HPSR Newsletter

Vol 1 Issue 1 February 2015

Introduction

We are happy to introduce the first issue of **Health Policy and Systems Research (HPSR) Newsletter**; an initiative Health Systems Research India Initiative (HSRII) supported by Public Health Foundation of India (PHFI) in its capacity as Nodal Institute for Alliance for Health Policy and Systems Research in India.

This first issue of HPSR Newsletter consists of abstracts of oral presentations presented by Indian Researchers in the Third Global Symposium on Health Systems Research. The Third Global Symposium on Health Systems Research was held at Cape town South Africa in October 2014.The symposium sought to visualize people as pivot to health systems or "people centred health systems "at both individual and population levels. The symposium aimed at building better healthcare systems by restructuring the health service delivery through integration, improving access to medicines social empowerment, financing and policy interventions.

The symposium included abstracts on four key aspects which included equity, knowledge interventions, capacity building and knowledge translation. In each of these areas the abstracts were categorized into (a) Governance, accountability and participation (b)Community-based health systems (c) Health equity and rights (d) Strengthening quality of care (E) Recognizing providers as people (F)Complexity science and people-centred systems (G) Financing for people-centred and equitable health systems.

We acknowledge the support by editorial team of HSRII and PHFI in developing HPSR newsletter. We look forward to hear comments and suggestions from our readers. Please feel free to write to us at mail@hsrii.org.

Happy reading!

Exclusion from the supplementary nutrition programme (SNP) and village life: Lived experiences of 'dalit' women in a Gujarat village

Nanjappan, Nakkeeran et al

'Dalits' in India remain one of the most subjugated and exploited groups of people facing multiple discriminations. Data reveals that 'dalits' form a large percentage of the target population end up not utilizing Integrated Child Development Services (ICDS). This study attempts to identify and understand community perspectives on exclusion of 'dalits' from ICDS and other aspects of community life. Methods: The study was carried out in one of the four villages, as part of four short ethnographies on exclusion and self-exclusion from the Supplementary Nutrition Programme (SNP). The objective was to understand the socio-economic and political consequences of being a 'dalit', particularly in accessing SNP. Findings: 'Dalit' - women in the village belonged to landless families having no cattle. They opined that 'dalit' identity was still considered 'impure' and 'dirty' by the majority village population. Dalit women reported that their social interactions with members of other communities were minimal and marked by derogatory attitudes, bordering on verbal abuse. Their occupational choices were limited to construction and diamond industry work, for which they had to seek employment away from their own village. Discussion: Despite constitutional protection as well as other legal and social protection frameworks that guarantee and facilitate access to all rights enjoyed by a citizen of India, 'dalits' face critical denial of rights on the basis of their caste and gender identity. Their non-participation in SNP is compounded by their poverty and social exclusion. This has major implications for the well-being and economic productivity of the next generation. Policy makers, administrators and health professionals involved in delivering the ICDS need to pay urgent attention within the context of a democratic society that promises equal rights.

Resource and support systems for community health workers increases demand for quality services and community participation in Uttarakhand
Chokshi, Heer et al;

In 2005, India's National Rural Health Mission introduced use of accredited social health activists (ASHAs), CHWs receiving performance-based remuneration, to serve as an interface between the community and the public health system. Hilly terrain, scattered settlements, and poor road connectivity in Uttarakhand adversely affected ASHAs' reach and potential remuneration. Methods: Under the USAID Innovations in FP Services Project (2005-2012), Futures Group provided technical assistance to the State Government of Uttarakhand to design a pilot to improve the effectiveness of selection, training, mentoring, and support for ASHAs. Under 'ASHA Plus' ASHAs covered flexible populations, were reimbursed for a wider range of services, trained in micro-planning tools and management information systems (MIS), had job aids and tools for record keeping. The government established a State ASHA Resource Centre, State ASHA Mentoring Group, and District ASHA Resource Centres. Results: Comparison of baseline (2006) and 2007-2008 MIS data indicated improved service uptake: 3 ANC visits (30% to 59%); early pregnancy registration (35% to 49%); and institutional births (27% to 58%). Community-level outcomes: better outreach to underserved areas, awareness of health schemes, demand for quality services, and community monitoring; at the systems level, increased linkages between service delivery points and response, record keeping, and interaction with other health cadres. In 2009, the government scaled up coverage in six districts (0.26 to 3.13 million people). In 2010, it expanded the supervisory system, the remuneration package, and established ASHA resource system statewide. Conclusions: Minor policy and systemic changes to suit local context, and strengthening capacities of CHWs can improve service uptake, accelerate improved health outcomes, and increase social participation and monitoring, with equitable service delivery leading to empowered communities.

Trust and team work matter': Community health workers' experiences of integrated service delivery in India
Mishra, Arima

The need for comprehensive and integrated service delivery to strengthen primary health care has been the major thrust of the National Rural Health Mission (NRHM) that was launched in 2005 to revamp the rural public health system in India. Though the logic of horizontal and integrated service delivery to strengthen health systems has long been acknowledged at policy level, empirical evidence on how such integration operates is rare. This paper, in this context, discusses the experiences of village-level health workers in integrating immunization with broader maternal and child health services through outreach sessions like the Village Health and Nutrition Days. The paper draws on ethnographic field work conducted in the state of Odisha, India in 2011-2012 that involved in-depth interviews, observations and focus groups discussions at the community and sub-district levels. The findings show that for the community health workers, the notion of integrated service delivery goes well beyond technical mixes of health services. Crucially they perceive 'building trust with the community' (beyond trust in health services) and 'team work' (among the health workers) as critical to integrated service delivery, although acknowledging the challenges posed by differential training, salary, status and role. However, the NRHM primary health care ideology - which the community health workers espouse - is in constant tension with important elements of the Indian public health system. These include the exigencies of narrow indicators used for health system performance; the highly hierarchical health bureaucratic structure that rests on top-down communications and the institutionalized privileging of statistical evidence

over field-based experiences. The evidence in the paper shows that it is important to capture the perspectives and experiences of the community health workers to unpack notions of integration and facilitating effective community engagement with formal health systems.

Informed, organized and empowered: poor rural women's negotiations for health and its social determinants in Uttar Pradesh, India
Dasgupta, Jashodhara

Uttar Pradesh state in India has high maternal mortality, and ranks near the bottom in terms of human development indices. Documented cases about poor rural women in UP who attempted to access reproductive health services indicate that they faced disrespectful behaviour, harassment for informal payments, downright negligence or denial of care. Similar disrespect and denial is reflected in women's experiences of seeking other state-provided services that impact upon health, such as subsidized food-grain provision, supplementary nutrition, schemes for employment guarantee or social security, and help when facing violence. These transactions reveal a culture of impunity embedded within asymmetrical power relations, when the women happen to be poor, non-literate, or from marginalized social groups like Dalits, tribal groups, and religious minorities. In response a strategy used by the NGO SAHAYOG in partnership with the grass-root organization Women's Health Rights Forum (MSAM) and local CBOs in several districts, was to promote women users' participation in monitoring their entitlements. Through capacity-building based on Paolo Freire's methodology, women analyzed their own experiences; gained information about their entitlements from the various departments; and built skills to monitor services using pictorial tools. After carrying out local monitoring of selected aspects of health and nutrition services, women presented the findings in annual non-adversarial dialogues with district officials each year. In addition the skills enabled women to negotiate entitlements within other schemes for rural employment, social security and decentralized budgeting. The cycle of capacity-building, citizen monitoring and regular dialogue has built the skills of poor women in negotiating improved quality services from government departments, and establishing their credibility as a source of real-time feedback about the services. The active participation of informed, organized and empowered women users has promoted a culture of answerability among frontline workers, providers and district managers, towards more respectful, accountable and better quality services.

The variance in understanding of the health rights of vulnerable groups in the Sundarbans, India
Ghosh,Upasona , Bose, Shibaji

Certain vulnerabilities like livelihood uncertainty, exposure to frequent climatic shocks, physiological status, ethnicity, age, sex or economic condition, place additional barriers in the way of accessing health care for vulnerable sections of population in socio-climatically challenged Indian Sundarbans delta in West Bengal, India. The study aims to explore the gaps both from the perception of special groups regarding their vulnerability in terms of maternal and child health rights and how other health system actors views these groups. Methods: Six scoping FGDs with community leaders and mothers of varying age group and ethnographic observation for two months had identified ˜special groups' that included people depending on forest products, crab collectors, 'tiger widows' and people living on the embankments in three geo-climatically distinct villages in Indian Sundarbans. Five case studies of mothers were taken from each group followed by in-depth discussion with grass root level health providers (four in each village). A right-based explanatory analytical approach was used to analyze the data. Results: The process and causal elements of vulnerability showed dependence upon structural and aptitude gaps

within the existing health system. The knowledge gap of grass root providers about the special needs of these groups further aggravated the non-acceptability of the health care services. Daily struggle for existence of the ˜special groups' in geo-climatically vulnerable areas exhibit their unfelt need for health care leading to participation gaps in the existing health system. Absence of linkages with locally dominant community groups and civil society has further constrained their voices for basic health rights. Discussion and significance of the field building dimension. The findings of the paper points to a lack of systemic understanding of the rights of these ˜special groups' due to perception variance and calls for infusing health systems with further dialogue to raise visibility and responsiveness for protecting their health rights.

Opportunities to strengthen spending for effective, equitable, and efficient primary care in India and Ethiopia: What can we learn from resource tracking and management assessment?
Mann, Carlyn et al

Effective use of health resources can make a difference in program success, especially in developing countries whose resources for health are scarce and flows often unpredictable. A number of different issues cause problems with resource flows that impact programs at district and lower-levels. We apply an analytical framework for financing to resource tracking and management (RTM) through rapid assessments for India and Ethiopia. Methods: The rapid assessments use an end-to-end RTM framework, consisting of resource- mobilization, allocation, utilization, productivity, and targeting. Our focus is resources received and use to identify areas to strengthen capacity and systems at lower-levels, leading to direct impacts on public health providers to improve both countries primary care systems. Results: The assessments find significant impediments affecting both countries' ability to allocate, utilize, and target finances more efficiently and effectively to improve health outcomes through primary care. Overall, both countries need strengthening in their bottom-up planning process, improvement in absorption of funds mainly by overcoming delays in submitting expenditure statements, and should analyze financial and physical output data jointly to assess efficiency of spending. India uses population norms to allocate resources while Ethiopia captures resource need and inequalities. Additionally, programs that target the poor in India use below poverty line registration system, while Ethiopia uses a community-identified approach; both are inaccurate with errors of inclusion and exclusion. Discussion/Conclusions: Opportunities exist in both countries to address key challenges presented, and develop work that focuses on providing improved evidence that lead to policies and programs that promote more efficient, effective and equitable primary care delivery systems. Furthermore, examples of successful innovations that address these challenges that could be better documented and scaled-up. We conclude with suggestions on ways forward to improve financing for people-centered and equitable health systems.

Whose UHC? Reflections from a national consultation on the role of community in relation to Universal Health Coverage in India
Nambiar, Devaki; Sheikh, Kabir; Dasgupta, Jashodhara

With the exception of India's High Level Expert Group on Universal Health Coverage (HLEG-UHC), there have been few gestures towards community participation as a component of UHC reform in India; the state's emphasis at least in most policy pronouncements- has thus far focused on financial mechanisms and service coverage. In November of 2013, a national consultation was convened to deliberate upon what the voice and action of community could be in relation to India's vision for UHC. The meeting comprised senior practitioners and activists who have been intimately involved in community mobilization, grassroots work, and civil society

action related to health in the country. This germinal event was centered around questions a) Exploring the conceptual understanding of the present and future role of community-based formations and organizations in UHC and b) Strategizing around policy recommendations to strengthen the role of community based formations and organizations in UHC in India. Discussions on conceptual understandings noted that India has great diversity of community formations and organisations. This diversity should be mapped, with attention to the legitimacy and representativeness of community-based organisations, as well as their alignment to the principles and goals of UHC. The group was not able to achieve consensus on the following themes, and called for greater reflection and dialogue on a) how to involve especially vulnerable and marginalised groups; b) whether or not to endorse the insurance-based model of UHC; and c) to what extent private for profit and other stakeholders should be engaged with. In relation to advancing policy, an urgent need was articulated to reach out to various stakeholders on the meaning and aspirational aspects of UHC. Given that health is a state subject, consultations at those levels were encouraged. Finally, a call was made for placing UHC and of health reform on electoral agendas, as part of India's upcoming elections.

Social Exclusion of Women in a health financing scheme in Karnataka, India
Ganesh, Gayatri et al

Indian women face exclusion at home, at work and in public life. Female heads of households shoulder the burden of being the sole breadwinner but face social stigma. Women in male-headed households have a lesser role in decision-making. This is the first study examining whether (and how) women are excluded from the India's Rashtriya Swasthya Bima Yojana (RSBY), the national health financing scheme for five members in below the poverty line households, and if so how can it be made gender-inclusive. Methods: We conducted a longitudinal survey (n= 6040 eligible households); stakeholder interviews (n=42) with government and insurance agencies, doctors and civil societies; group discussions (n=23) with eligible individuals; and qualitative interviews (n=14) with members excluded from RSBY. We conducted multivariate analysis using logistic regressions; grounded theory principles were applied to analyse the qualitative data. Results: Female-headed households are less likely to be aware (OR 0.8, $p>0.05$), Muslim female headed households (OR 0.167, $p>0.05$) and tribal female-headed households (OR 0.22, $p>0.005$) are less likely to enrol in RSBY. In 75% of five member households, some male and female members were not enrolled but in 44% only women over 14 years were not enrolled. Those with less developed social networks are less likely (OR 1.54, $p>0.1$) to get enrolled. We found that women suffer from an internalised sense of inferiority; they lack a sense of entitlement or the capacity to demand inclusion in social welfare programs, and face social antipathy. Conclusion: For a more inclusive, equitable and gender-sensitive RSBY, awareness campaigns must target vulnerable women. Their social networks, where information is disseminated and collective capacities fostered, should be improved. To address intra-household exclusion, the scheme should enrol the entire household or enforce more than one female member is insured. Disaggregated geographical enrolment data to identify female exclusion could effectively target resources.

Negotiating professional sensibilities and public health necessities: A case study of India's efforts to introduce mid-level healthcare providers
Mairembam, Dilip Singh et al

In 2002, the province of Chhattisgarh in India, with the lowest health human resource densities in the country, and perhaps in the world, introduced a 3-year course to train medical professionals to serve in rural areas. The initiative faced a fair share of hurdles including

legal action by the Indian Medical Association and 3 major student strikes. This resulted in dropouts, lesser enrollments and finally closure of the course in 2008.However, this unique one-time endeavor led to deployment of more than 1000 Rural Medical Assistants in underserved remote areas, which had been struggling to find any qualified doctor for years. Subsequent assessment of RMA revealed that their knowledge, skills and patient satisfaction were at par with MBBS doctor in delivering primary healthcare. Assam, in 2006, initiated a similarly structured 3-year Rural Health Practitioner (RHP) Course, with much better organized legal support. By March 2013, 370 RHPs were placed in Health Sub-Centers thereby upgrading them to fully functional curative, preventive and promotive units. The learnings from past experience led to a more sustainable effort Chhattisgarh and Assam experiences, studied and communicated appropriately, have shaped the perception of policy makers in India, who now recommend a mid-level cadre through a 3-year Bachelor of Rural Health Care Degree Course and posting them as Community Health Officers in Health Sub-Centers. However institutional barriers remain, showing that there is much more to decision making than merely the existence of evidence.

Role Stress among Nurses in India
Vasava, Paul and Purohit, Bhaskar

Role Stress (RS) is an important concept that has not been studied much in public health. RS is experienced when the inter-relationship between the self and various roles a person occupies has an imbalance or imbalance between the focal role and various other roles that others play in the organization. Methods: The study aimed at assessing the Role Stress (RS) among 84 Auxiliary Nurse Midwives (ANM) in one district, India. Stratified sampling technique was used for selection of ANM working government health centers. A structured instrument with established reliability and validity called Organizational Role Stress was used to measure 10 dimensions of RS based on 5 point Likert rating scale that contained 50 unidirectional negative statements, 5 for each dimension. Results: The highest role stress among ANMs was experienced for Resource inadequacy followed by Role overload and Role stagnation. Resource Inadequacy indicates that ANMs feel quite frequently that they do not have adequate amount of resources, full facilities, financial support as and when required and no support from the high levels authorities. Role Overload indicates that ANMs feel that there are too many expectations from their role by several people which gives them a feeling that sometimes they have so much work that they are not be able to prioritize which work is more important. Similarly Role Stagnation means that ANMs feel frequently that there they do not have enough opportunity for future growth. Discussion: Understanding the concept of role and role stress is important as the study results indicate high Role Stress experienced by the ANMs. More focused research on the RS in needed in the public health system.

The VOICES initiative to strengthen Village Health Committees in two Indian states: findings of implementation research
Mondal, Shinjini et al

India's 480,000 VHCs are crucial platforms for community engagement for health. Under the National Rural Health Mission, VHCs have been envisaged as local participatory bodies bringing frontline workers, local elected officials and community members together for planning, delivery and monitoring of health services. VHCs require strengthening through enabling institutional mechanisms and environments to realise the goal of better health action at community level. Methods: The findings reported are from the first phase of implementation research on an institutional support package to enhance community engagement in 100 villages in Rajasthan and Tamil Nadu. Research methods are primarily qualitative and draws on actor-centered implementation analysis. Data was

collected through in-depth interviews, focus group discussions, observation and documentation of organisational processes and review of selected indicators on process and outcomes. Analysis follows the framework' approach, combining inductive and deductive process. Results: Study findings demonstrate the influence of policy and social contexts in determining the pathways and mechanisms for intensified community engagement. In Tamil Nadu, with a more hierarchical health systems, committees faced challenge from reflecting purely system priorities to becoming fora for articulating community voice and playing a larger social role moving beyond monitoring of a narrow package of core health services. Rajasthan, while having a policy environment more open to community engagement, faced hindrances from the social context of status of women and marginalised communities. Discussion: VHCs in both states require institutional support to understand their roles and responsibilities, and to function as institutions that are truly representative of communities and their interests. The pathways to strengthening them vary due to the health system and social contexts they are embedded in. The study contributes to new knowledge on community engagement by VHCs, and provides valuable comparative perspectives and evidence for scaling up institutional support for VHCs across geographies. Communities reclaim the Health system, making services people-centred.

Lessons from community monitoring and planning of Health services in Maharashtra, India

Shukla,Abhay and Jadhav, Nitin

Community based monitoring and planning (CBMP) of health services in Maharashtra state of India is a powerful participatory approach for improving accountability and quality of health services. Linked with widespread and significant impact, CBMP is now being implemented in nearly 1000 villages across 20 districts of Maharashtra, making it unique in the health sector in India. CBMP was launched in 2007 as part of the National Rural Health Mission framework in selected states. In Maharashtra the process has progressively expanded, being organized at village, PHC, block, district and state levels. Health officials, elected representatives, civil society organisations and community members participate in monitoring and planning committees at each level, where community awareness generation, regular community assessment of services with public report cards, action oriented dialogue in committees and mass public hearings are organised. Complementary community based planning aims to improve participation and appropriateness regarding use of health facility level funds. Multi-dimensional study of CBMP taking into account two major external evaluations, interviews of diverse stakeholders, documentation of stories of change, analysis of successive rounds of CBMP data, and patterns of utilization of local budgets, validates substantial improvements in accountability, responsiveness and services across varied CBMP areas. Effective innovations identified as CBMP lessons: interactive methods to ensure rights based community participation; appropriate community feedback through relevant and user-friendly tools; regular multi-stakeholder dialogue and mass accountability events; chain of reinforcing actions across health system levels; coalition of rights oriented civil society organisations; system of entitlements with official sanction for community accountability; and positive engagement with providers. CBMP is now being generalised to new districts and villages, while being extended to child nutrition services. An approach enabling communities to substantially reorient Health system governance from below, making this people-centred, CBMP has significant potential for generalisation to other social settings and public services.

Promoting Governance and accountability through active citizen participation: A case study of the Mera Swasthya Meri Aawaz project (My Health My Voice)
Sandhya, Yatirajula

Maternal mortality remains unacceptably high in many parts of India; at the same time ICT is increasingly being used to promote maternal health and mobile phones are viewed as effective means to address 'demand side' challenges to maternal health. However mobile phones have not been used to track service side barriers such as demands for illicit fees which act as a deterrent to access care. The Mera Swasthya Meri Aawaz (MSMA) project of SAHAYOG was designed to test whether an open-source software (Ushahidi) could be used to increase citizen-led activism in documenting illicit fees charged for maternal health care services that, should be free in Uttar Pradesh, India. This system was designed to enabled reporting of informal payments anonymously, thus ensuring witness protection. Methods: With the visual evidence of the informal payments produced through Ushahidi, women's groups and SAHAYOG advocated for decreasing the practice of informal payments for maternal health services in government facilities. Findings (i)Data shows that it was an acceptable method of monitoring, as is reflected in the 873 reports of illicit payments made at 40 public health facilities to the hotline between January 24th to May 24th 2013 ii) The project provided women with information and tools to strategize more systematic actions. iii) It was well received by health officials who found the technology appealing and took action to improve the situation. Discussions and Conclusion: i) The project proved that poor, rural women were able to use mobile phones to make confidential complaints thus bursting the myth that illiterate women could not use modern technology. ii) It enabled community women to call for accountability without being victimized as it provided anonymity. iii) Technological innovations alone are not sufficient to promote greater accountability - active citizens participation is need to stop illicit demands.

Scaling up community participation for Health in Chhattisgarh, India: A Realist Exploration
Sheikh, Kabir; Nambiar, Devaki

Community participation for health (CPH) encompasses a range of actions involving citizens and communities in planning and delivering health services, holding them accountable, and mobilizing demand. CPH is increasingly recognized as being essential to the achievement of Universal Health Coverage, especially in Low and Middle Income Countries (LMIC), yet there are few reports of CPH being successfully undertaken at a large scale. We undertook a retrospective study on the decade-long experience (2002-2012) of Chhattisgarh state, India, of supporting CPH at scale. Methods: We undertook a retrospective realist evaluation study to understand the 1) mechanisms through which, and 2) contexts in which CPH had been scaled up in that state. Qualitative research methods were employed, including policy document review (n=40), in-depth interviews with health system actors and community stakeholders (n=79) and focus group discussions (n=6) with community health workers. Data were analysed thematically following the 'framework' approach. Results: Our analysis revealed interlinked mechanisms and contexts of scaling-up CPH. The formation of a new state in 2000 reportedly provided a favourable environment for governance innovations, such as the creation of a State Health Resource Centre (SHRC) - a 'hybrid' organization involving state and non-state institutions. Multiple constituencies including the state bureaucracy, NGOs and aid agencies, were engaged in creating and supporting the SHRC and its programmes. Programme goals and operations tended to be explicitly aligned with broader, local agendas of community mobilization. The SHRC's attempts to recruit, and equip personnel with technical as well as softer 'social' skills were helpful in sustaining

community engagement. Finally, conscious efforts to ensure bipartisan political support facilitated endorsement of the programme across political regimes. Discussion: A combination of relevant mechanisms and contexts for scaling up CPH were elicited. This investigation produced a useful set of themes for further testing in other LMIC settings.

Development of a composite indicator to measure the extent of Universal Health Care in India
Prinja, Shankar et al

Provision of Universal Health Care (UHC) is considered as a major health policy goal in many low and middle income countries. We developed a methodology to compute single composite indicator to measure the extent of UHC in India. Methods: Data from a large scale cross-sectional household survey covering more than 275,000 individuals in Haryana state was used to estimate the coverage of various services which are being considered to be essential for inclusion in the benefit package in India. The services covered maternal health, child health, family planning, under-5 child care services and curative care. Services of both preventive and curative nature were covered. Financial risk protection and quality of care indicators were also included. In order to account for wealth-based distributional differences in service coverage, concentration index and inequality-adjusted service coverage was estimated for each indicator. These indicators were aggregated into a Composite UHC Indicator (CUHCI) using two methodologies - geometric mean; and weighted average in which weights are derived by applying factor analysis and multiple linear regression. All 21 districts in Haryana state were ranked based on the CUHCI. Sensitivity analysis was performed to estimate the effect of individual indicators and weighting on the Composite UHC Indicator (CUHCI).Results: Inequality-adjusted coverage of complete antenatal care, full immunization among 12-23 months children and institutional care for delivery were 20%, 64% and 77% respectively. Increase in poverty headcount (at $1.25 PPP) and catastrophic health expenditures as a result of hospitalization was 15% and 27% respectively. Overall coverage of UHC ranged from 12% in Mewat district to 70% in Kurukshetra district. Although there is high correlation between the CUHCI among unweighted and weighted estimates (r=0.74), district rankings changed significantly. Conclusion: Measurement of a composite indicator of UHC remains a useful metric for assessing progress of various strategies to universalize health care.

Local partnerships for global challenges: Lessons from local intersectoral work for tobacco control and health promotion
Hebbar, Pragati

Globally there has been a growing momentum towards including Health in all policies. Tobacco control is one such area of public health where this concept has been utilized by many advocates to further the goal of health promotion. In 2011 six millions people died due to tobacco use of which nearly 80% were from low and middle income countries. These countries offer tobacco industry a safe haven due to their struggling economies and weak tobacco control legislations. India has strong tobacco control legislation more than a decade old, but implementation of the same is lacking. Our goal was reduction in prevalence of tobacco users and protecting people from the associated morbidity. Technical content: Mid and high level administrative/ political, media and legal advocacy were the main tools utilized. The key actors affected directly or indirectly by our work included tobacco users, non-users, law enforcers, political class, bureaucrats, legal experts, media in various forms, empowered patient groups, networks of other NGOs/ individuals working in the field of tobacco control etc. This rich interaction at state, district and local level was a key determinant for health promotion in our experience of tobacco control. Target audience: Health advocates working on various public health issues, policy makers, researchers

to help translate science into policy and action, self-help group representatives. Significance: Our work has helped understand the dynamics of inter-sectoral work from the bottom up as well as the top down approach. What have been the effects of focused efforts to ensure stringent implementation of a law on various actors of the system? How steps and decisions taken by individuals within the system bring about impactful changes? We want to share with a wider audience these and other learning from our experience of local inter- sectoral people centered action.

Real time monitoring of performance of special new born care units in India and follow up tracking of newborns after discharge.
Gupta, Gagan et al

Government of India has made huge investments to strengthen facility based new born care to address high neonatal mortality with 470 special new born care units (SNCUs) established at district level across India. The State of MP in central India with a population of 72 million and highest neonatal mortality rate in the country took lead and achieved universal coverage in all 50 districts. However there was no system to monitor performance of these units and follow new-born after discharge. UNICEF in 2012 supported government of MP in developing an online monitoring system to monitor quality of care in SNCUs and follow up after discharge. Focus/Content: The system records information of admitted new born and generate real time reports on more than 125 parameters like, admission profile, outcome by weight and maturity, causes of death, disease specific mortality, congenital malformations, antibiotic usage, duration of stay, comparison between SNCUs etc. This is used by program managers to monitor quality of care, compare performance of different units and guiding policy for new born at state and national level. Follow up after discharge is done till one year with reminder SMSs sent to family and community worker. Significance: This system has been adopted by Government for national scale up, already covering 175 SNCUs in 5 states with 250,000 new born registered making it biggest neonatal data base in India. Once scaled fully, will add half a million new born annually, subsequently private sector units will also be included. The data base has guided policy decisions like introduction of antenatal steroids; Kangaroo mother care, foetal nurses in delivery room, CPAP for premature babies, ROP screening, supportive supervision and follow up OPDs.

Local mentorship for CHWs in India: why are policies not implemented?
VR, Raman et al

Community health worker programmes are a prominent form of community engagement, and occupy a key role in Indian health policy. Locally supportive institutional arrangements, such as mentorship support, are being recognized as crucial determinants of CHW performance, especially in large-scale programmes such as India's. This study was conducted on the ASHA Sahayogini CHW programme in one block (sub-district) of Rajasthan state, to understand how mentorship policies are translated into action in real-world settings. Methods: Following a 'bottom-up' approach of policy implementation analysis, the study explored the implementation of mentoring support through the perspectives of the participant actors including CHWs, CHW mentors, health systems actors, and community representatives. The qualitative methods used included in-depth interviews, focus group discussions and document review, and data were analysed using 'framework' approach. Results: Several aspects of mentorship policies were found to be poorly implemented. Instances of implementation gaps included non-availability of personnel to provide mentorship, poor capacity building for mentors, lack of actual mentorship support provided, absence of regular planning and review, no evaluation of mentorship, and limited involvement of health officials, local political bodies and civil society. A range of

factors were linked to these gaps, including ambiguities in written policies and guidelines, lack of role clarity amongst different actors, absence of strategies to address recurrent human resource gaps, power relations that subordinated CHW supervisors to health systems staff, and poor coordination between different actors and agencies. Conclusions/Discussion: The study underlined the importance of strengthening institutional arrangements for ensuring CHW mentorship, through clearly articulated policies, consistent review and capacity building of actors at different levels of the system. In particular, CHW mentorship programmes call for enabling environments and support for designated mentors, by way of adequate remuneration to ensure retention, capacity building, performance review, and ensuring their empowerment and respect within the systemic hierarchy.

Impact of leadership & governance on clinical and physicians' outcomes in Public Hospitals in India

K, Ellangovan;TJ, Kamalanabhan; L, Prakash Sai

Public hospitals in India are managed by clinicians, selected on service seniority with no management or leadership training. Poor financial and operational autonomy makes management of these hospitals rather difficult, leading to inefficiencies affecting both clinical and physician outcomes. This study is to understand the physicians' perspectives on leadership and governance and how they affect the clinical and physicians' outcomes. Methodology: Responses from 482 physicians working in secondary care public hospitals in the states of Tamil Nadu and Kerala were analysed. A purposive sampling of physicians with a minimum of 2 years experience was chosen. A questionnaire based on Likert's scale was developed using literature survey, group discussions was validated using a pilot study. The final questionnaire has 10 items each for governance and leadership, 6 items for clinical outcomes and 3 items for physicians outcomes. Findings: Data was analysed using factor analysis (EFA) and multiple regression. Factor analysis revealed significant loadings of all items (0.61 to 0.82) and grouping into 'planning' and 'autonomy' under governance and 'staff orientation' and 'managerial expertise' under leadership dimensions. Results of multiple regression showed a strong and positive relationship between governance and clinical outcomes (R2 = 0.21) and physicians' outcomes (R2 = 0.25). Similarly leadership showed a strong association with clinical outcomes (R2 = 0.27) and physicians' outcomes (R2 = 0.25). Discussions: The study highlighted importance of a well articulated annual plans, regular meetings of hospital development committee, operational flexibility under governance and recognition for good work, impartiality in handling staff matters and 'leader as a role model' under the leadership dimension. The need to delegate financial and administrative powers to public hospitals and the importance equipping the leadership with managerial skills has been reiterated in this study.

Socio-cultural and service delivery dimensions of maternal mortality in rural central India: a qualitative exploration using a human rights lens

Jat, Tej Ram et al

Despite the avoidable nature of maternal mortality, unacceptably high numbers of maternal deaths occur in developing countries. Considering its preventability, maternal mortality is being increasingly recognized as a human rights issue. The objective of this study was to explore socio-cultural and service delivery related dimensions of maternal deaths in rural central India using a human rights lens. Methods: As part of a qualitative study design, verbal autopsies were conducted for 22 cases of maternal deaths during 2011 in Khargone district of Madhya Pradesh province in central India. Relatives of the deceased women having witnessed the circumstances leading to death

were interviewed. The data were analysed by using thematic analysis. The 'three delays' framework was applied to classify the factors associated with maternal deaths. These factors were further examined by their linkages with the essential elements of a human rights approach. Results: All 22 deceased women tried to avail medical assistance in occurrence of obstetric complications but various factors delayed their access to appropriate care. The underestimation of complication symptoms by family members, gender inequity hindering women's decision-making power and negative perceptions regarding delivery services delayed decisions to seek care. Transportation problems and care seeking at multiple facilities delayed reaching appropriate health facilities. Negligence by health staff and unavailability of blood and emergency obstetric care services delayed receiving adequate care after reaching health facilities. Conclusions: This study concludes that normative elements of a human rights approach to maternal health, i.e. availability, accessibility, acceptability and quality were not fully upheld. The deceased women were unable to claim their entitlements and the duty-bearers could not fully meet their obligations despite their conscious efforts to improve maternal health. In order to prevent maternal deaths, further concentrated efforts are required for better community education, women's empowerment and health systems strengthening to provide appropriate, timely and high quality services.

An equity analysis of institutional delivery uptake and maternal mortality reduction in context of cash transfer program (JSY): results from nine states of India
Randive, Bharat et al

Access to skilled birth attendance (SBA) and emergency obstetric care (EmOC) are critical to reduce maternal mortality; however SBA coverage was the least equitable in countdown to 2015 countries. Only 13% pregnant women in poorest population quintile of India delivered in health facilities against 84% in richest (2005-06). To address this inequality, in 2005 Indian government launched conditional cash transfer (CCT) program (JSY) for promotion of institutional deliveries (ID). MMR reduction was expected faster in poor population with anticipated increased ID and disproportionately high MMR among them. We assess JSY's consequences for inequality in ID and maternal mortality. Method: All 284 districts from nine states were ranked based on socioeconomic (SE) status. Using grouped data concentration curve (CC) and concentration index (CI) were derived for ID and caesarean section (proxy for EmoC), and CI was decomposed. Slope and relative index of inequalities (SII&RII) in MMR was estimated using division level data. Results: CC for ID in 2007-09 was closer to the equality line than in 2004-06 (pre-JSY), and CI decreased from 0.1620 (pre-JSY) to 0.1038. Degree of inequality in EmOC availability contributes 33% to overall inequality in ID, followed by that of male literacy (22%) and proportion of poorest households in district (16%). Caesarean in three poorest district quintiles was <2% with CC lying below equality line and CI of 0.2413. SII for MMR in 2010 was -135, suggesting richest division has 135 points lower MMR than the poorest. RII was -0.49, indicating 49% less MMR in richest division. Reduction in MMR was four times higher in richest divisions between 2007-09 to2010.Conclusion: SE inequalities in ID, although reduced, persist after CCT. Higher MMR in poor areas with slow decline, inequalities in EmOC availability and factors contributing to inequalities revealed CCT alone is not sufficient to achieve equity in maternal health.

Equity, justice and safety in maternal health: Evidence from rural Karnataka, India
Iyer, Aditi; Patel, Priya; Sen, Gita

Equity and justice are the hallmarks of people-centred health systems. Just cultures are also considered essential for safety in health

organizations. However, justice in the context of of a learning culture for health workers. We explore the relationship between equity, justice and safety in maternal health by considering the needs and rights of both health workers and patients. Methods: Our research is based in Koppal, the most backward district in Karnataka (India). We analysed equity, justice and safety in the public health system from (1) the beliefs, behaviours and customs that contributed to preventable harm, as captured by detailed qualitative verbal autopsies of all maternal deaths (N=33) and near misses (N=3) in 67 villages between April 2008 and March 2011; (2) perspectives of a sample of government doctors and staff nurses from across the district, as captured by in-depth interviews. Results: The autopsies revealed a public health system riddled with hazards and errors that contributed significantly to preventable maternal mortality. Piecemeal safety protocols and processes were safety is a limited notion focused on the creation weakened or distorted in a resource-scarce organisational culture by discriminatory and inequitable rationing. The management of pregnancy-related risks was unsystematic and guided by culturally-biased notions of severity. Routine obstetric practices reflecting informal learning in medical/nursing schools were often abusive or harmful. Maternal death reviews pitted individual families against individual providers, masked system failures and perpetuated a culture of blame. Health workers operated in a milieu that incentivised concealment, blame shifting and responsibility-shirking. Conclusion: Safety can be assured by health systems only when it is embedded in organisational cultures that respond uniformly to health needs (and voices) across social divisions, reduce the scope of discriminatory practices and abuses of power, and enable continuous learning.

The HPSR Newsletter is an initiative of Health Systems Research India Initiative (HSRII) supported by Public Health Foundation of India (PHFI) in its capacity as Nodal Institute for Alliance for Health Policy and Systems Research in India.

Editorial Team: Gautam Chakraborty, Joe Varghese, Muhammad Shaffi, Edwin Sam, Vaishnavi Shankar

Supported by Public Health Foundation of India (PHFI) in its capacity as Nodal Institute for Alliance for Health Policy and Systems Research in India