An exploration of district-based health decision-making in West Bengal, India

Research snapshot[1]

Since 2005, health planning has been increasingly decentralised in India, through the Health Sector Reform Programme and the National Health Mission, leading to increased district-level health decision-making and the integration of health plans into multiple sectors. This qualitative study aimed to assess health decision-making processes in two districts in West Bengal, exploring the extent to which local data is used for decision-making, planning and resource allocation for maternal and child health across health-related sectors.

Direct observations of four key decision-making meetings and qualitative interviews with 16 key informants from multiple departments were conducted between June and October 2015. Data templates contributing to the Health Management Information System (HMIS) were also collected to understand the types of data available and data-sharing mechanisms. Findings were subsequently triangulated thematically based on the World Health Organization's health system building blocks.

Findings revealed that, despite decentralised planning being one of the pillars of India's Health Sector Reform Programme, health plans and resource allocations have remained structured around the State and Central Government's core agenda rather than district-level priorities. The contribution to decision-making by other departments is limited as programmes are already planned according to the State Government's health agenda. The analysis of data templates revealed no harmonisation or sharing of data across departments. In observed district health meetings, 21 issues were discussed and action plans developed. Yet, despite data being available for all of these issues, decisions on only nine (such as institutional delivery and immunisation services) were based on available data. Discussions about infrastructure and supplies were not supported by data and planning targets were not linked to health outcomes. Findings show that existing local data is underutilised for decision-making. This highlights the need for strengthening the use of data for priority-setting and follow-up at district-level in India.

[1] Bhattacharyya, S, Issac, A, Girase, B, Guha, M, Schellenberg, J, Iqbal Avan, B (2020) "There Is No Link Between Resource Allocation and Use of Local Data": A Qualitative Study of District-Based Health Decision-Making in West Bengal, India. Int J Environ Res Public Health. 2020;17(21):8283. Published 2020 Nov 9. doi:10.3390/ijerph17218283

Greater precision of interactions between community health workers and household members to improve maternal and newborn health outcomes in India

Research snapshot[1]

In low- and middle-income countries, community health workers (CHWs) provide basic but lifesaving support for those who have little access to formal healthcare. To identify which CHW actions and messages enable good outcomes and respectful care, the authors used logistic regression to study the associations between CHW actions and household behaviours during antenatal, delivery and postnatal periods in Uttar Pradesh, India. This large-scale survey was conducted in the context of a mature government programme which has operated at scale nationally, using close to a million CHWs, for 15 years. Data was collected on a uniquely linked set of questions on behaviours, beliefs and care pathways from recently delivered women (n=5,469), their husbands (n=3,064), mothers-in-law (n=3,626) and CHWs (n=1,052).

Results show that pregnant women who were visited earlier in pregnancy and who received multiple visits were more likely to perform recommended health behaviours including attending multiple check-ups, consuming iron and folic acid tablets and delivering in a health facility, compared to women visited later or receiving fewer visits. Counselling the woman was associated with the higher likelihood of attending three or more check-ups and consuming 100+ iron and folic acid tablets, whereas counselling the husband and mother-in-law was associated with higher rates of delivery in a health facility. Certain behaviour change messages, such as the danger of complications, were associated with more check-ups and delivery in a health facility but were only used by 50%–80% of CHWs. During delivery, 57% of women had the CHW present and their presence was associated with respectful care, early initiation of breastfeeding and exclusive breastfeeding but not with delayed bathing or clean cord care. Home visits after delivery were associated with higher rates of clean cord care and exclusive breastfeeding. Counselling the mother-in-law (but not the husband or woman) was associated with exclusive breastfeeding.

CHW presence, the number and the timing of visits, behaviour change messaging strategies and a focus on specific household members for different behaviours were associated with better maternal and newborn care practices in this context. Understanding the perspectives of the household decision makers, emphasising the importance of home visits and identifying what messages are shared helped to identify ways to increase the impact of CHW home visits.

Programme managers can use these insights to adapt CHW training, incentives and tools to achieve greater impact, understanding that it is not just the skills of the CHW but the trust between the CHW and the beneficiary built up over time that is important.

Measuring MUAC during a home-visit to a pregnant woman identified as at-nutritional risk in India

[1] Smittenaar, P, Ramesh, B M, Jain, M, Blanchard, J, Kemp, H, Engl, E et al (2020) Bringing Greater Precision to Interactions Between Community Health Workers and Households to Improve Maternal and Newborn Health Outcomes in India. *Global health, science and practice, 8*(3), 358–371. https://doi.org/10.9745/GHSP-D-20-00027