvard TH Chan School of Public Health
jarrieta@IHI.org

May 23, 2025

Don Goldmann and Jafet Arrieta have no conflicts of interest or disclosures in relation to this presentation



What can we learn from history? Where do we stand today?

Cholera Pie

Valais, Switzerland

?Originated in 1836 during epidemic when food supply disrupted

OR

Derived from *chola* or *cholu*, Valais German term for coal on which pie cooked, or *cholara*, the bakery room where coal was stored

Ingredients

500g puff pastry

40g butter

200g raclette potatoes

200g apples

200g leeks

200g onions

250g AOP Valais raclette cheese

Salt, pepper

Le Petit Journal

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SEINE et SEINE-ET-OISE	2 fr.	3 fr. 50
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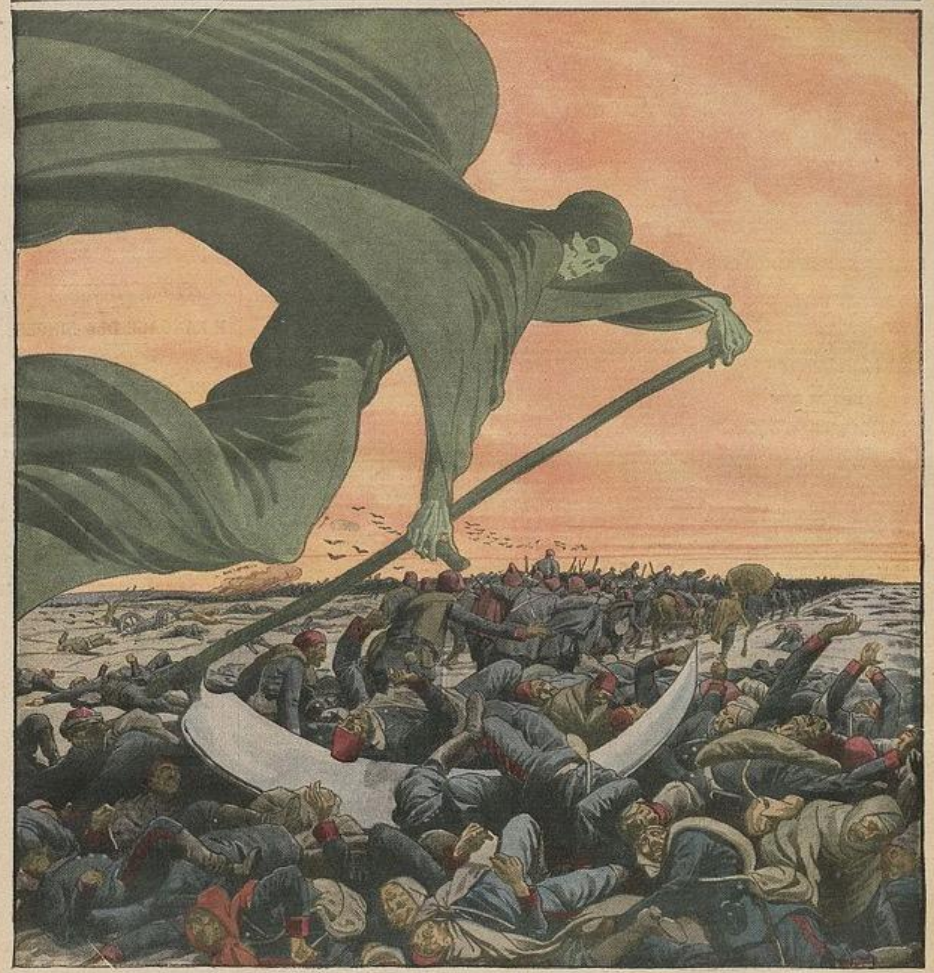


LE CHOLÉRA

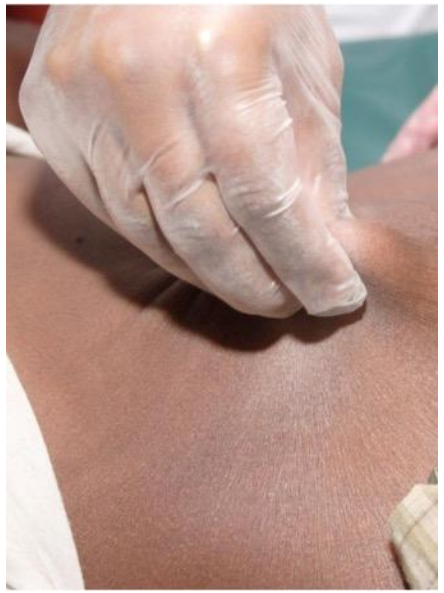
Japanese Woodblock Prints of Carbolic Acid Spraying Cholera: Late 19th Century

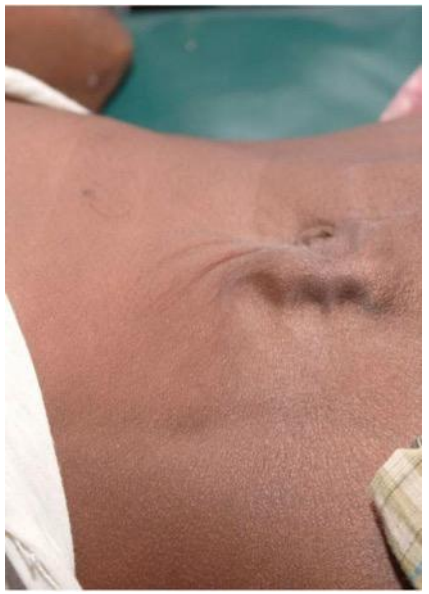
Archives and Special Collections, Library and Center for Knowledge Management, University of California, San Francisco

“Rice Water” Diarrhea

3-5 gallons per day! Massive leak of fluid and electrolytes, including sodium chloride and bicarbonate (causing acidosis) – No fever!

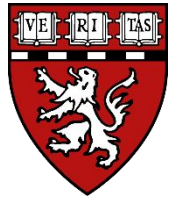
Cholera Cots





London Cholera Epidemic of 1854

You may want to look at the HarvardX MOOC, Prediction X
https://www.edx.org/course/predictionx-john-snow-cholera-epidemic-harvardx-soc1-jsx



Dickens' London

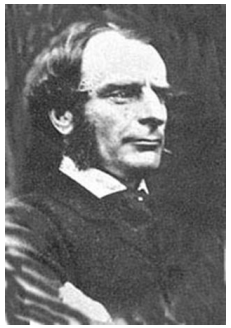
- 2.5 million people crowded together
- Animals, residue of slaughterhouses, blood in the streets
- No systematic sewer system – 7 companies, 1,065 commissioners, rampant corruption
- Irony of Nuisances *Removal and Contagious Diseases Prevention Acts*, 1848 and 1856 (miasma mitigation)

Miasma: foul vapor believed to spread disease via the air

I turned into an alley 'neath the wall-
And stepped from earth to hell.-The light of Heaven, The common air was narrow, gross, and dim-
The tiles did drop from the eaves; the unhinged doors
Tottered o'er inky pools, where reeked and curdled The offal of a life; the gaunt-haunched swine Growled at their christened playmates o'er the scraps.
Shrill mothers cursed; wan children wailed; sharp coughs

The Saint's Tragedy, Charles Kingsley

- Clergyman
- Historian
- Novelist
- Professor



The Saint's Tragedy, Charles Kingsley (1810-1875)

I turned into an alley 'neath the wall-
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Tottered o'er inky pools, where reeked and
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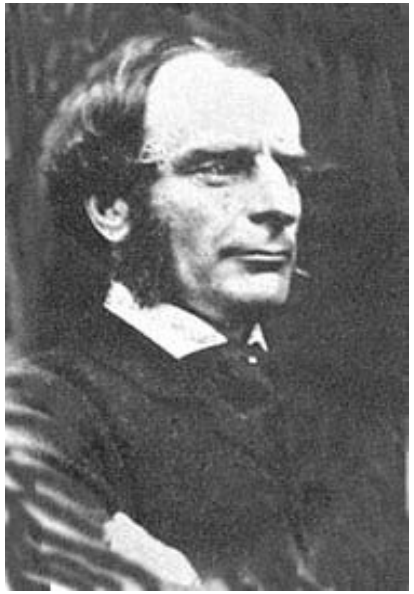
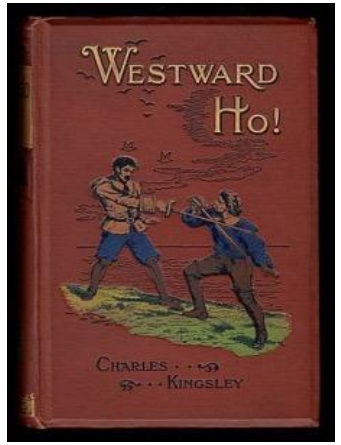
swine Growled at their christened playmates o'er
the scraps.
Shrill mothers cursed; wan children wailed;
sharp coughs
Rang through the crazy chambers; hungry
eyes Glared dumb reproach, and old
perplexity,
Too stale for words; o'er still and webless



Clergyman, University Professor, Historian, Novelist



William Farr's Miasma Theory

- Eminent statistician
- Ally of Florence Nightingale who used flawed statistics about hospital mortality to advocate for reform
- Correlation of cholera mortality with elevation above putrid Thames

Mean Elevation of the Ground above the High-water Mark.	Mean Mortality from Cholera.	Calculated Series.
0	177	174
10	102	99
30	65	53
50	34	34
70	27	27
90	22	22
100	17	20
350	7	6

$$c = \frac{90 + 13}{e + 13} \cdot 22 = \frac{103 \times 22}{e + 13} = \frac{2266}{e + 13}.$$

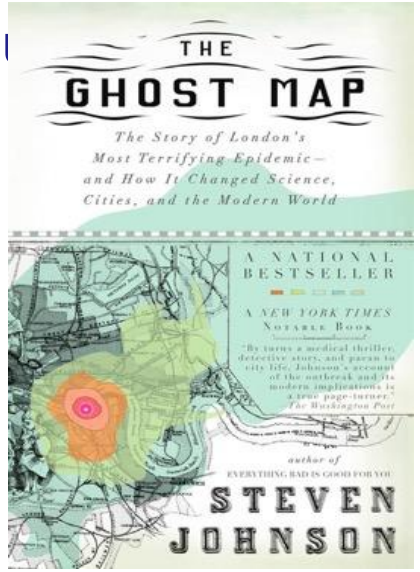
"This made it probable that a certain relation existed between elevation and the power of cholera to destroy life."

John Snow's Theory

- Witnessed first case as apprentice surgeon-apothecary in 1838
- Novel theory in 1848-49:
  - Disease confined to the gut and probably due to ingestion of a microorganism ("cell") and multiplication in the gut
  - Death caused by fluid loss
  - Transmission via soiled linens/clothes, waste, and by water, **not** air/miasmas

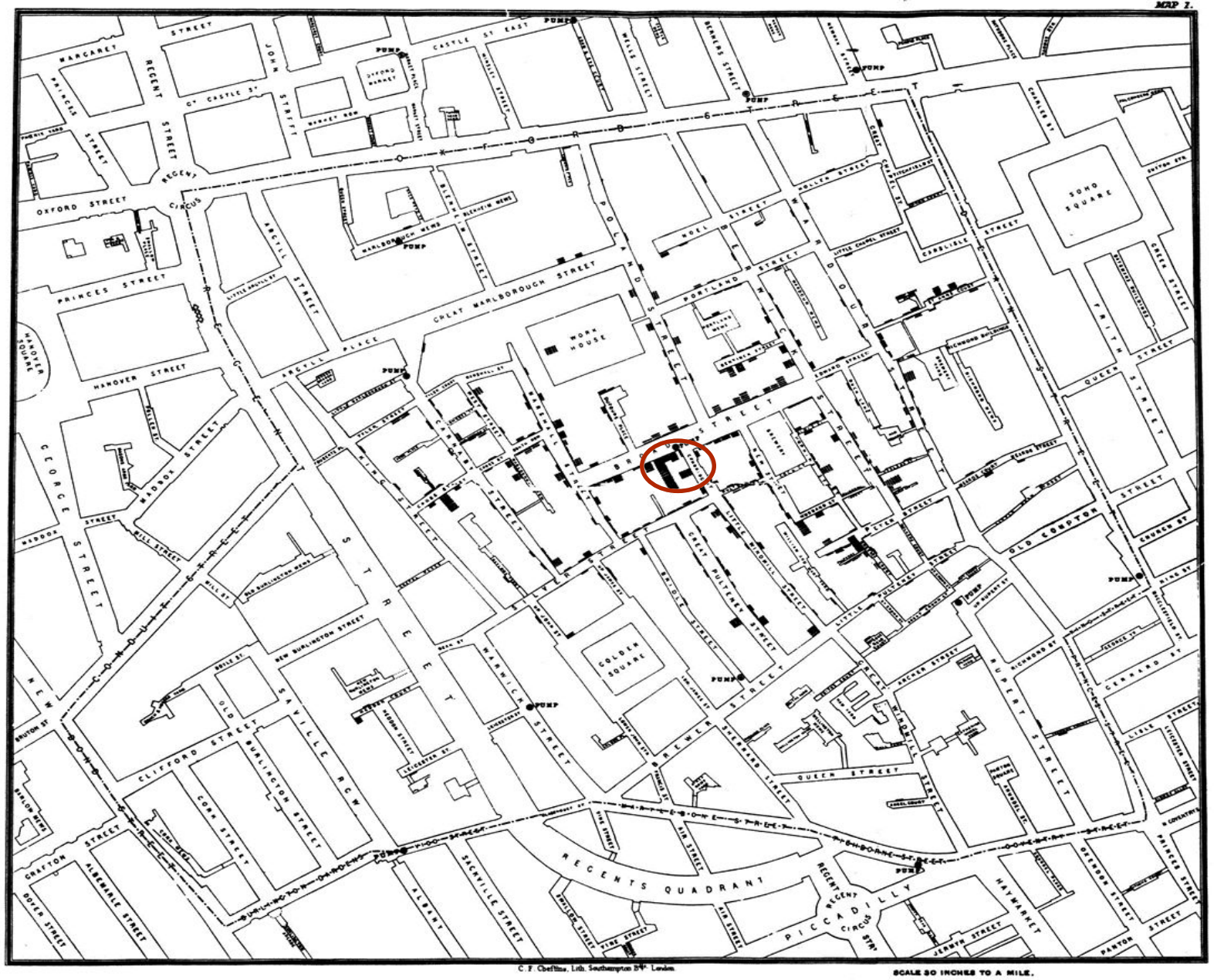
A Massive Natural Experiment

- Severe outbreak in Golden Square (Craven's Field, Soho) in 1854 provided another opportunity to test hypothesis
  - 500 deaths, Aug. 31-Sept 9
- Many people preferred pump water to company water
- Inspected 5 pumps supplying area on Sept. 3
  - All had obvious particulate matter except Broad Street P
    but resident said it had been foul the day before
  - Obtained from General Registrar 83 deaths ascribed to cholera in Golden Square starting August 31



Building the Case

- “Exception that proves the rule:” Cases in far away Hampstead (Eley family) had consumed Broad Street water from barrels
- Of 10 deaths nearer to other pumps, 5 preferred Broad St. water, 3 had children at school near pump
- Lion Brewery, 50 Broad St. no deaths (water from private supplier, few drank water at all!)
- Investigated 616 more deaths and found 574 houses in which deaths had occurred
- Initially missed the index case (sick child who died from cholera)

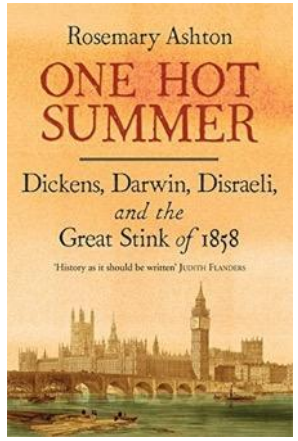


Snow's Spot Map of Golden Square Outbreak, 1854

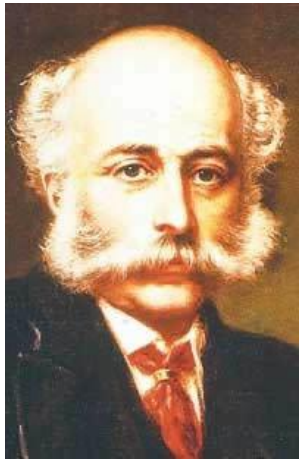
Pump Handle Removed Sept. 8 (After Index Patient Died!)

General Board of Health rejected Snow's findings.

"Science Deniers" advocated for miasmas for many years.



The Great Stink of 1858



- So overpowering that the curtains of Parliament were soaked with chloride of lime (in vain)
  - No uptick in the incidence of cholera, despite the miasmas!
- Led to funding of sewer construction
- 1859 sewer plan of Joseph Balzalgette, civil engineer, accepted

One of Monet's Famous Images of London

'Waterloo Bridge. Veiled Sun' (1903) PHOTO: BRIDGEMAN IMAGES

Edwin Chadwick and the English Sanitarian Movement: Population Health Reformers?

- Chadwick considered a pioneer in sanitation and public health
  - Still believed in miasmas
- Epidemiology studies showing filth in poor districts led to disease and epidemics
  - Habits of the poor contributed– with a “moral” slant
- Sanitation, especially sewars, would alleviate filth and disease
- No comprehensive effort to uplift the poor or deal directly with social determinants of health
  - Primarily interested in a healthy workforce for the Industrial Revolution
  - Feared spread of disease from poor districts to the rest of the populace
  - Sanitation a bulwark against social unrest and crime
- Architect of the “New Poor Laws”

Poor Law Amendment Act of 1834 ("New Poor Laws")

- Chadwick member of the Royal Commission into the *Operation of the Poor Laws*
- Foundations in Utilitarianism (Bentham), Malthusianism, Iron Law of Wages
  - People will choose pleasant options and will not choose what is unpleasant
- Workhouses (welfare system) only place to provide relief
  - Husbands and wives separated
  - Mothers of illegitimate children denied child support
  - Conditions described in Dickens' *Oliver Twist*
- Conditions so harsh that no one would want to be housed there

"Into such a house none will enter voluntarily; work, confinement, and discipline, will deter the indolent and vicious; and nothing but extreme necessity will induce any to accept the comfort which must be obtained by the surrender of their free agency, and the sacrifice of their accustomed habits and gratifications.”

Chadwick's 1842 Report: *Sanitary Conditions of the Labouring Population*

- Impressive quantitative and qualitative data on living conditions and their impact on health outcomes
  - More urban deaths per annum than in any war Britain had fought
  - 43,000 new widows and 112,000 new orphans per annum
  - East London resident life expectancy 29 years less than the wealthy
    - Disparities still: e.g.: 6-year difference for women in Tower Hamlets vs. Kensington and Chelsea
  - Loss of worker productivity

https://www.gutenberg.org/files/65090/65090-h/65090-h.htm

Rudoph Virchow (1821-1902): A True Pioneer in Population Health

- Best known for pioneering work on cellular biology, pathology, leukemia, thrombosis, anthropology, forensic medicine, parasitology and much more
- "Father" of social medicine (social, environmental, economic) with the goal of improving population/public health
- Politician, member of the Reichstag, advocating for public health policy
- Epidemiological studies of typhus outbreak in Upper Silesia in 1847-48
  - Impoverished peasants, famine
- Determinants:
  - Poverty
  - Malnutrition
  - Housing
  - Sanitation
  - Education

Lange KW. Global Health Journal 5 (2021) 149–154

Virchow

- Believed that medicine was not just treatment of patients with typhus and providing food, clothing and housing in the course of an outbreak, but rather comprehensive reforms to improve the health of the entire population
- "Radical" who believed future epidemics would be avoided only through revolutionary change to improve public health.
- – Fought on Berlin barricades is Revolution of 1848
- There is virtually nothing in the Social Vulnerability Index, CQL Social Determinants of Health Index, or other contemporary indices that would have surprised Virchow
- The Triple Aim is not possible without major policy changes aimed at structural inequality and social determinants
  - – QI is important but without reform will reach dead ends

Virchow's Principles

- Public provision of medical care for the indigent (including free choice of physicians in place of the "paupers' doctors")
- Prohibition of child labor
- Protection for pregnant women
- Reduction of the working day in dangerous occupations
- Removal of toxic substances, and adequate ventilation at work sites
- Medicine to be reformed on the basis of four principles:
  - Health of the people is a matter of direct social concern
  - Social and economic conditions have an important effect on health and disease, and these relations must be investigated scientifically
  - Measures taken to promote health and to combat disease must be social as well as medical
  - Medical statistics will be the standard of measurement

Paraphrased from *Eisenberg L, Am J Med 1984. 77: 524-532*

Reflection Question

How confident are you that your country's/region's policies are addressing social and structural determinants of health?

- Very confident
- Somewhat confident
- Not confident

Infant health in Amsterdam, 1856-1926

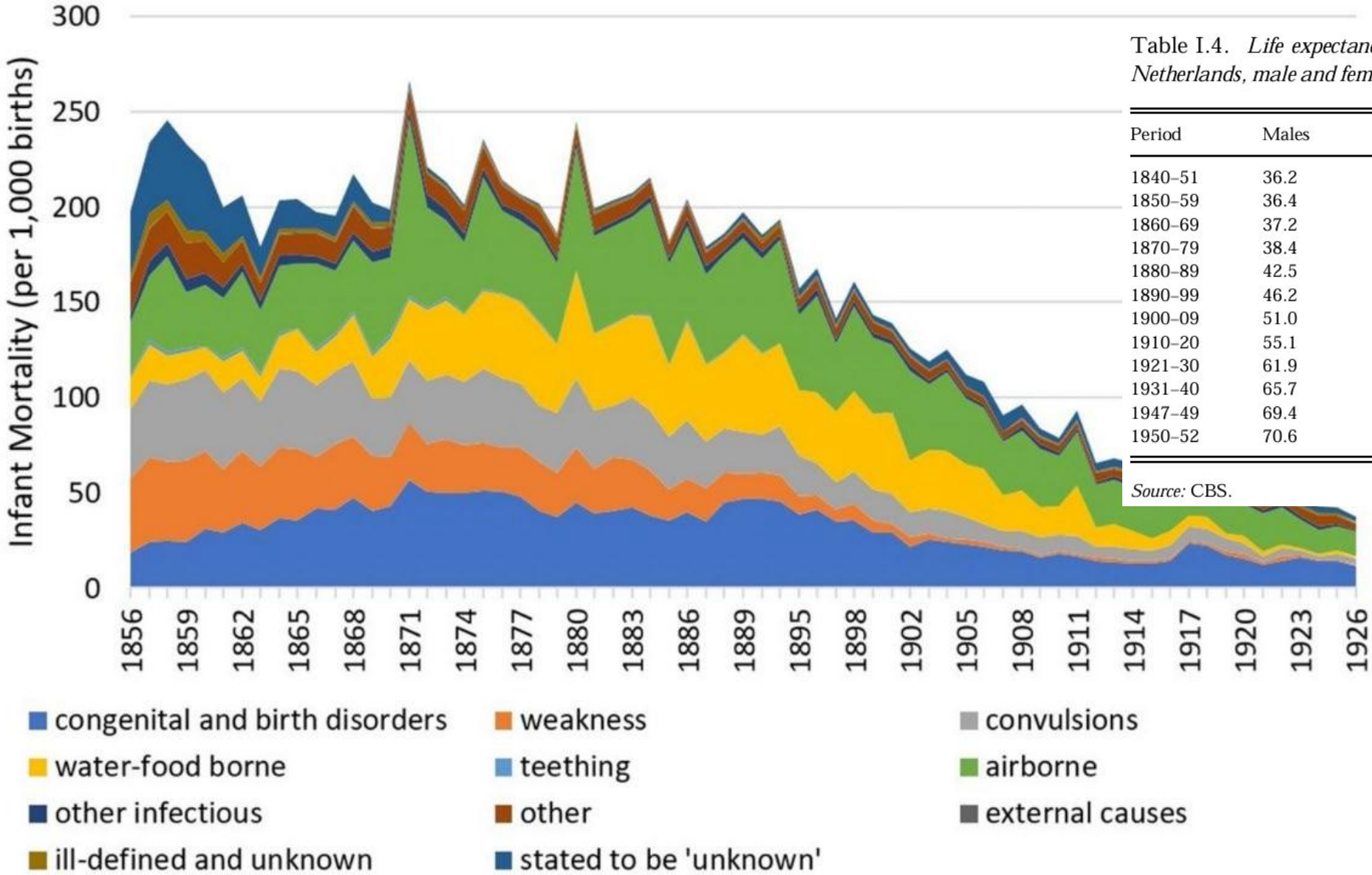


Table I.4. *Life expectancy at birth in the Netherlands, male and female, 1840–1952.*

Period	Males	Females
1840–51	36.2	38.5
1850–59	36.4	38.2
1860–69	37.2	39.1
1870–79	38.4	40.7
1880–89	42.5	45.0
1890–99	46.2	49.0
1900–09	51.0	53.4
1910–20	55.1	57.1
1921–30	61.9	63.5
1931–40	65.7	67.2
1947–49	69.4	71.5
1950–52	70.6	72.9

Source: CBS.

Source: www.doodinamsterdam.nl

LongRunHealthMatters.com

The Potato Eaters, Van Gogh, 1885, Van Gogh Museum

Colonies of Benevolence,' founded by Genaral Johannes van de Bosch in 1818, included 7 seven sites in Belgium and the Netherlands. Goal was to reduce structural poverty through social employment in new agricultural settlements. They were a social experiment at a time when Europe was extremely impoverished. Colonies were either 'free' - for families who received the chance to run small farms, or 'unfree' - large collective structures for vagrants and orphans.

The Bazalgette's Sewer System Plan

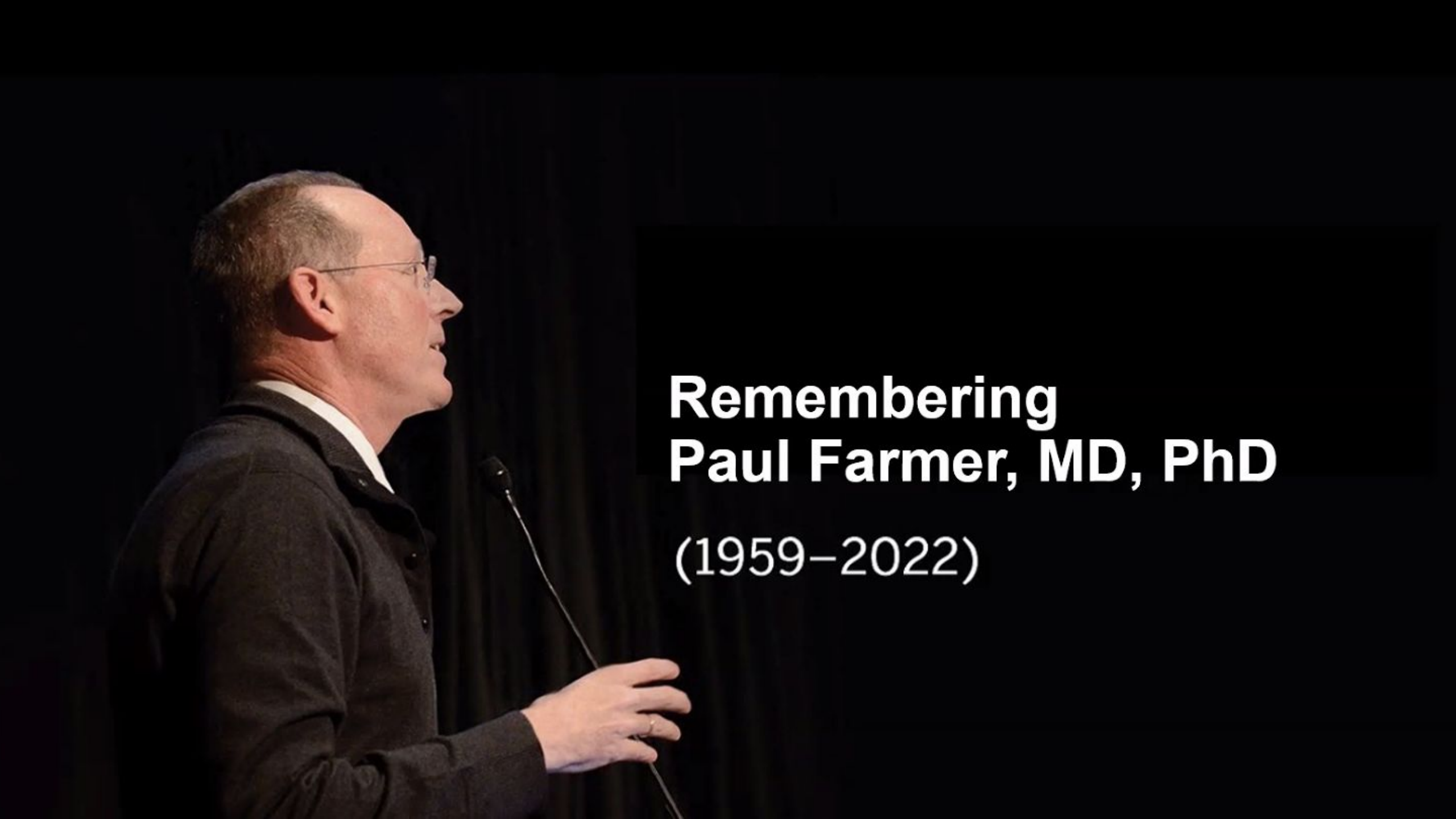
- Premise based on miasma theory!
- 82 miles of brick sewers to connect to 1100 miles of existing sewers
- Special impervious brick, not the brick used to build Victorian London
- Four pumping stations
- Dumped untreated downstream in the Thames (no treatment until 1900)
- Foresight: calculated diameter based on most dense population, generous per-person allotment, and doubled it

London Sewer System

Dylan DeGeorgio Blog, March 2014
dylan-degiorgio.blogspot.com/2014/03/industrial-revolution.html

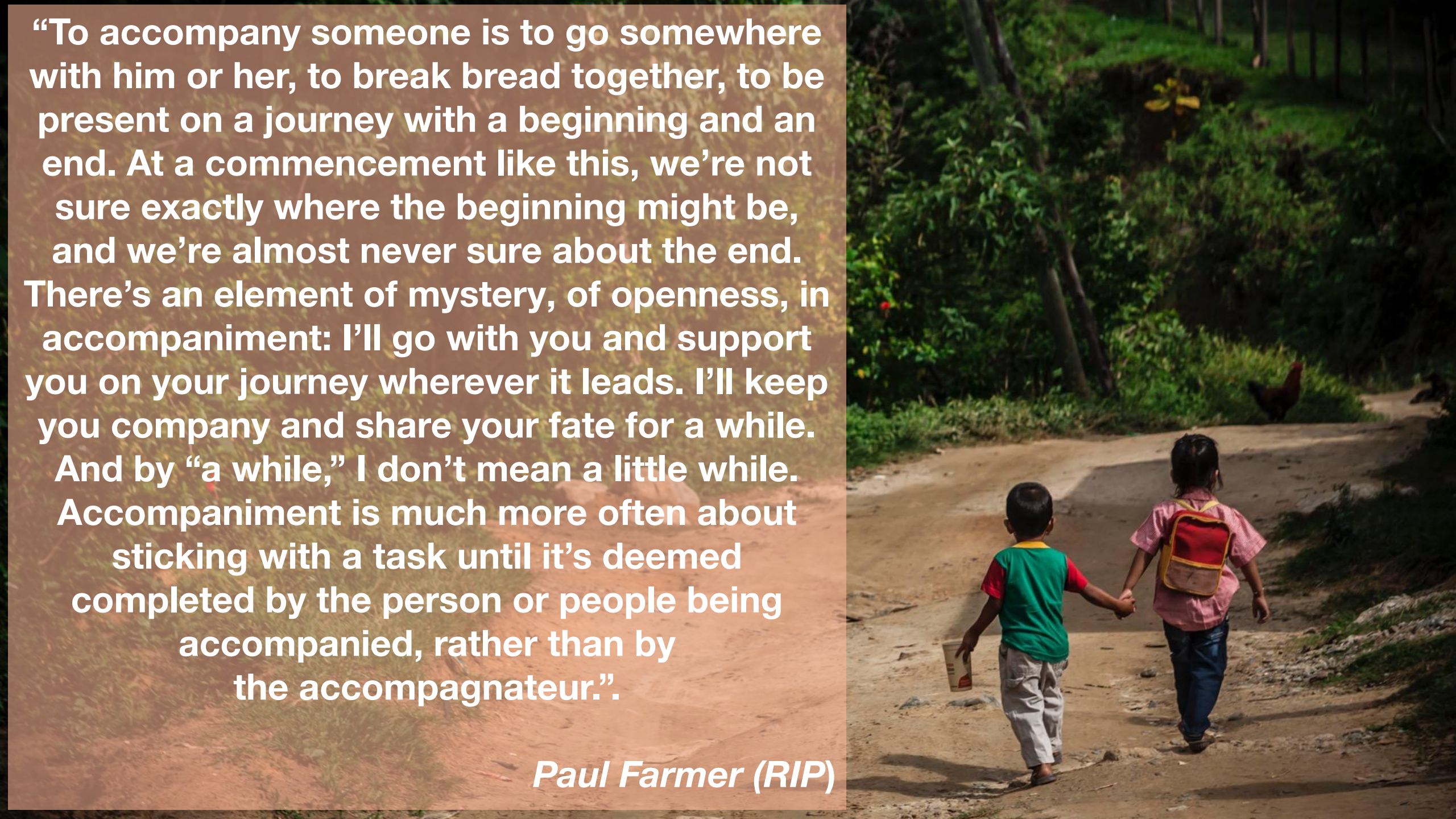
Paul Farmer's Accompaniment Model

Jafet Arrieta


Remembering
Paul Farmer, MD, PhD
(1959–2022)

“Haiti made me.”
-Paul Farmer

C21
BOSTON
COLLEGE



"To accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end. At a commencement like this, we're not sure exactly where the beginning might be, and we're almost never sure about the end. There's an element of mystery, of openness, in accompaniment: I'll go with you and support you on your journey wherever it leads. I'll keep you company and share your fate for a while. And by "a while," I don't mean a little while. Accompaniment is much more often about sticking with a task until it's deemed completed by the person or people being accompanied, rather than by the accompagnateur.".

Paul Farmer (RIP)

Reflection questions

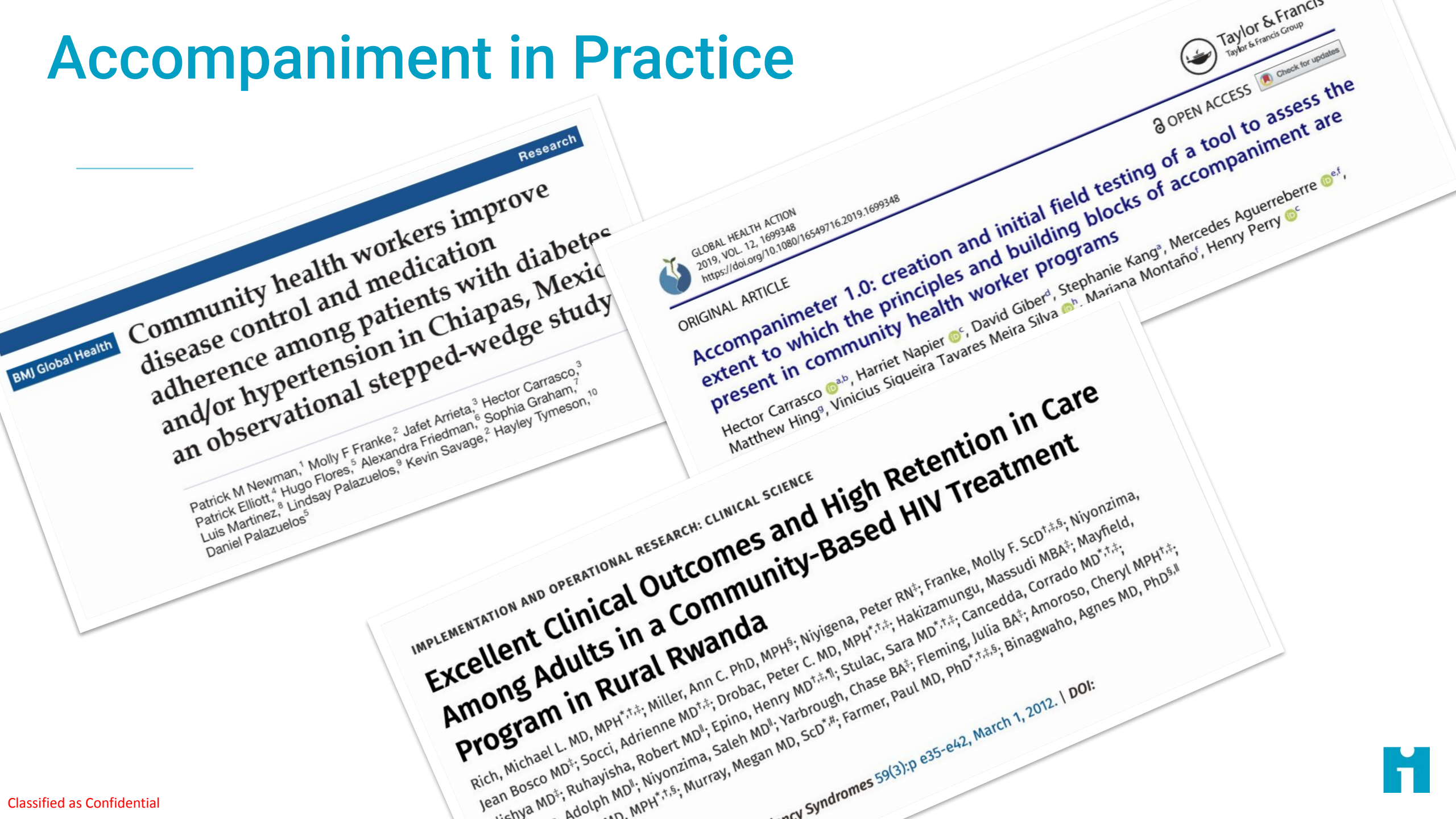
- What does “accompaniment” mean to you?
- Have you ever felt truly “accompanied”?
    - What did that feel like?
- Have you ever ”accompanied” others?
    - What was it like?

Accompaniment is both a philosophical stance and a rubric for programmatic design. In practice, it amounts to walking with the patient through a journey.

The moral responsibility of the healer is to step inside patients' experiences and accompany them through the worst moments with empathy and expertise

Community Health Workers, Yadira Roblero and Magdalena Gutiérrez, walk down the mountain side to make home visits in Chiapas, Mexico.
Photo by Aaron Levenson / PIH

Accompaniment in Practice



BMJ Global Health

Research

Community health workers improve disease control and medication adherence among patients with diabetes and/or hypertension in Chiapas, Mexico: an observational stepped-wedge study

Patrick M Newman,[1] Molly F Franke,[2] Jafet Arrieta,[3] Hector Carrasco,[3] Patrick Elliott,[4] Hugo Flores,[5] Alexandra Friedman,[6] Sophia Graham,[7] Luis Martinez,[8] Lindsay Palazuelos,[9] Kevin Savage,[2] Hayley Tymeson,[10] Daniel Palazuelos[5]

GLOBAL HEALTH ACTION
2019, VOL. 12, 1699348
https://doi.org/10.1080/16549716.2019.1699348

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ORIGINAL ARTICLE

Accompanimeter 1.0: creation and initial field testing of a tool to assess the extent to which the principles and building blocks of accompaniment are present in community health worker programs

Hector Carrasco[a,b], Harriet Napier[c], David Giber[d], Stephanie Kang[a], Mercedes Aguerreberre[e,f], Matthew Hing[g], Vinicius Siqueira Tavares Meira Silva[h], Mariana Montaño[f], Henry Perry[c]

IMPLEMENTATION AND OPERATIONAL RESEARCH: CLINICAL SCIENCE

Excellent Clinical Outcomes and High Retention in Care Among Adults in a Community-Based HIV Treatment Program in Rural Rwanda

Rich, Michael L. MD, MPH*,†,‡,‖; Miller, Ann C. PhD, MPH§; Niyigena, Peter RN‡; Franke, Molly F. ScD†,‡,§; Niyonzima, Jean Bosco MD‡; Socci, Adrienne MD†,‡; Drobac, Peter C. MD, MPH*,†,‡,‖; Hakizamungu, Massudi MBA‡; Mayfield, Ruhayisha, Robert MD‖; Epino, Henry MD†,‡,¶; Stulac, Sara MD*,†,‡; Cancedda, Corrado MD*,†,‡; Adolph MD‖; Niyonzima, Saleh MD‖; Yarbrough, Chase BA‡; Fleming, Julia BA‡; Amoroso, Cheryl MPH†,‡; MPH*,†,§; Murray, Megan MD, ScD*,#; Farmer, Paul MD, PhD*,†,‡,§; Binagwaho, Agnes MD, PhD§,‖

Syndromes 59(3):p e35-e42, March 1, 2012. | DOI:

Community Health Workers and Accompaniment

Three Key Principles:

(1) CHWs must be professionalised members of the care delivery team, which means they are recruited, paid, and supported for long-term retention;
(2) CHWs must be positioned as bridges to care, not islands;
(3) CHW programme budgets must make room for community work, and not health work alone, by assigning appropriate patient ratios and a manageable scope of work.

Description of CHW activities

The CHW-led intervention designed by CES, titled '*Acompañantes*', follows a 'community-based accompaniment' approach, which has been previously shown to be effective in improving medication adherence and disease outcomes among patients with HIV.[22–24] In this approach, CHWs serve as a bridge between clinic and patient, promoting medication adherence, reinforcing basic disease education, providing psychosocial support and promoting active case retention. The CHWs in this intervention are women who were nominated at community meetings (either by self or community nomination), wherein CES staff presented the proposal, and then selected on the basis of a formal interview process focusing on leadership potential, motivation as well as basic literacy and education. They were trained in four-times-weekly group sessions for 1 month, covering basic pathophysiology, diagnosis and treatment of chronic diseases such as diabetes and hypertension, as well as practical training on the elements of a home visit and the logistical requirements of the role. They also participated in monthly refresher training sessions, covering themes such as brief motivational interviewing, recognising emergencies and complications and navigating interactions with challenging patients. CHWs work longitudinally with four to eight patients, conducting home visits which begin weekly then change in frequency based on a collaborative assessment of the patient's needs by the CHW and clinic physician. CHWs escort patients to clinic visits and meet regularly with clinic physicians to discuss patient management. CHWs are compensated with household food and consumable items, worth a dollar amount approximately equivalent to the monthly stipend given to participants in *Prospera* (formerly *Oportunidades*), a Mexican national conditional cash-transfer programme.

Table Community health strengthens the value chain to achieve equity of outcomes

	Prevention	Surveillance, diagnostic tests, and start of treatment	Ongoing management of the disease	Management of clinical deterioration and end-of-life care	Results	Larger health-care system strengthening efforts
Haiti: village health workers for tuberculosis	Information, education, communication	Active case finding and referral for tuberculosis	Daily home visits for 1 month (tuberculosis medications brought to patient's home) with monthly reminders to follow up at the clinic. Additional social supports include $30 monthly cash stipends for 3 months, nutritional supplements, transport reimbursement ("donkey rental fees")	Home visit from clinic staff if patient fails to follow up, side-effect surveillance	100% clinical cure in all patients receiving free care and socioeconomic supports *vs* 56% cure, 10% death in free care alone patients[2]	Functioning referral facility with hospitalisation, basic lab capacity, no user fees, staff support (for MD, nurse, other ancillary staff), improved supply chain, integrated team care, contact screening, BCG vaccine for infants
Haiti: *accompagnateurs* (accompaniers) for HIV	Information, sexual, education, communication, condom promotion, family planning, vaccines	Active case finding and referral (for tuberculosis, HIV, STDs)	Daily home visits for DOT-HAART (HIV medications brought to patient's home), personal emotional support, confidentiality assurance. Additional social supports coordinated with social work team, and sanitation engineer employed to improve access to clean water	Side-effect surveillance, early referral for known complications, active case retention via home visits from clinic staff	Reaching a population of 550 000, 8000 patients with HIV actively followed; 0% mortality in first 100 fully supported patients, *vs* 14–29% mortality in other groups; 86% suppressed viral load in a subset of patients[3]	Voluntary counselling and testing, comprehensive treatment for HIV and OIs, tuberculosis, STDs, and women's health (including prenatal care and PMTCT), functioning referral facility with hospitalisation (including extensive renovations, space for clinical exam, pharmacy, addition of electricity, safe blood transfusion), basic lab capacity including flow cytometer, staff supports (for MD, nurse, pharmacist,
Chiapas, Mexic *acompañantes* (acompaniers) diabetes, hype other chronic c						ient care, ncillary re
Peru: CHWs for tuberculosis						y patient unication nd ns to s, staff
Malawi: village health workers for Kaposi's sarcoma and palliative care	Information, education, communication	Active case finding and referral	Routine home visits for psychosocial support and to promote ART/chemotherapy adherence. Additional social supports include transport voucher (for those with oedema or dyspnoea)	to care when interim illnesses requiring attention identified, active case retention via home visits, end-of-life care (symptom control and emotional support)	83% survival 12 months after chemotherapy (95% CI 74–89), 77% retained in care[6]	g referral facility with hospitalisation, referral network supports including access to referral oncologist if needed, basic lab capacity (including biopsy confirmation if needed), no user fees, staff supports (including task shifting to trained clinical officers), improved supply chain, availability of chemotherapy (bleomycin/vincristine or paclitaxel), premedication, antibiotic prophylaxis and ART via standardised protocols, integrated team care
Lesotho: maternal mortality reduction agents for maternal health	Information, education emphasising the benefits of facility-based care, communication	Active case finding and referral of pregnant women	Routine home visits for progress assessments by CHWs (many of whom are former traditional birth attendants), escorting to care (to ANC, delivery, and postpartum services). Additional social supports include food in the maternal lying-in house, new baby-starter packs for all mothers, breastfeeding replacement option for HIV+ mothers	Early referral for known complications	No deaths in first 2 years despite a >350% increase in deliveries by the second year; 49 transferred for complications[7]	Comprehensive care (including risk screening, tetanus immunisation, family planning, pap smears, tuberculosis, HIV, pMTCT and STI care)linked to maternal health care, compassionate care in a functioning birthing centre, maternal lying-in houses, functioning referral facility with hospitalisation (and access to caesarean section and transfusion), basic laboratory capacity, no user fees, staff supports (especially to nurse midwives), integrated team care
Rwanda: *accompagnateurs* (accompaniers) for HIV and tuberculosis	Information, education, communication	Active case finding and referral, proactive HIV testing in clinics	Daily home visits for DOT-HAART, emotional support (CHW companionship, support groups), progress assessments, motivational interviewing, escorting to care. Additional social supports include nutrition support (monthly food packages), transport allowances for routine visits, and for the most vulnerable, housing assitance or home repairs, employment training/microfinance activities, intermittent economic support and school or health insurance fees were available	Side-effect and OI surveillance, early referral for known complications, active case retention via home visits	92·3% retention (versus 70% Africa average), 97·5% with viral load less than 500 copies per mL, 5% mortality[8];44·3% reduction in prevalence of depression, more than twice the gains in perceived quality of life, increased perceived social support in the first year of treatment[9]	Functioning referral facility with hospitalisation, ambulance network to facilitate district hospital access for acutely ill, basic laboratory capacity including flow cytometer, tuberculosis screen with chest x-ray, no user fees, staff supports including mentorship and enhanced supervision (MD, nurse, other ancillary staff), electronic medical record to support continuity of care and to prompt clinical responsiveness, integrated team care

"The accompaniment approach in action has achieved remarkable clinical results in multiple disparate contexts, many unprecedented. The table presents how CHWs have contributed to larger health-care system strengthening efforts, their tasks mapped out across the care delivery value chain, to produce excellent outcomes for different diseases and in disparate contexts."

Source: Community health and equity of outcomes: the Partners In Health experience Palazuelos, Daniel et al.
The Lancet Global Health, Volume 6, Issue 5, e491 - e493

Summary and Invitations

1. Get proximate

2. Change the narrative

3. Stay hopeful

4. Be willing to do things that are uncomfortable and inconvenient

Take-home questions

- In your work to improve population health, do you have access to social and environmental data that is at least as good as what Chadwick and Virchow developed?
- How might you apply Paul Farmer's principles of accompaniment to your improvement work?

Additional Resources

- *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, a Man Who Would Cure the World* by Tracy Kidder
- *Pathologies of Power: Health, Human Rights, and the New War on the Poor* by Paul Farmer
- *Foreign Affairs* article : "Partners in Help: Assisting the Poor Over the Long Term"
- "Accompaniment as Policy": Address to the Harvard Kennedy School of Government, May 2011
- Rwanda case study: http://www.pih.org/blog/rwanda-study-community-based-hiv-program-yields-high-success-rates
- Haiti case study http://www.pih.org/blog/research-on-pih-cholera-vaccine-project-released-in-journal

Thank YOU!

For more information:

jarrieta@ihi.org

dgoldmann@ihi.org

@jafet-arrieta

@don-goldmann

IHI.org

@IHI (Follow us!)

Leicester Institute for Advanced Studies

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www.le.ac.uk

Historically Informed Quality Improvement for Black Maternity and Motherhood Health Experiences in Leicester & Leicestershire

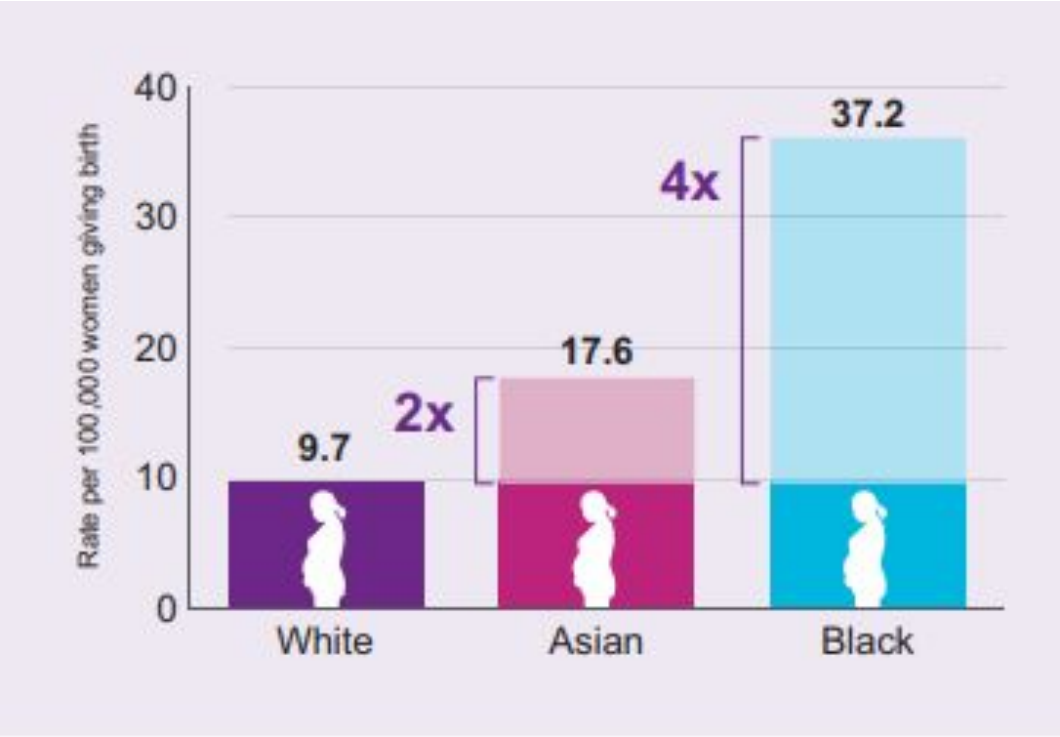
Dr Jennifer Creese, University of Leicester
Dr Bharathy Kumaravel, Leicestershire County Council

Leicestershire County Council

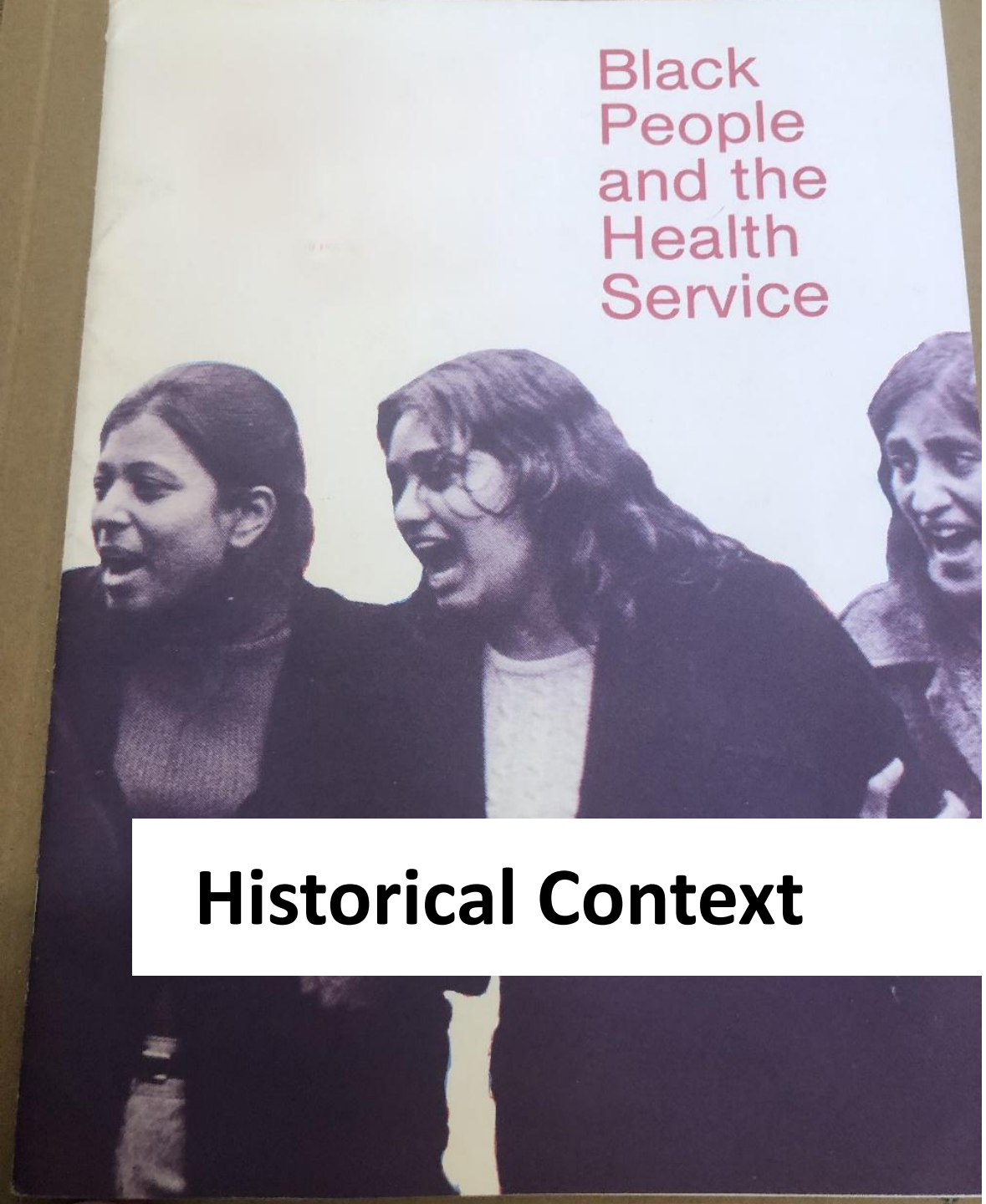
NHS University Hospitals of Leicester NHS Trust

UNIVERSITY OF LEICESTER

MBRRACE-UK 2023 Report



There remains a nearly four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White women.



Historical Context

Demographic changes:

Leicestershire, like many areas in the UK has experienced demographic shifts due to immigration, influencing local health care needs and services.

Community initiatives:

Various initiatives emerged to support Black mothers addressing gaps in healthcare.

Recent developments and ongoing issues:

Despite Improvements disparities still exist in maternal outcomes for Black women.

Research continues to improve better practices and policies.

Project Background

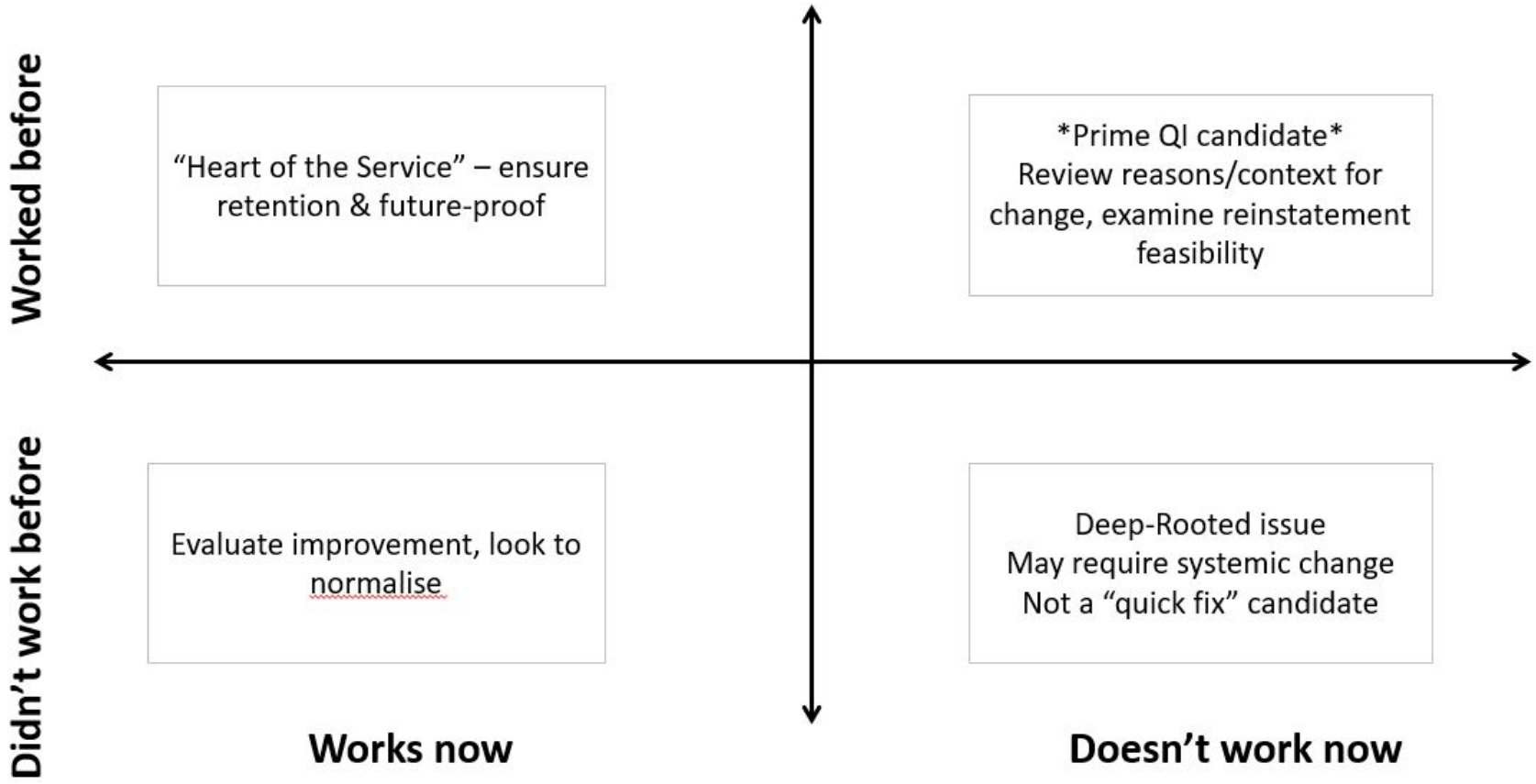
- Maternity care in Leicester & Leicestershire is marked by health inequalities, particularly among Black mothers.
- Recent research carried out by the Leicester Medical School identified a need for more research gathering local intelligence to help service providers.
- The University Hospitals of Leicester NHS Trust is embarking on a wide-reaching project of quality improvement in maternity services with support from Leicestershire County Council's Public Health team and the LLR Integrated Care Board.

Why history?

"You can't really know where you are going until you know where you have been" - Maya Angelou

- Current trends (in society, in healthcare) rooted in historical realities
- Previous interventions and practices often undocumented (unavailable to new staff)
- Influence of community and intergenerational memory on attitudes to and relationships with health services

Historical Insights for Quality Improvement (HIQI) matrix



Methods

- First we conducted oral history interviews with local Black women from previous generation (gave birth 1984-2004) about their experiences of maternity, childbirth, and early motherhood.
  - No. of Interviews: 10 women, Black British, Black African or Caribbean
  - Age range: 47-56
  - Hospital: Royal Infirmary, General Hospital, Glenfield Hospital
  - Date range: 1984-2002
- Compared this with findings from UHL's recent research on late maternity care bookings with Black mothers

Findings from the Past

Positive:

Trust in health care provider "My midwife was really nice…I could really open up to her"

Continuity: "When I walked through the door **they recognised me**, that was nice"

"Our concerns were turned down by the **expertise** of the staff, the way they handled everything"

Information sharing "when I asked questions, I feel like things were explained."

Staff taking **time**: medical team constantly checks upon you, they'll call you, there is that love and concern coming from them."

Negative:

Hostility/Racism being called "that Black woman", body shaming

Lack of **cultural sensitivity** "did not respect my cultural beliefs, or practices"

Inability to speak out "If I tried to draw attention to something they waved it off"

Inability to communicate "I was unable to tell her [midwife] things I was supposed to tell her"; "Would not turn to **listen** to what I had to say"

Unconscious bias: **assumptions** about women based on race/social standing

Findings from the Present

Positive:

Good relationships with midwife/GP made positive experiences

Cultural representation: seeing Black midwives made them happy and comfortable

Staff asking about **mental health or social** concerns as well as medical

Negative:

Wanting **continuity of care** but not getting it

Too long between **contact times** with care staff, relationship suffers

Concerns about baby **ignored** or lacking empathy

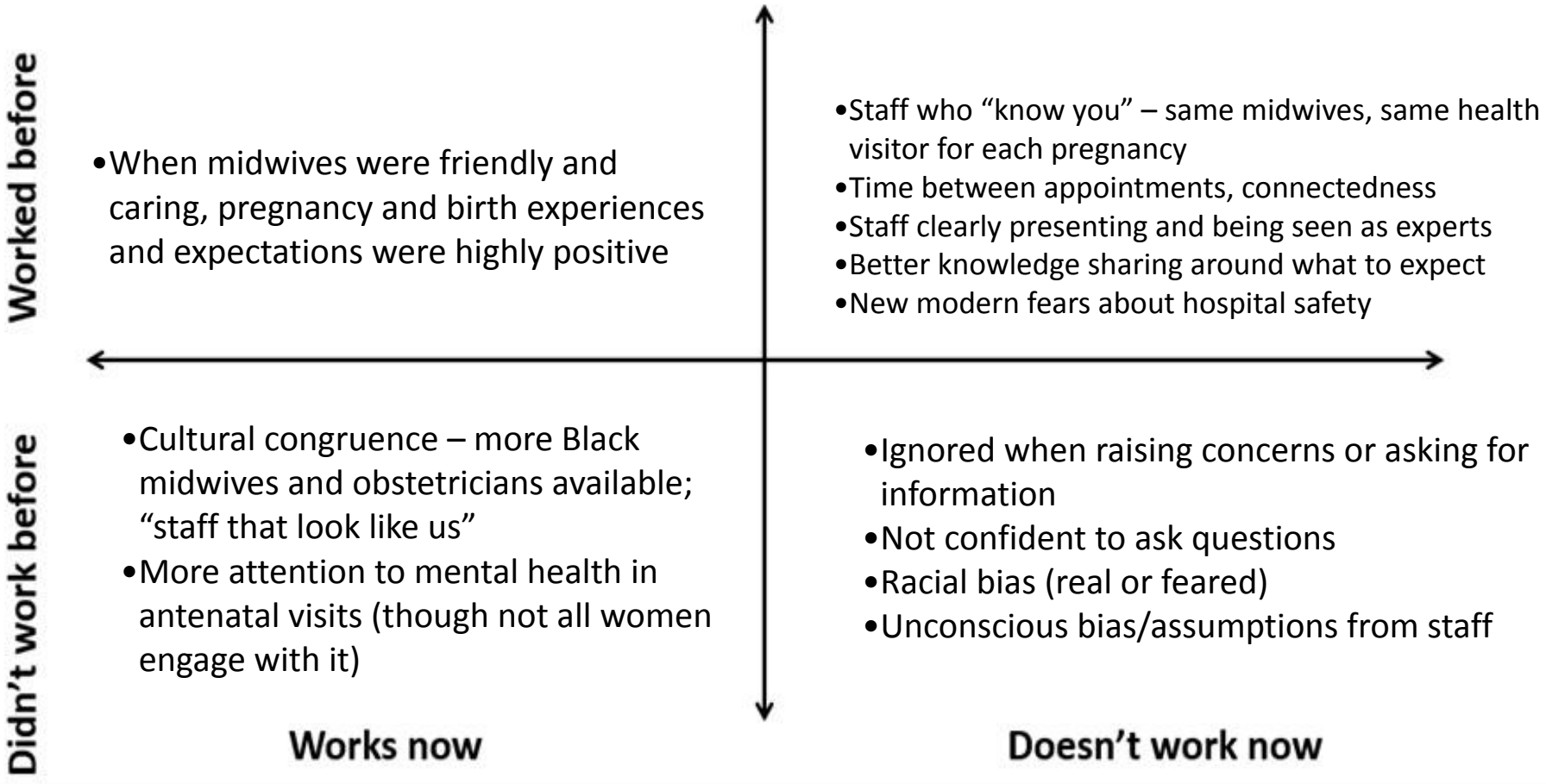
Negative press about hospital made women feel scared, less confident

Lack of **information**, not knowing what to expect

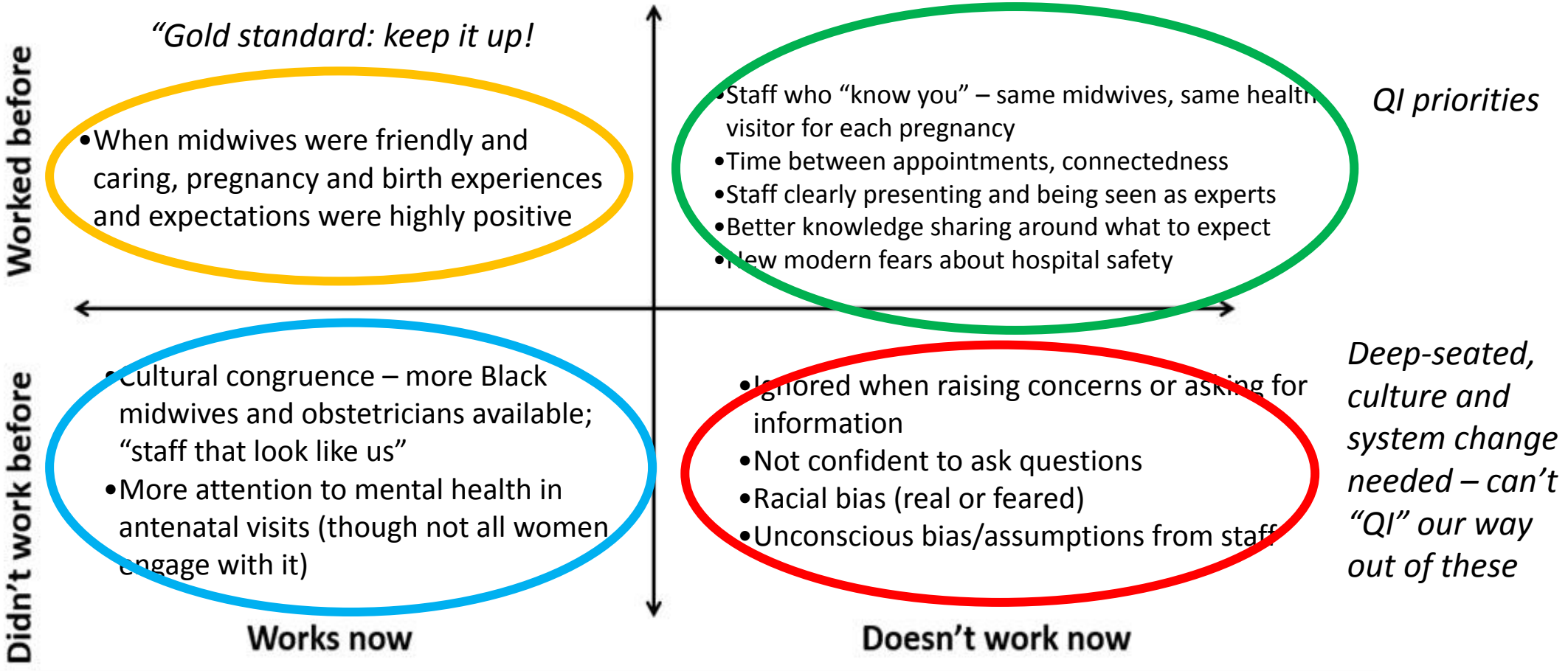
Worried about **racism and bias**

Perceived **lack of care quality** in postnatal

Mapping to the HIQI Matrix



Mapping to the HIQI Matrix



Next Steps

- Prioritise QI opportunities and normalisation priorities
  - QI projects (continuity/midwife “matching”, between-appointment communication) in collaboration with medical education
  - Normalisation of improvements (diverse hiring; biopsychosocial approach)

- Additional opportunities arising from process:
  - Engage with “Grandma Generation” as partners in the health and wellbeing of mothers and babies
  - Useful partnership with local authorities and community stakeholders

Thanks to all involved

- Dr Kellie Moss, Mrs Maxine Chapman, Dr Natalie Darko (University of Leicester)
- Dr Ruw Abeyratne, Mrs Floretta Cox,Ms Sallie Varnam (University Hospitals Leicester NHS Trust)
- Dr Laura French (Leicester City Council)

- Please contact us if we can be of any assistance going forward with these ideas!
  - Jennifer.creese@leicester.ac.uk
  - Bharathy.Kumaravel@leics.gov.uk

Summarising: What role could history play in your QI?

- The issues we want to improve often have long-standing roots; understanding these helps us understand “where we are” and “what else could things look like”
- Can combat loss of organisational memory and help understand why changes were made to contextualise previous improvements
- A better way of understanding what is “culture” vs what is “practice”

Take-home questions

How confident are you that your country's/region's/organisation's policies are addressing social and structural determinants of health?

How can you get better at understanding local historical social and environmental data to inform the improvement work that you do?

Where are the challenges in accessing contextual social and environmental data and using it effectively?