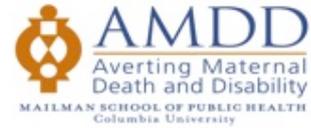




PUBLIC  
HEALTH  
FOUNDATION  
OF INDIA



*Global Consultative Meeting on*

**Posting and Transfer Practices in the Health Sector”**

*Hotel Suryaa, New Friends Colony, 9-10 April 2013, New Delhi.*

*Organized by*

**The Health Governance Hub  
Public Health Foundation of India (PHFI)**

*Supported by*

**The Averting Maternal Death and Disability (AMDD) Program  
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## EXECUTIVE SUMMARY

Even as global movements calling for Universal Health Coverage and Health for All gather momentum, several challenges impede progress towards realisation of such goals, including problems pertaining to the governance of the health workforce. The issue of posting and transfer practices in the health sector typifies these problems. Despite tacit acknowledgements among health personnel that informal posting and transfer practices not only exist but highly impact health services and outcomes, little is known about the complex adaptive systems characterizing such practices.

The Health Governance Hub, Public Health Foundation of India (PHFI), in collaboration with the Averting Maternal Death and Disability (AMDD) program of Mailman School of Public Health, Columbia University conducted a global, consultative meeting on the 9-10 April, 2013 in New Delhi, followed by a research workshop on the 11-12 April, with the aim of understanding multifarious aspects of posting and transfer practices within health systems, and tracing its linkages to health outcomes.

Participants included researchers and experts from India, Indonesia, Ghana, Australia, UK and USA, in addition to senior Indian health administrators, civil society organizations and donor agencies. The first two days witnessed intensive brainstorming wherein participants were engaged in conceptualising the issue and identifying its characteristics. Senior bureaucrats shared policy insights when dealing with the P&T challenges while representatives of community based organizations in India highlighted their experiences of their interactions with the health system. Researchers discussed cross-country experiences of the issue, encompassing the contexts, histories and institutions that shape these practices. The ensuing workshop focused on developing a research agenda to study the practices that characterise P&T. Group exercises were undertaken to develop draft protocols for conducting a multi country study of posting and transfer practices.

Significant ideas generated at the meeting include the necessity of broadening the scope of understanding postings and transfers from a narrow frame of corruption to a much broader frame of human resources for health. Although country contexts were varied, the posting and transfer practices and attempted proposed solutions were often similar across contexts. Methodologies and methods to research this are must be context sensitive and have to include the perspectives of vulnerable sections within the health workforce. The significance of P&T practices for health system performance currently remains at the speculative level and not enough evidence is available to assess its effects. Mutual learning partnerships between implementers and researchers is necessary if we are to enhance our understanding of this sensitive but important issue.



## Group Photo



## Abbreviations

AMDD	Averting Maternal Death and Disability
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homeopathy
BMC	Brihanmumbai Municipal Corporation
DAIA	Deprived Area Incentive Allowance
HRH	Human Resources for Health
LMICs	Low and Middle Income Countries
LSHTM	London School of Hygiene and Tropical Medicines
MI	Mission Inconsistence
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PPP	Public Private Partnership
P&T	Posting and Transfer
SNEHA	Society for Nutrition, Education and Health Action
TB	Tuberculosis (Tubercle Bacillus)
TCAM	Traditional, Complementary and Alternative Medicine
UHC	Universal Health Coverage
WHO	World Health Organization

# Narrative Report

## Consultation (Day 1 & 2)

### Day 1

#### 1.1 Objectives of the Meeting (Raman V R, Dr Kabir Sheikh & Dr Lynn Freedman)

The meeting commenced with a welcome note delivered by Raman VR, followed by detailing of the objectives of the consultation by Kabir Sheikh. The purpose of the meeting was to understand the *how* and *why*, by identifying the problem in its context, framing the question appropriately and subsequently devising a methodology to study it. A *systems thinking approach* was deemed to be particularly relevant in this case as it is often the '*context*' or the '*complex systems*' that are ignored during the inception of the policy, which later emerge as major stumbling blocks, impeding successful actualisation of policies and programs. Through this meeting, a creation of a network of global researchers who can jointly work to deconstruct the problems of P&T- both at the national as well as the international level was also to be initiated. Following a formal round of introductions, the partnering institutions- Health Governance Hub, Public Health Foundation of India and AMDD Program, Mailman School of Public Health, Columbia University presented views on aberrant P&T practices and its implications on the health workforce and health system outcomes. The rationale for focusing on P&T as an important area of inquiry was elaborated.

#### 1.2 AMDD and Governance Hub (PHFI) on P&T: (Dr Kabir Sheikh & Dr Lynn Freedman)

The presenters made the case that review efforts to collect and document P&T policies (and practices) from different regions proved to be a difficult exercise and information on policies and documentation of the practices was difficult to access. From, what was accessible, the mal-distribution of human resources for health from across countries was a common theme with the underlying issue of inconsistent P&T practices not in sync with the overall objectives of health programs. A widespread feeling of organisational injustice among the health workforce due to these inconsistencies and the impact on worker motivation to deliver broader health goals was also highlighted. It was stated that inconsistent P&T practices are not merely episodic problems but systemic in nature. An alternative and possibly more fruitful approach to understanding P&T would be to visualise health systems as core social institutions (deeply embedded within particular contexts) that not only delivered different services but are also a place to realise rights, entitlements, values and government and social interactions. Undertaking the systems approach could provide scope to explore avenues like accountability- as experienced at the frontlines (where the state directly interacts with its people) and better understand informal institutions driving the power dynamics within the society.

#### 1.3 Posting and Transfer Practices-Core Concepts: (Ms Marta Schaaf)

In this session findings from a preliminary background work undertaken for the purposes of the meeting were presented. The need to define the '*mission*' of the health system and the challenge of studying health systems as core social institutions with a mandate to deliver certain goals was discussed. For understanding P&T practices studying informal norms practiced on ground, understand factors that lead to their emergence and studying what the actual policies and practices are could be a beneficial foray. P&T practices (for example: the urban bias within the system) may be

embedded in a system (a bequest from the colonial historical past), which may not in itself advance the goals of the present health systems (universal health coverage for example). This emphasises a need to focus not only on the outcomes but also the processes.

The usage of the term 'mission inconsistency' defined as *deployment of workforce in a manner not aligned with the goals of the state to ensure equitable and high quality health care for all* was debated and it was clarified why certain terms like 'irrational', 'intentions' etc. were not being used to explicate the problem. This is based on recognition that what might be rational for the individual need not be necessarily consistent with the overall goals of the health system.

Commonly used frameworks for the study of P&T and problems associated with them was discussed. The corruption framework, which associates certain costs with certain posts, remains the dominant lens through which P&T practices are studied. Another is the *principle-agent problem* approach, which has been criticized for oversimplifying problems (by categorizing people as 'principle' and 'agents') and neglecting some important aspects that govern decision-making. Frameworks like the Weberian bureaucratic model and new public management model, which dominate most of the current discussions, tend to ignore the complex, interconnected nature of the problem. The presentation concluded by emphasising certain *key strategies* that could be useful while framing the problem of P&T. Apart from adopting an *emic approach* to study the health system, the importance of strategically engaging with political agents and decision-makers (nationally & globally) was acknowledged.

Issues related to decision-making and how it is influenced; one policy does not fit all, words, concepts and terminologies and lack of context specific clarity; for research on P&T to be relevant the need to link it with broader health systems goals; sensitivity and representative of context as important element and suitability of inductive methodological approaches were discussed by the participants

#### **1.4 Experiences of Indian health administrators: (Sh. Keshav Desiraju, Dr T Sundararaman & Dr Girija Vaidyanathan)**

In this session Sh. Keshav Desiraju (Chief secretary to the Ministry of Health and Family Welfare, Government of India), Dr T Sundararaman (Executive director, National Health Systems Resource Centre) and Dr Girija Vaidyanathan (Secretary to the Ministry of Power, the Government of Tamil Nadu who had earlier served as a bureaucrat in the ministry of health), presented the challenges faced by policy-makers and bureaucrats while dealing with P&T issues.

Dr Girija Vaidyanathan shared her experiences of P&T policies and practices in the Indian state of Tamil Nadu mainly through case studies (both successful and unsuccessful) highlighting some commonly faced challenges with respect to P&Ts. She shared the key features of the P&T policy of Tamil Nadu and explained the process of *counselling*<sup>1</sup> that has been introduced into the system to efficiently handle P&T and increase accountability and transparency She specified that P&T was not a regular feature but only occurred during the *transfer season* when:

- Fresh recruitments occur and new candidates enter the system. It was presumed to be the best time to send them to areas where there was a shortage of staff.

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<sup>1</sup> Counselling: It's a process whereby the health posts & locations available for filling are made known to the interested applicants following which they make their choices.

- Vacancies that were advertised annually: which generally come about due to retirement, etc.
- The government wanted to transfer people for different reasons.

Although these are the stated official reasons, quite often, a transfer happens at the behest of the employee who seeks to move. The challenges faced in *effective policy implementation* are multiple and are due to competing interests of multiple stakeholders.<sup>2</sup> Embeddedness of power and associated power relations in the system of P&T, often lead to the trade of monetised value for postings. Groups and associations (of health workers) exert considerable influence on the practice of P&T and asymmetric information exchange fosters space for non-transparency. The discussion that followed the presentation deliberated on the need for congruency between individual and health system goals; the P&T policies were meant for whom; the role of incentives as part of P&T policy/practice and the nomenclature of 'counselling' were discussed

Dr Sundararaman focused on role of institutions and defined them as *instruments through which the dominant social class seek to achieve their social objectives overcoming resistance (which constitutes both coercion and negotiation)*. Linking the concept of hegemony to the issue of P&T, he stated that the challenge lay not only in defining clear P&T policies and implementing them, but understanding and reforming broader institutional frameworks that provided the rationale for the framework of P&T. Regarding the problem of distribution and retention of personnel in difficult areas, he stated that the problem was not unique to India but similar problems were faced in other parts of the world as well, the Nordic countries for example have problems posting people near the Arctic Circle. He emphasised the need to move beyond the available theoretical frameworks while analysing P&T practices. The starting point for such an analysis can be an attempt to understand the *rationale behind the present set of institutional framework that continues to govern the institutions and hence the norms*. In addition, there is a need to *understand the genesis and rationale of the rules before attempting to devise the methods that aim to reform them*.

He stated that regulatory mechanisms, incentives (monetary), positive work environment, educational reforms and location-based selection<sup>3</sup> are common measures used to solve problems of P&T. However, he specified, all of them have been successful and simultaneously unsuccessful, in different contexts. Therefore, possibly a common solution to the entire country (India) may not be the best solution. Often the *incremental norms that worked in favour of any reform attempts. Therefore, there was a need to ensure local adaptability before making any changes to the current system*.

Bringing in a policy-makers dilemma to the P&T discussion, Sh. Keshav Desiraju (Ministry of Health and Family Welfare, Government of India) said that the basic premise on which the entire issue/ problem could be positioned within the fact that *the system needs the doctors more than the doctors need the system*- meaning that there was an unequal distribution of power between the state and health workers, and therefore any negotiation was bound to be skewed towards the one who had more power. He also said that it was time for the system to acknowledge the reality that doctors had more bargaining power than the state, which needs doctors to attain its health goals and that doctors are reluctant to go and serve in locations perceived as undesirable. This problem is aggravated by the

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<sup>2</sup> An illustrative example was the 'Gautambadi Syndrome' wherein all the specialists sought to be transferred to a particular district hospital (at a place called Gautambadi in the state of Tamil Nadu (India). This hospital had few patients providing plenty of time for private practice.

<sup>3</sup> A useful measure is to recruit people from a district, train them and put them back into the same district so that the problem of staff movement can be solved. There has been considerable success with this technique, for example in West Bengal, which trained ANMs from a particular district and sent them back to the same district. Similar methods are being applied under NRHM (India) whereby ASHAs are selected from the same community in which they have to work.

lack of coherent P&T policies, leading to inefficiency in healthcare delivery and emergence of malpractices within the system. He added that financial incentives, special allowances and hill/ remote area allowances have not been successful in motivating staff to stay in remote areas.

He stated that certain steps had been taken under the National Rural Health Mission (India) to ensure staff retention in remote areas citing the example of the ASHA worker who is recruited from the community in which she is expected to work. However, at the level of the ANMs, the lowest health worker within the hierarchy, the problem of P&T continue to challenge policy-makers. Studies have shown that there is a substantial difference in the health outcomes in areas where the ANMs stay in their deputed areas as against places where they don't. He mentioned that sometimes, the ANMs do not stay in their allocated locations even though they were provided with basic facilities and living quarters. As regards to the AYUSH personnel who have recently been incorporated within the health system under the NRHM, their efficiency and effectiveness is yet to be documented.

### **1.5 Experiences from the Field: (Sunil Kaul, Shanti Pantvaidya & Dilip Singh)**

During this session the three presenters highlighted common experiences from different states of the country. Issues pertaining to illogical distribution of skilled staff who are often unable to work without each other's assistance; Lack of effective P&T policy-making, especially with respect to conflict zones (Kashmir & Assam) and difficult areas (like the slums of Mumbai); Resistance to P&T due to lack of facilities, overcrowding and lack of security in the area; Different policies in different states and public-private partnerships (initiated in Uttarakhand for example to retain staff at undesirable locations) increasingly being tried to increase the overall efficiency by enabling flexibility in the entire process. During the discussion it was observed that prevailing P&T practices reflected inconsistencies in deployment of staff and the most inexperienced people were deployed in areas where there was a great need for experienced service providers. Therefore, there was a need to rethink the mission and objectives of the P&T policies.

Dr Kaul initiated the discussion and anecdotal accounts of P&T related issues that he had been witness to during his career. Using the example of conflict prone areas in Assam where despite having all the basic facilities within a hospital, it continued to be non-functional due to the lack of skilled staff. Further, the illogical distribution of skilled staff across districts (who are often unable to work without each other's assistance) made it difficult for any facility to efficiently function. Drawing on his experiences as a doctor in the armed forces posted in Kashmir, he recalled instances when he was the *only* medical officer catering to a conflict zone. The system being resigned to the fact that doctors would never willingly serve in a conflict zone; did not even assign the resources there. He pointed to the complete lack of effective policy-making, especially with respect to conflict zones and difficult areas in matters pertaining to P&T.

A different perspective of the P&T problem was put forth through Dr Pantvaidya's presentation who shared the urban experience (of the Brihanmumbai Municipal Corporation (BMC) to elucidate the P&T problem. Stating policy guidelines, which require that personnel in the health department in the BMC to be transferred every ten years, she stated that transfers were generally made at the request of the transferee and rarely initiated by the state. The state avoided purposely disrupting the smooth proceedings of maternity homes if it functioned well and delivered its objectives. It was only on occasions where the system failed to deliver that the health staff were changed. The problem was regarding posting residents in maternity homes, located deep within the slums. Giving the example of residents who refused to be posted in such areas due to lack of facilities, overcrowding and lack of security issues, she highlighted how P&T was not merely a rural problem.

This was followed by a presentation from was Dr Dilip Singh, who has been both- a practicing doctor within the health system as well as researcher studying issues of health resource management. He presented the present policies of P&T in the Indian states. For example, he stated that Punjab had a relatively simple and clearly P&T policy. Similarly, Andhra Pradesh had a robust policy with a mandatory three years of rural service. He also, highlighted the example of Assam, which was trying to bring greater transparency within its P&T policy. There was a mandatory three years of difficult area service following which transfer orders were considered, provided there was a vacancy. Human resource development software is being used to aid the P&T process. Through the website vacancies and the date of counseling are advertised, candidates are allowed to select their place of posting from the available list and is automatically reflected on a screen. Appointment letter and letters of acceptance are distributed at the spot. This has allowed for a certain level of transparency to this process.

### **1.6 Posting and Transfer through the HRH Lens: (Surekha Garimella)**

In this session, the benefit of looking at P&T through the conceptual lens of Human Resources for Health (HRH) was explained. By locating P&T in the context of health workforce governance its *significance* to adequacy of human resources for health, quality of service provision and welfare of the workforce can be better understood. P&T policies in India are mostly non-uniform, unclear and non-transparent according to available studies. The gaps in the literature emphasized the bias towards studies focussed on the rural areas; and most of them failed to capture the role of P&T policies and practices and how they impact (or not) the health system and the degree to which they help in attaining the actual policy objectives. The discussion that followed looked into issues of movement of people, contextual factors, purpose of P&T policies; gap between policy and practice and differing state policies.

## **Day 2**

### **2.1 Special address by (Sh. Vishwas Mehta)**

Through a mix of personal and official reflection he stated that P&T is accepted as an intrinsic part of public service in India and rarely questioned or debated. The aim of P&T policies is to *strike a balance* between places where there was a scarcity of human resources for health as compared to those where they were in abundance. Changes in governments, the practice of deputation and social capital of some individuals were some of the factors he highlighted as having an impact on the practice of P&T. In the discussion that followed, the interaction between doctor centric health system and P&T policies and the need to explore alternatives like placing nurse practitioners at the first point of contact was discussed. The role of mandatory rural practice as an eligibility criterion for attaining a medical degree; restrictions on dual practice by doctors with compensatory increase in salaries and the role of personal commitment were also discussed.

### **2.2 International Researchers' Presentations and Panel: (Lyn Freedman, Krishna Hort, Genevieve Aryeetey, Andreasta Meliala)**

The focus of the session was to discuss the merits and de-merits of adopting a multi country perspective while studying P&T. Dr Freedman through her experiences in her dealings with maternal mortality highlighted that improper P&T practices were frequently cited as one of the factors for adverse maternal health outcomes. P&T shaped people's perceptions of the system as a whole and affected how they interacted with the system. She hoped that a global discussion would consequently encourage discussions at the local level although there would be similarities and dissimilarities within and across countries.

### *2.2.1 P&T within a regulatory framework (Krishna Hort)*

According to this conceptualisation P&T could be viewed as regulatory mechanism acting at the interface between the health system and the workforce, balancing the interests of both the actors- in the market like scenario, and in the process- creating a range of resultant transactions that often served against the interests of the overall health systems. Hence, there was a need to access the processes (by undertaking research studies) and devise substantial regulatory mechanisms to keep these transactions in check.

Dr Hort proposed to two hypotheses. Firstly, as the health systems progressed towards a mixed system, there is greater autonomy given to the various actors and a forced shift from the *command and control approach of regulation* (where the Ministry of Health is the central authority in charge of determining health needs and staff deployment) towards a more complex system of regulatory approaches. Secondly, as a country develops, regulations become more focussed towards distribution issues (and hence the movement of health personnel), often neglecting quality aspects. Such a scenario was increasingly being witnessed in countries like India and Indonesia. Contrastingly, developed nations like Australia focussed more on regulating the performance rather than distribution, which was left open to the markets.

Criticising the command and control approach of regulations that is witnessed by most of the LMICs, it was stated that such kind of a scenario was vulnerable to a high level of corrupt practices as individuals often tried to influence the decision of the central authority. Situations like these are characterised by low motivation, absenteeism and poor performance. He also presented the alternative model of regulations- the responsive regulatory approach whereby local authorities have the autonomy of determining workforce needs and locations, while simultaneously collaborating with professional associations. Incentives are provided to encourage serving under-served areas by the central authority and the focus is on obtaining a motivated workforce providing high quality services. The regulations of performance, in this case, required the regulation of training institutions, licensing for practice and its renewal and professional practice in itself.

In places like India and Indonesia where the responsibility of P&T is usually with the central or local authority, there exists an increased chance of political or personal influence in the appointments. Moreover, in the context of performance management, there is a dearth of sanctions for poor performance and incentives for good performance. This encourages workers to undertake activities to compensate for the low salaries in public sector. It is worsened by the fact that people who join the public services do so permanently, the time spanning the length of their careers if they so desired. Hence, there were no pressures in terms of consistency and performance. The challenge faced by the policy makers is to balance the interests of system and individual, in the process intervening at areas wherein markets failed to deliver the desired outcomes.

### *2.2.2 Perspectives from Ghana: Dr Genevieve Aryeetey (University of Ghana)*

Dr Aryeetey gave a presentation on P&T policies and practices as experienced within the Ghanaian context. Starting with a brief introduction specifying the core features of the healthcare system in Ghana, she said that health service provision was majorly under the Ministry of Health in Ghana, which employed 80% of all the health staff. Moreover, there were huge gaps in terms of staff availability including nurses, community nurses, medical assistants and physicians. The distribution of doctors, nurses and pharmacists was skewed in favour of the densely populated and affluent southern half of the country while the northern half faced acute shortages.

The P&T policies were similar for all health professionals. Initially, everybody is posted in their choice of location (one out of their three preference areas), following which they are not transferred for a period of three years. Though the government provided certain benefits like- Deprived Area Incentive Allowances (DAIA), it consistently failed to attract workforce in remote locations due to the absence of proper housing arrangements and other facilities. As regards to P&T practices, she stated that negotiations and lobbying for and against transfers was a common practice in Ghana. Staff distribution was often based on willingness of employees to accept postings rather than on needs and vacancies of the system, simply due to the shortage of available skilled personnel. Lack of supervision and incentives for people working in the deprived areas further complicated the issue by adding to the dissatisfaction levels. There was little scope to update the knowledge and enhance the skills of the health workers that adversely affecting the quality of care. She shared, as an example measures undertaken by the state to penalize workers who failed to report to their position of duty. Not only was such a measure (stopping payment, demotion of staff, etc.) meant to punish those who failed to perform their duty, it was also seen as a measure to incentivise good work by punishing non performance.

Currently, the Ministry of Ghana has given away the operational distribution of workforce to other agencies (professional councils) who are responsible for recruiting and distributing staff across their allocated areas. Though the Ministry still retained overall control in terms of ensuring equity, monitoring, etc. most of the work has been outsourced to these agencies. She stated that a comprehensive strategic direction to train and retain staff was needed, including well-designed motivation packages. The session concluded with some suggestions on the different ways to improve work force retention, mainly through:

- Overall improvement and development of the economy and health (road networks, housing, schools, electricity, water)
- Encouraging people to work in their hometowns (facilitated by establishing health training schools)
- Posting young professions (young and unmarried) in rural areas which they are less likely to resist
- Designing policies that enhance career improvement as an incentive to encourage people to take up rural postings

### *2.2.3 Perspectives from Indonesia: Dr Andreasta Meliala*

Dr Meliala shared the Indonesian experience of P&T policies and practices. Starting with a brief introduction to the Indonesian health system, he said that the decentralisation plan in Indonesia was extremely similar to that of India and entrusted the responsibility of human resource based policy making, planning, regulation and national distribution of health workers to the central government. The provincial/ regional management, on the other hand, ensured policy implementation and organised province level institutions. District management was responsible for operations and performance of human resources. Moreover, NGO's and professional associations played a major role by filling in the

gap of training provision. The health workers were posted either on temporary basis for 2-3 years or on permanent basis, both in rural and urban areas.

Reflecting upon the practices, he stated that engagement with the private sector by government service employees was a common practice in Indonesia - not just dual practice but multi job holdings in public and private sectors. This phenomenon was noticed in case of doctors, nurse and all the other health care workers. The health workers in Indonesia were permitted to hold up to three to four jobs in public and private sector, rotating between technical and administrative work. For example a nurse in the government hospital could work as a manager in the private sector and work as a staff nurse in another private hospital. Multi job holding was a usual practice and transfers took place between institutions and between jobs at the same time.

He summarised and concluded his presentation stating some of the key changes brought about by decentralisation. For example, the modes of transfer (within the system) have become more limited (from seven to four) and have impacted on the career development and human resources allocation.

Before 2001 doctors had to engage in compulsory service that led to queuing up in favourite areas. It also leads to questions regarding human rights of doctor's with reference to compulsory rural service. Post decentralization (from 2002 onwards) the services were made optional but due to unavailability of doctors in PHC's, semi compulsory services have been introduced since. The impact of this is currently being evaluated. Once again compulsory services have been recommended (under the Universal Health Coverage (UHC) agenda). Additionally, there are plans of introducing special policy for special regions to support P&T mechanisms for sustainability of services.

The ensuing discussion centred around understanding the repercussions of compulsory rural postings and their long-term implications on the performance of the health workforce. It was suggested to study the relationship between the system and the provider, working within a set of rules (based on a market perspective) and then understanding how the health workers look at these existing set of rules. Thematically, discussions were centred on:

- Delegation of Staff Deployment to External Agencies and professional organisations: There were discussions on the usage of professional councils for staff deployment, as seen in Ghana. However the impact of this practice has not been evaluated so far. All agreed that there was a need to study the role of these external agencies for distribution purposes and how successful/ unsuccessful they were.
- Insurance and UHC as key drivers of changes: Under the broad canvass of Universal Health Coverage (UHC), health insurance has driven changes in the health system of Ghana. The impact is seen in the increase of health professionals and their trainings. It also led to re-designing the health system, where the government has considered needs of health professionals like making housing arrangements in the rural areas. Attention has been paid to special regions. The workload on health professionals and specialists has also increased. Though categorisation is made in to normal and special (underserved) areas, the normal areas usually being urban cities and special areas being the remote areas. The suggestion that came up during the discussion was to understand the role of the private sector in the special areas and in the normal areas vis-à-vis the public provision.
- Dual practice/ Multiple Job Holding: In dual practice in Indonesia health workers serve in both public and private sector and draw dual salary. This is common in the big cities. The effect of this practice on P&T, its social status and governments polices in and around need to be

explored. This is a unique phenomenon where on a single day some hold two posts as the transfer or holding post can happen between the public and private or within private sector itself. . The social status issue of dual practice – in Indonesia: Government is planning to limit practice in maximum 3 institutions! However in discussion it was pointed out that this has thrown up challenges as both in Indonesia and Ghana, health professionals do not serve in deprived areas.

- Regulatory Perspective: Regulatory perspective on P&T is a way to look at P&T practices as markets where there is a relation between the system and health service providers based on a set of rules. One can study these rules and also how employees respond to these rules.
- Context specificity of mission consistency/inconsistency: Issues related to P&T varies with countries. Ghana and India faces the issue of service providers leaving their country and Indonesia faces the issue of multiple job holding. The idea of Mission Inconsistency came from the inconsistency of health system driven by informal setting. A lot of informal systems exist parallel to the formal system, which are practised but are not in paper or policy. Mission Inconsistency will also capture the choices driven by informal processes and how the goals of the health system get affected. The examples of three countries illustrated different experiences, possibilities they offer and challenges that were thrown up to understand the context of mission consistency as linked to P&T.

### **2.3 PHFI's research on Human Resources for Health: (Kavita Chauhan, Devaki Nambiar, Kavita Narayan)**

This session highlighted some interesting research studies currently being undertaken by PHFI in relation to health systems. Some of the showcased studies included those on nurses, traditional, complementary and alternative medicine practitioners and allied health professionals. Of direct relevance to the issue of P&T was the study on traditional, complementary and alternative medicine practitioners (TCAM) presented by Devaki Nambiar. The TCAM practitioners that include the AYUSH service providers are looked after by multiple jurisdictions in Delhi. If the doctors trained in these fields are added up with the existing workforce of allopathic physicians then the doctor patient ratio norm can be reached easily. The cadre includes doctors on contractual appointment and also the ones recruited on permanent basis through UPSC since 1990's. They are posted in co-located facilities and also in multispecialty hospitals. The post creation is user/ demand driven, highly variable and usually protracted. The AYUSH providers go through multiple postings and responsibilities.

In addition, Solomon Salve (LSHTM) presented his reflections from experiences of posting and transfers affecting health service delivery in TB. He stressed on the importance to build relationships on trust in the community where health workers provide services. Especially services for TB require maintenance of a certain amount of confidentiality and the development of a trust based relationship. The transfer of a health worker in such a scenario resulted in loss of time in re-building relationships and it affected whole range of processes in partnerships. The change in the field level leaderships affected team spirit and the connectivity with community was lost. The discussion that followed centred on context specific use of terminologies. The terms public-private partnership and civil society stand for a range of entities and could mean different things different contexts. The term PPP for example encompasses a range of meanings from resource sharing at the community level to international collaborations. The conflation between NGOs and civil society was felt to be problematic because 'civil society' is much broader than NGOs and includes a number of non-NGO actors such as

trade unions, associations, interest groups etc. The group suggested that a clear delineation of terminologies is essential for a nuanced understanding of these terms and how they are used.

The group also deliberated on the practice of traditional medicine in India, Indonesia and Ghana. Integration of traditional health practitioners within the public healthcare system was discussed. It was mentioned that although these practitioners have been incorporated within the system, their effectiveness is yet to be seen. Anecdotal evidence indicates that these practitioners remain underutilised by the public health system they continued to remain underutilised. For example, in Delhi, the AYUSH practitioners in co-located facilities serve 100-300 patients on a daily basis, often recommending allopathic medicines to patients, which are not their area of expertise. In Indonesia, there was a growing the problem of licensing and accreditation prevails. There is a widespread practice of Chinese medicine in Indonesia but adequate research is not done on its efficacy and scope. Traditional medicine practitioners provide services through private clinics in Ghana. They are not organized as providers and not incorporated in the health system.

## 2.4 Emerging Perspectives

The final session of the day highlighted some of the emerging field and policy perspectives, summarising the outcome of the day's sessions. The following points present some of the important aspects of the discussion:

### *2.4.1 Field Perspectives panel (Sunil Kaul, Sushma Shende, Shanti Pantvaidya, Surekha Garimella, Marta Schaaf, Andreasta Meliala & Genevieve Aryeetey)*

This panel discussed perspectives from the field that need to be considered in any research endeavour on P&T practices. The importance of explaining and justifying the usage of the term '*mission inconsistent*' during the course of the study was re-emphasized; especially since there was a possibility that the research study would be an experiential study understanding perspectives of people working both- *within and with- the system*. Clarity of terms was seen to be essential. The panel also felt that in order to fully understand the complexities of all the prevalent practices, the mechanism of punishment transfers and its effects on health outcomes related through workforce psychology need to be explored. The requirement of compulsion clause in workforce deployment policies and their long-term consequences affecting factors like motivation, quality of care, among others was another interesting and important but remains poorly understood. The intricacies of power dynamics within the posting and transfer practices need to be fully understood to understand the present practices and norms guiding the P&T processes. The informal power structures created by people through networks and the way that power is dispersed across the system was also perceived by the panel to be an interesting area of study. The responsive regulatory framework summarised in the pyramid on regulatory frameworks presented by Dr Hort could be a useful tool while undertaking policy analysis and deconstructing the P&T problem. The panel also felt that insights on the typology of regulatory strategies and classifying these strategies to deal with P & T could also be linked to this tool.

### *2.4.2 Policy Perspectives panel (Krishna Hort, Joe Varghese, Dipa Nagchowdhury, Raman V R, & John Porter)*

During this panel discussion, it was agreed by all present that there was a need to engage with policy-makers in order to better understand the challenges faced by the decision makers while resolving P&T issues while also coming up with actionable suggestions through the research. The mechanisms through which policy dynamics are managed and the ways in which the interests of the individual/

populations/ bureaucrats/ health workers/ unions/ clients/ private and corporate perspectives balanced against the health system objectives/ interests was seen to be interesting points of enquiry. Unravelling these mechanisms would possibly throw light on how policy making is influenced and how these processes are initiated and by whom. An understanding of existing institutional mechanisms in place to actualise the P&T process is necessary to know what works and what does not. The panel also felt that exploring the positioning and understanding of gender based exploitation and social discrimination within postings and transfers practices is an important area of enquiry. Exploring informal networks that exist within the system and their influence on the P&T process was another area of enquiry suggested by the panel. Federal and state/local level government relationships and balance/imbalance between urban and rural priorities in relation to P&T policy

## **Research Workshop (Day 3 & 4)**

### **Day 3**

#### **3.1 Synthesis of Learning (Marta Schaaf)**

In her synthesis of two days of consultations, Marta highlighted that throughout the deliberations of previous days *recurring interest was expressed to study and analyse the dimensions of power dynamics entrenched within the P&T processes*. Exploring the role played by the allied health professionals in attaining health goals of the system was also an important feature of the discussions. Understand rationales behind varied practices (informal norms) that have emerged due to obscure policy guidelines came up as another area of interest. Ethical aspects of any inquiry into P&T practices came up as an important marker. It was felt that going beyond simplistic models to decipher pathways through which soft negotiations are conducted would allow situating 'power' as a central motif of explanatory models. Uncovering nuances of processes came up as a necessity to allow for context sensitive policy analysis. While the market lens brings a different perspective, participants were unclear about its explanatory power. The discussion that followed reiterated these points

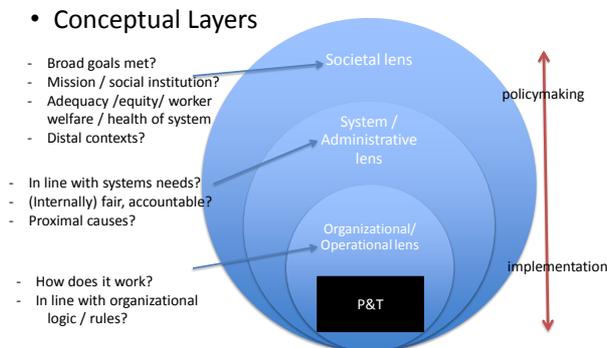
#### **3.2 Emerging Implications for Research: (Kabir Sheikh)**

Dr Kabir Sheikh presented implications for research that had emerged over the course of the meeting. He put forth different ways of anchoring the issue; encapsulating various debates across different fields. For example, he stated that the research study could analyse the problem through the perspectives of mission consistency/social institution lens, good governance framework, workforce management framework focused on outputs and outcomes or look at equity, adequacy of service quality and workforce welfare issues. In terms of broader theoretical frameworks, the systems thinking lens was seen to be useful while studying underlying relations between systems hardware and software (human resources being the hardware and issues like relationships, norms, values and power being the software).

The presentation encapsulated the problem around three conceptual layers (figure below) that could be useful while framing the issue. The first organisational or the operational layer defined the problem, understanding how it functions within the system and mechanisms through which different actors interact within it. The second systems/ administrative layer looked at the needs of the system, whether it was functioning as per its needs and objectives while also being fair, accountable and equitable to

all. The third looked at broader societal aspects in terms of mission, political goals, social and gender issues that were embedded in the society.

## Framing the issue



The need to delineate the research objectives was considered to be important. Other areas that were discussed involved rural/ urban focus of the study and involving gender/ caste based affirmative action among others. With regards to the objectives of the study, it was mentioned that the study could be either *question driven* or *hypothesis driven*. Another technique suggested was using an exploratory research method with an open-ended question initially and subsequently setting up the hypothesis based on the outcomes of the research.

The discussion that followed suggested the need for some detailed preparatory processes before initiating the research since the research was perceived to have wider policy implications in the long term. In the Indonesian context, for example, it was mentioned that such a research would require constant engagement with policy-makers and health-workers. Moreover, studies had to be *perceived as relevant by the policy-makers* in order to engage with them and ideally serve to attain wider UHC goals (the current health system objective in Indonesia). The themes of *good governance (equity, adequacy and quality)* were also considered to be appealing to policy-makers. Within the Ghanaian context, research related to worker welfare and equity was expected to be of interest to policy-makers. P&T was considered to be an extremely sensitive issue and the Ministry of Health (Ghana) played a key role in the entire P&T process. It was stressed that the research should aim to be inclusive, aspiring to capture the concerns of the most vulnerable and neglected groups while also engaging with policy-makers.

### 3.3 Research focus and objectives: (Roundtable)

The session, chaired by Dr Hort, was focussed on devising focus areas and objectives for the research study. Reaching out to vulnerable people (capturing their perspectives) within the workforce, generally posted in remote areas and difficult locations, was believed to be of utmost importance. Questions like- whose aspirations are being addressed through the P&T practices, whether the workforce distribution was equitable or not, were some of the suggested research questions. Capturing staff perspectives in terms of organisational justice and power relationships, across locations, times, cadres and gender was deemed to be important.

Developing tracers was considered to be a useful technique during the course of the study. It was suggested that case studies like the Brihanmumbai Municipal Corporation (Mumbai) could be used as it presented an example of an entire system. It was reiterated that broader goals of equity and human

resource issues had to be engaged with in any study of P&T in order to link it to broader health goals. Research should reflect upon the limitations of existing policy practices and recommend policy measures addressing issues of common concern, preferably across countries. The discussion that followed deliberated on

- **Programs as an entry gate:** Focussing on a particular program was considered as an entry gate into studying the issue. However, the limitations of such an approach were also discussed whereby it was stated that vertical programmes might not adequately reflect systemic problems.
- **Leadership and service delivery:** Linkages between good leadership and service delivery was an area, which required further investigation. Moreover, cases of ad hoc transfers within well functioning teams (and their subsequent effects on healthcare delivery) were considered interesting focus areas.
- **Organizational justice:** Organisational justice and perceptions of the health workers were considered to be important since they were directly linked to staff motivation and thus healthcare delivery.
- **Realist evaluation:** Having measurable outcomes help, also need to swift through the context and mechanisms. There can be engagement of a different type of political economy in the whole process.

### **3.4 Creating and Sustaining a Partnership Network: (Roundtable)**

Dr Lynn Freedman chaired the final session of the day. The objective of the session was to identify mechanisms by which the current network of experts could be sustained, strengthened and further evolved. Linkages with existent global networks engaged in health systems or human resources for health research were suggested. Others mechanisms identified included proposing panel discussions on P&T in Global Health Symposium in 2014 (Cape Town), Health Systems in Asia 2013 (Singapore) and a multi country proposal for the Bellagio Centre. Some key potential donors identified for the research study were: Asia Pacific Alliance for Human Resource for Health, Transparency International, Asian Development Bank, European Union, WHO, Rockefeller Foundation and Social Accountability Fund of World Bank was also identified for this purpose. Representatives from Ghana and Indonesia were delegated with the task of catalysing preliminary discussions centred on posting and transfer issues with their respective stakeholders to explore the possibility of a future study.

## **Day 4**

### **4.1 Taking day 4 forward (Lynn Freedman & Kabir Sheikh)**

Dr Lynn Freedman outlined the agenda for the day and Kabir Sheikh shared an email from Dr Girija Vaidyanathan in which she re-emphasised the *need to handle the issue strategically by making the study relevant at the national level*. The use of certain terminologies and the sensitiveness surrounding them were highlighted and it was pointed out that in-spite of the global discourse on governance distinctly propagating a corruption free state with greater accountability and transparency,

the closer one got to discussions at the local/ national level, the words became sensitive and subtlety needed to be exercised when dealing with such *delicate* matters.

It was recognised that the sensitiveness surrounding the issue might result in people closing down and not cooperating with the researcher. As suggested in the e-mail, the need to associate certain degree of relevance to the study was considered fundamental in order to engage with policy-makers. Moreover, it was mentioned that although phrases like P&T could be used in the global context, but at national policy-making level, using terms like deployment, human resources might be more prudent. It was further suggested that the study could be positioned with the objective of attaining greater health goals (like universal health coverage or primary health care) instead of merely criticising existing policies and programmes in order to better engage policy-makers. In the Indonesian context the issue of P&T, apart from being a sensitive domain was also an area of contestation among various stakeholders. Therefore, policy-makers might not want to involve themselves with such research, presuming that it might act as the catalyst initiating agitations among the workforce. This was echoed in the Ghanaian perspective as well.

#### **4.2: Presentation of VOICES Protocol (Kabir Sheikh)**

A protocol, recently prepared by the Health Governance Hub, was presented in this session as an example of what a P&T research protocol may look like and major aspects that will need to be considered. Some salient features that emerged from the comparative exercise include having separate goals and objectives for the P&T study. The goals could be broader in terms of relevance and the objectives could be specific, dealing with specific issues suitable to country contexts. The rationale for the study, on the other hand, could be to have a well functioning health system serving the dual purpose of workforce and the people whom they serve. It was suggested that the outcome could also be to increase accessibility of healthcare in general. This could emerge as an actionable point for policy-makers who were already struggling with ways to improve accessibility of healthcare. Regarding cross-country variation- it was realised that the objectives may not be necessarily similar across countries.

Since the framing of a study design is complex, understanding the mechanism of P&T (in itself), its functioning and the objectives it was expected to serve (within the policy processes) was seen as the first step before proceeding with the study. Examples of realist evaluations were given (and proposed as an alternative approach) where the starting step could be to develop a formative research base by asking general questions and eventually moving on to hypothesis based questions.

Extrapolating study results was considered to be fairly simple as it was a common bureaucratic process within a country. But, cross-country results were expected to be substantially different although it was mentioned that health administration across the colonial regime was roughly similar. An interesting suggestion was made to study the level of truth telling among the system and maybe study how that changes as one moves up the system. Regarding state selection, it was suggested (in case of India) to pick three major provinces that existed during the colonial period to make up for cross-country variations.

### **4.3 Building the Concept Note (Kabir Sheikh)**

The final session of the day was structured around group work with the objective of developing a problem statement and rationale for the study, methods that could be used and a concept note for every country. The groups later converged to present their respective sections.

#### *4.3.1 Rationale for the Study*

Kabir Sheikh presented a problem statement and the rationale for study. P&T are directly linked to worker welfare and its distribution, which in turn shapes factors like the quality of, care and access to services- the direct objectives of the health systems. However, despite its relevance and linkages to broader health goals, the domain of P&T was under explored. While there is enough documentation on the implementation of health programmes and how they were affected due to inefficient P&T, there was a general lack of understanding in terms of factors that influence policy-making, shape practices and the impact of these policies and practices on those who work in the system.

#### *4.3.2 Proposed Method*

Following from the rationale, a prospective method that could be adopted for the purposes of the study was proposed by Kabir Sheikh. The proposal was based on adopting the realist research framework, modified to suit different contexts (countries) that would explore the role of P&T practices and their role in health systems strengthening. The broader objectives would be to synthesise the findings and draw comparisons across countries.

Moreover, the role of the research would be to change the processes in a positive way. The suggested approach was to use a realist framework to understand the context, mechanisms and outcomes of P&T practices, which would also help in cross-country analysis. Within a country, the study would use a mixed methodology combining qualitative and quantitative research methods to analyse the depth, breadth and significance of the issue. Locating the study at the interface of the people and their interactions with the health system, it was envisaged to provide a balance of the micro perspective while at the same time linking it to greater health goals. It was also recommended to use the complex adaptive systems perspectives to understand the pathways and mechanisms (generally diverse and heterogeneous and often influenced by differing local institutions) contributing to both expected and unexpected outcomes within P&T.

Reflecting on the outcomes of the study, it was stated that the most prominent contribution of the study would be creation of new knowledge and shared understanding of the contexts and mechanisms that characterise P&T. Its wider implication on the global platform would be in terms of cross country comparison of practices and processes as well as reflecting on issues pertaining to good governance and accountability in low and middle income countries. Stressing on the involvement of policy-makers as well as community based organisations, it was envisioned to enhance reflections within dominant discourse as well as catalyse systemic reforms thus transforming the health systems.

## 4.4 Country Perspectives

### 4.4.1 Indonesia (Krishna Hort)

One of the driving factors in the Indonesian context was the development of new knowledge, which apart from its intrinsic value was also perceived to be instrumental in understanding some of the present problems of management of human resources for health- mainly workforce shortage, practitioners engaged in dual practice and geographic imbalance affecting accessibility. Hence, the aim of the study within the Indonesian perspective would be to contribute to the HR policy to address this imbalance in staff. The specific objectives could be to research the willingness and commitment of the workforce (workers perspective), study the management of HR at the district level and its impact on the workforce and examining the mechanisms and occurrences of inter district and inter province transfers.

### 4.4.2 Ghana (Genevieve Aryeetey)

Two studies were proposed within the context of Ghana titled '*Posting and Transfer Practices: Meeting Human Resource and Health Workforce need in Ghana*' and '*Linking Posting and Transfer Practices: Health Workforce Retention and Migration*' out of which the first was elaborated upon. The main dilemma facing policy-makers in Ghana is the overarching problem of ensuring equitable distribution of health workforce, especially in deprived areas (in terms of health benefits) with only 15% of the total workforce. Recognising the shortage and the refusal of staff to be posted in these areas, the government has already instituted the Deprived Area Incentive Allowance (DAIA). However, it has not been very successful in attaining equitable distribution of staff and areas continue to be deprived of health services. Therefore, a research on P&T practices was seen to be important as it will not only ascertain whether the claims made by the health workers are valid or not but also open dialogue and negotiations among stakeholders on ways to ensure equitable distribution. Some of the areas that the research could focus on are issues surrounding the nuances of the system like power, negotiations and trust and the interplay between them while attaining health goals.

### 4.4.3 India (Surekha Garimella)

In the Indian context, the P&T problem was perceived to be important from the perspective of health workforce planning strategy. Moreover, most of the studies in this area have adapted the corruptions lens highlighting malpractices impregnating the system. Little has been documented on the role of effective P&T policies and practices in attaining greater health objectives. Thus the research would investigate the phenomenon of P&T practices in the health sector, as a critical aspect of health workforce governance. More specifically, the research would focus on the nature of P&T policies, the existing practices & significance of these practices for governance of Human Resources for health.

The proposed method for the study was to explore and analyse emic accounts of the workforce, their motivations and their experiences related to the P&T practices. The methods presented mostly centred around conducting policy reviews and semi structured interviews whereas the outcome was highlighted to be a better understanding of the linkages between P&T practices and health goals. It was suggested to study the hidden dimensions of power within the context of the study, ideally capturing their perception of power and the feeling of 'powerlessness' across cadres.

#### **4.5 Concluding Remarks (Lynn Freedman & Kabir Sheikh)**

Certain areas where decisions had to be made were identified to be:

- Role of each group within the existent network
- Ownership of the data collected
- Decision-making processes
- Authorship guidelines
- Decisions based on the synthesis of ideas/ contribution of national studies

It was clarified that the relationship between research partners (and the process of decision making) was distinct from the flow of fund that was required for the study. Each country needed to chalk out its own way of progressing with the study and advance broader health goals. Presently, two major areas that needed to be focussed upon were 1) the synthesis that would be drawn upon from the meeting 2) framing the issue both globally and nationally- not necessarily in a similar manner. It was felt that the ideal scenario to progress with the study would be to have separate funding for each country but collaboration of the synthesis of learning at a global level.

### **Learning from the meeting**

The presentations and discussions from the 4 days were rich and insightful in their content, salient learning's are presented briefly in this section. Significant ideas generated at the meeting included:

- The necessity of broadening the scope of understanding postings and transfers from the narrow frame of corruption to a much broader frame of human resources for health.
- Although country contexts were varied the posting and transfer practices and attempted/proposed solutions were mimetic in nature raising the question why this is so?
- Words, terminologies and their meanings used in discourses surrounding P&T merit special attention and are very important because this is a sensitive issue and needs to be dealt with care.
- Methodologies and methods need to be context sensitive and have to include the perspectives of vulnerable sections within the health workforce.
- There was a general consensus that realist methodology may be appropriate for studying P&T issues in LMICs because it allows for context specific concerns and particularities to be taken into consideration.
- The significance of P&T practices for health system performance currently remains at the speculative level and not enough evidence is available to assess its effects.
- Mutual learning partnerships between implementers and researchers is necessary if we are to enhance our understanding of this sensitive but important issue.

## List of Participants

1.	Dr Andre Meliala	Universitas Gadjah Mada, Indonesia
2.	Dr Devaki Nambiar	Public Health Foundation of India
3.	Dr Dilip Singh	National Health Systems Resource Centre
4.	Ms Dipa Nagchowdhury	MacArthur Foundation
5.	Sh Keshav Desiraju	Ministry of Health & Family Welfare
6.	Mr Edward Premdas	Public Health Foundation of India
7.	Dr Genevieve Aryeetey	University of Ghana School of Public Health
8.	Dr Girija Vaidyanathan	Government of Tamil Nadu
9.	Mr Harsh Sahni	Public Health Foundation of India (Intern)
10.	Dr John Porter	London School of Hygiene & Tropical Medicine
11.	Dr Kabir Sheikh	Public Health Foundation of India
12.	Ms Kaveri Mayra	Public Health Foundation of India
13.	Ms Kavita Chauhan	Public Health Foundation of India
14.	Ms Kavita Narayan	Public Health Foundation of India
15.	Dr Krishna Hort	Nossal Institute of Global Health, Melbourne
16.	Dr Lynn Freedman	Columbia University
17.	Ms Marta Schaaf	Columbia University
18.	Ms Namrata Verma	Public Health Foundation of India
19.	Mr Raman VR	Public Health Foundation of India
20.	Mr Saroj Sedalia	Columbia University
21.	Dr Shanti Pantvaidya	SNEHA, Mumbai
22.	Ms Shinjini Mondal	Public Health Foundation of India
23.	Ms Shruti Chhabra	Columbia University
24.	Ms Sneha Palit	Public Health Foundation of India
25.	Mr Solomon Salve	London School of Hygiene & Tropical Medicine
26.	Dr Sunil Kaul	Action Northeast Trust, Assam
27.	Dr Surekha Garimella	Public Health Foundation of India
28.	Ms Sushma Shende	SNEHA, Mumbai
29.	Dr T Sundararaman	National Health Systems Resource Centre
30.	Dr Venkatesh Narayan	Public Health Foundation of India
31.	Sh Vishwas Mehta	Ministry of Health & Family Welfare

## Agenda

Time		Speaker	Panel	Chair
<b>DAY 1, 9 APRIL</b>				
900-915	Introductions			Raman VR
915-925	Objectives of the meet	Kabir Sheikh		
925-935	AMDD view	Lynn Freedman		
935-945	Governance Hub view	Raman VR		
0945-1045	Postings and transfer practices: core concepts	Marta Schaaf		Krishna Hort
<i>TEA</i>				
1115-1200	Pacesetting	T. Sundararaman		Kabir Sheikh
1200-1230	Keynote	K Desiraju		
1230-1315	Expert view	Girija Vaidyanathan		
<i>LUNCH</i>				
1400-1530	Indian researchers talks and panel	Sunil Kaul		Lynn Freedman
		Shanti Pantvaidya		
		Dilip Singh		
<i>TEA</i>				
1600-1645	Posting and transfer in India: the HRH lens	Surekha Garimella		Dipa Nagchowdhury

<b>DAY 2, 10 APRIL</b>				
0900-0930	Day 1 Recap	Edward Premdas		Lynn Freedman
0930-1000	Special Address	V Mehta		Lynn Freedman
<i>TEA</i>				
1100-1300	International Researchers talks and panel	Krishna Hort		Lynn Freedman
		Genevieve Aryeetey		
		Andreasta Meliala		
<i>LUNCH</i>				
1345-1430	Showcase: PHFI's research on HRH	Kavita Chauhan		Raman VR
		Devaki Nambiar		
		Kavita Narayan		
<i>TEA</i>				
1530-1615	Emerging perspectives discussion	field panel	Sushma Shende, Shanti Pantvaidya, Surekha Garimella, Marta Schaaf, Andreasta Meliala, Genevieve Aryeetey	Sunil Kaul
1615-1700	Emerging perspectives discussion	policy panel	Joe Varghese, Dipa Nagchowdhury, Dilip Singh, Raman VR, John Porter	Krishna Hort

Time		Speaker/ Panel	Chair
<b>DAY 3, 11 APRIL</b>			
0930-1000	Recap of Day 2	Edward Premdas	
1000 – 1045	Synthesis of learning from 2 days	Marta Schaaf,	Edward Premdas
<b>Tea</b>			
1100-1200	Emerging implications for research	Lynn Freedman Kabir Sheikh	John Porter
1200-1300	Framing the issue - Normative view - Applying theory - Conceptual layers	Roundtable	John Porter
<b>Lunch</b>			
1400-1545	Research focus and objectives - Subjects of inquiry (doctors/admins/others) - Research questions - Macro and micro perspectives	Roundtable	Krishna Hort
<b>Tea</b>			
1600-1700	Creating and sustaining the network - Global network / Indian network - Conferences / meetings / funding	Roundtable	Lynn Fredman

Time		Speaker/ Panel	Chair
<b>DAY 4, 12 APRIL</b>			
0930-1000	Recap of Day 3	Edward Premdas	
1000 – 1045	- Presentation of VOICES protocol - Plan for concept note	Kabir Sheikh	Lynn
<b>Tea</b>			
1100-1200	Brainstorming on concept note - Framing and problem statement - Methods statement - Country thematics	Roundtable	John
1200-1300	Breakouts	- Marta, Lynn - Problem statement - Kabir - Methods - Surekha, Eddie – India thematic - Kris – Indonesia thematic - Genevieve, John – Ghana thematic	
<b>Lunch</b>			
1400-1530	Regroup – review and refine outputs	Roundtable	Lynn
<b>Tea and close</b>			

## WELCOME NOTE FOR PARTICIPANTS

The **Health Governance Hub, Public Health Foundation of India**, in partnership with the **Averting Maternal Death and Disability (AMDD) program of Columbia University Mailman School of Public Health**, welcomes you to a 2-day consultative meeting of experts, decision-makers and researchers on “Posting and Transfer Practices in the Health Sector”. We are hopeful that the meeting will serve as a springboard for action to strengthen research and policy on health workforce governance in India and globally. The consultation will also directly inform the core researchers’ workshop (11-12 April), in which we will focus on developing a study design for India and creating a global thematic network.

The Problem: Even as global movements for Universal Health Coverage and Health for All gather momentum, several challenges in many low and middle-income countries impede progress towards these goals, including – significantly – problems in *governance of the health workforce*. These problems are typified by the issue of posting and transfer (P&T) practices in the health sector. The phenomenon of P&T practices that do not serve to maximize health outcomes and/or health worker professionalism – is widely observed in India, and also in varied settings globally. We use the term “*mission-inconsistent*” to describe such deployment of the workforce in a manner that is not aligned with the goals of the state to ensure equitable and high quality health care for all.

Mission inconsistent P&T entails irrationalities, inconsistencies and delays in deploying personnel. It can be linked to complex systems of patronage and transactions, systemic inefficiencies and omissions, and acts of discrimination and injustice. It impacts on all aspects of workforce optimization – equitable distribution, service quality, and wellbeing. Despite widespread acknowledgement that inappropriate P&T practices adversely affect health service processes and outcomes, little is known about the complex adaptive systems characterizing P&T practice.

Focus on Learning: This consultative meeting has been organized to collectively learn and germinate ideas and insights on this widely acknowledged but poorly understood subject. The specific *objectives* of the consultation are to:

1. Strengthen understanding of the *types and character* of P&T practices
2. Strengthen understanding of *institutional, social and political contexts* in which P&T occurs
3. Identify the *significance* of P&T practices for health system performance and goals
4. Draw insights into how best to *research* the topic
5. Draw early insights into how to *strengthen P&T practices and policies*

In your folder: is an agenda, list of participants and background papers prepared by PHFI and AMDD.

Thanks and Welcome!

Kabir Sheikh and Lynn Freedman (on behalf of the Health Governance Hub, PHFI and AMDD, Columbia University)

## Biographies of participants

### **Dr. Andreasta Meliala:**

Andreasta Meliala's background is a medical doctor by training and has been working on human resource for health (HRH) issues for 10 years as an academic and consultant. He became interested in the links between the health system effectiveness and the human resource for health with its complex dimensions in the early 2000s. In his master thesis and doctoral dissertation (in a finalization phase), he applied the concept of human resource management to strengthen health care service, in micro level, and health system, in macro level, using a context-based behavioural analysis. He graduated from Faculty of Medicine, Universitas Gadjah Mada, Indonesia and hold Master degree in hospital management from the same university. He also the alumni of School of Public Health, Leopold Franzen University, Tyrol, Austria, and hold Master in Advance Science degree. He is currently a student in doctorate program of Faculty of Medicine, Universitas Gadjah Mada, Indonesia. He works as a consultant (2002-now) for the Center for Health Service and Management, Faculty of Medicine, Gadjah Mada University, Indonesia, to apply the concept of HRH management that he teaches in the classroom (2002-now) to the student of Hospital Management Post Graduate Program, in the same university. As a consultant, he has served various clients, from local government, private sector, and international organizations. He has published number of books as a co-author, articles about human resource management, and presenting research findings in several international symposia.

### **Dr. Devaki Nambiar:**

Devaki Nambiar is a Research Scientist at the Public Health Foundation of India, affiliated with its Health Governance Hub. She is also adjunct faculty in the Indian Institute of Public Health–Delhi. A former Fulbright scholar and U.S. National Institutes of Health pre-doctoral and postdoctoral fellow, her research applies critical theory and mixed-methods to understand policy making on health and its social determinants, focusing in particular on the role of civil society in health promotion across the life span. She was a core member of the technical secretariat for India's High-Level Expert Group on Universal Health Coverage and has conducted research on case studies of community action in health, private philanthropy in health priority setting, and integration of systems of medicine for essential health care delivery. She has conducted research and has ongoing research collaborations in Low and Middle Income Countries in South Asia, Southeast Asia, and East Africa. She is a member of the Medico Friend's Circle and the American Public Health Association. She has authored a number of peer-reviewed publications and is a peer reviewer for Global Public Health, Health Policy and Planning and Reproductive Health Matters. She has a Ph.D. in public health from the Johns Hopkins Bloomberg School of Public Health

### **Dr. Dilip Singh:**

Dr. Dilip Singh is the Advisor for Human Resources for Health at the National Health Systems Resource Centre (NHSRC). He is a medical doctor who practices public health. He started his career in public health about 15 years back as a Primary Health medical officer, at the grass roots level. He is currently involved in research on policies that influence Human Resources for Health.

### **Ms. Dipa Nag Choudhury:**

Dipa Nag Chowdhury is Deputy Director of the India office of the MacArthur Foundation. She leads MacArthur's grant making on Population and Reproductive Health in India – these programs supports work on two themes - improving maternal health; and advancing young people's sexual and reproductive health. She also manages the Foundation's portfolio of grants on girls' secondary education. Prior to joining the Foundation in 1998, Dipa worked with the Naz Foundation Trust in India, the Mailman School of Public Health, Columbia University and the International Food Policy Research Institute in Washington D.C. Dipa has Masters Degrees in Political Science from Bombay

University, India, and Public Administration from Syracuse University.

**Mr. Keshav Desiraju:**

Mr. Keshav Desiraju belongs to the Indian Administrative Service (1978 batch) and was educated at the Universities of Bombay, Cambridge and Harvard. Mr. Desiraju has held several positions such as Special Secretary and Additional Secretary to Ministry of Health, Government of India. He was secretary to the Government of Uttar Pradesh and Principal Secretary to the Government of Uttarakhand. He is currently posted as Secretary to the Government of India in the Department of Health and Family Welfare, Ministry of Health and Family Welfare.

**Mr. Edward Premdas Pinto:**

Mr. Edward Premdas Pinto is Human Rights and Public Health professional & practitioner actively engaged in the issues of policy implementation in the communities of Dalit Women, Unorganised Sector and marginalised communities for last 18 years. His field of work has been Health, Human Rights, Legal and community interventions for human dignity and social justice. He has post-graduation in social work and in law and has combined both these professional perspectives to engage with the profession of public health from the perspective of human rights and social justice. He has completed PG Diploma in Human Rights Law from National Law School, Bangalore. His approach has been of active engagement with and empowerment of communities, training, research and people's advocacy for health, wellbeing and dignity. His research work include the areas of systemic marginalization of Dalits, health rights of the marginalised in Karnataka, public health and law in India, functioning of Village Health and Sanitation Committees (VHSCs), Rural Incentive Scheme in Karnataka, children and malnutrition, Access to Health Care and Challenges faced by women in Urban slums in Bangalore. He is currently pursuing doctoral course from Jawaharlal Nehru University, New Delhi in the area of public health and law.

**Ms. Genevieve Cecilia N. O. Aryeetey:**

Genevieve is a public policy analyst especially on Health Insurance and Poverty and Rural Development. She has Bachelors in Economics from the University of Ghana and a Masters in Arts in International Development. Proven research skills and experience in conducting various research surveys and data analysis and data management. She held the position of National Financial Secretary, with Ghana Methodist Students' Union for two years in 2002-04. She is a Japan International Cooperation Agency (JICA) Scholar. She has been associated as a Research Assistant and Principal Research Assistant with the Institute of Statistical, Social and Economic Research (ISSER) at University of Ghana, Legon.

**Dr. Girija Vaidyanathan:**

Dr. Girija Vaidyanathan is Currently Chairperson & Managing Director, Tamil Nadu Power Finance and Infrastructure Development Corporation Limited. She is an officer of the Indian Administrative Service (1981 Batch). She did her PhD in Health Economics and MSc in Physics from Indian Institute of Technology, Chennai- She is also a Chartered Financial Analyst. Dr. Vaidyanathan served the TN Government in different capacities from sub-district to state level. In the area of health and nutrition she served the State Government of Tamil Nadu in different capacities, such as Project Coordinator of Integrated Child Development Scheme, Project Director of Reproductive and Child Health, Commissioner Maternal and Child Welfare, Special Secretary, Secretary and Principal Secretary of the Ministry of Health and Family Welfare.

**Dr. John Porter:**

John Porter is Professor of International Health at the London School of Hygiene and Tropical Medicine (LSHTM). He trained in paediatrics in London and then in public health at the Harvard School of Public Health and the Center for Disease Control and Prevention in the United States before joining the London School. Although trained in infectious disease epidemiology and disease control (TB, HIV and leprosy) his focus has increasingly turned towards research on health systems, policy and ethics with interdisciplinary collaborative projects in Southern Africa and India. He is currently the Chair of the LSHTM Ethics Committee.

**Dr Kabir Sheikh:**

Dr. Kabir Sheikh is a Senior Research Scientist at the Public Health Foundation of India (PHFI) and Director of the Health Governance Hub - PHFI's interdisciplinary programme of health policy & systems research and research capacity building. Dr Sheikh is also Honorary Senior Lecturer at the London School of Hygiene & Tropical Medicine (LSHTM) and visiting faculty at the University of Melbourne, BRAC University Dhaka and the University of Delhi. Dr Sheikh has a PhD in public health and policy from the LSHTM, and formative training in social medicine (University of Delhi) and infectious disease epidemiology (LSHTM). He has been engaged in health policy & systems research, teaching and training, health systems strengthening and policy development in 15 states of India, Sub Saharan Africa, the Asia Pacific, Bangladesh, Brazil and globally through assignments with WHO HQ, and DfID and AusAID research consortia.

Dr Sheikh is an editor (health systems research) of the journal Health Policy & Planning. He has published extensively in international and Indian peer-reviewed journals, and edited (with Asha George) the volume: 'Health Providers in India: On the Frontlines of Change' (Routledge) in 2010. In 2011, he led the technical team (citizen and private sector participation) for the Government of India commissioned report on Universal Health Coverage. He has been a University of Cape Town expert-in-residence (2013-14), a Bellagio scholar-in-residence (2011), an Aga Khan Foundation international scholar (2003-06) and a JN Tata scholar (2003-04), and has won research grants from noted agencies including WHO, DFID, IDRC, Oxfam, Wellcome Trust, and the Sir Dorabji Tata Trust.

**Ms. Kaveri Mayra:**

Kaveri Mayra is a Research Associate with Health Governance Hub, Public Health Foundation of India. She started her career with ANSWERS (Academy for Nursing Studies and Women Empowerment Research Studies) in Hyderabad as a Research Assistant and worked with Dr. Prakasamma. She has worked as Technical Advisor ANM Trainings, with Jhpiego- an affiliate of Johns Hopkins University, in their ACCESS- FP project in Jharkhand. Her work involved Quality Assurance, Monitoring and Evaluation of ANMTC's and District Hospitals in three districts in Jharkhand according to SBMR (Standards Based Management and Recognition) methodology. She has a Master's in Public Health from School of Public Health, SRM University and Bachelors in Nursing from West Bengal University of Health Sciences.

**Ms. Kavita Chauhan:**

Kavita works on Health Promotion and Advocacy initiatives at PHFI. Her work combines teaching, action research, designing innovative approaches for health communication and developing capacity building modules. Kavita teaches modules in Health Communication, Nutrition Policy Processes, Health Promotion and Adolescent Health. Kavita has over ten years of applied public health experience. During the inception phase of PHFI, Kavita successfully contributed to building institutional partnerships, development of an award winning website (Healthy India), designing learning modules for academic programmes and writing grant proposals. Her current work at the Health Communication Division includes supporting knowledge mobilization, advocacy and capacity building efforts around strengthening Human Resources for Health policies, practices and strategies. She is part of an effort that aims at developing alcohol control initiatives and establishing a Centre of Excellence in Alcohol Control at PHFI. Her earlier work at CARE India integrated planning, and implementing programme strategies related to HIV and AIDS and reproductive health needs of communities. At Futures Group, under the POLICY Project, she participated in formulating HIV/AIDS policy interventions with the Government, faith-based organizations and NGOs, and supported decentralised planning of programmes. She reviewed programming issues related to care & support for children affected by HIV/AIDS in low-prevalence settings and provided technical support for developing evidence for advocacy under the Essential Advocacy Project (*Avahan*). Kavita interned with the Child and Adolescent Health and Development Department at WHO, Geneva where she contributed to the development of an information system to review and analyse adolescent health

data for policy and programme planning. She has MSc in Public Health from the London School of Hygiene and Tropical Medicine, Masters in Social Work from Jamia Millia Islamia University New Delhi, and a Diploma in Human Rights from International Institute of Human Rights, Strasbourg, France.

**Ms. Kavita Narayan:**

Kavita Narayan is a Fellow of The American College of Healthcare Executives; Kavita has several years of experience in hospital and health systems design, planning and turnaround leadership in the United States. In her present role, at PHFI, Kavita co-leads the strategy and operations of the youngest unit within PHFI - the Health Systems Support Unit (HSSU). She is responsible for building strategic partnerships and relationships with the Ministry of Health and Family Welfare and other associated entities in several states and the centre as well as bilateral/multilateral development partners and the industry.

Kavita's areas of expertise include hospital board structure and governance, private – non-profit partnerships, physician relationships, capital management, leadership development and customer service programme design. Kavita is closely involved as part of the High level Expert Group on Universal healthcare, set up by the Planning Commission and leads that part of the secretariat focussed on healthcare delivery norms. She also co-leads the strategic road mapping on the National Initiative for Allied Health Services (NIAHS), a cabinet-approved 1100 crore rupee project of the Ministry of Health and Family Welfare to augment the paramedical capacity in India through the establishment of nine training institutes, for which PHFI-HSSU was recently named technical partner. She also represents PHFI in the establishment of the sector skill council for healthcare in conjunction with the NSDC and the CII. Kavita also serves as the Indian representative to the Board of the American College of Healthcare Executives and is involved in setting up the India chapter of ACHE, an organisation aimed at promoting excellence, professionalism and lifelong-learning among healthcare leaders.

**Dr Krishna Hort:**

Deputy Director, Head of the Health Systems Strengthening Unit, and technical director for the Health Policy and Health Finance Knowledge Hub at the Nossal Institute for Global Health, University of Melbourne. Kris has a background as a doctor in paediatrics and public health, and started his career as a volunteer doctor in a charitable rural hospital in Bangladesh. Since then, he has worked in the Australian health system as a regional director of public health in Western Sydney, and in health assistance programs in developing countries of the South and SE Asia regions. Kris has experience as a team leader on a reproductive health project in Indonesia, technical director of projects in Indonesia and Vietnam, and consultant in project design, evaluation and implementation in Bangladesh, Indonesia, Philippines, China, Laos and Vietnam. He has been particularly engaged in health systems policy development in Indonesia with researchers and policy makers over the last 15 years. His interests include health systems reform, the relation between knowledge and policy, environmental health, maternal and child health, and mechanisms for development assistance.

**Dr. Lynn P. Freedman:**

Lynn P. Freedman is the director of the Averting Maternal Death and Disability (AMDD) Program and of the Law and Policy Project, both in the Mailman Schools Heilbrunn Department of Population and Family Health. She is trained at Yale University, Harvard University Law School and Columbia University. Before joining the faculty at Columbia University in 1990, she worked as a practicing attorney in New York City. Professor Freedman has been a leading figure in the field of health and human rights, working extensively with women's groups and human rights NGOs internationally. She has published widely on issues of health and human rights, with a particular focus on gender and women's health. She is currently serving as a senior adviser to the UN Millennium Project Task Force on Child Health and Maternal Health and is the lead author of the Task Force's Final Report "Who's Got the Power: Transforming Health Systems for Women and Children."

**Ms. Marta Schaaf:**

Marta Schaaf is a Senior Program Officer at the Averting Maternal Death and Disability Program at the Columbia University Mailman School of Public Health. In this role, she develops program research and implementation to promote accountability for maternal and other health programs. Through this project, AMDD partners with governmental, academic, and non-governmental agencies to study and devise ways of ensuring that women have access to the quality care that their governments have committed to provide. Marta comes to AMDD having worked in health and human rights for over 10 years. Most recently, she managed paediatric HIV and drug supply chain programs for the Clinton Foundation in West Africa. She has also worked on access to health care, minority health, and health systems for the World Lung Foundation, HealthRight, the Open Society Foundation, and the World Health Organization. Marta has a Masters in International Affairs and a Masters in Public Health from Columbia University.

**Ms. Namrata Verma:**

Namrata Verma is a Research Associate in the Health Governance Hub at Public Health Foundation of India, New Delhi. Namrata chose to become a public health researcher after completing her biomedical engineering degree from Manipal University. She has worked with the IKP Centre for Technologies in Public Health, Chennai where she was part of the Health Financing and Technology Vertical. Namrata completed her PG Diploma in Health Economics, Financing and Policy from Indian Institute of Public Health, Delhi, following which she joined PHFI where she has worked in the areas of Universal Health Coverage, Community Participation and Decentralization. She has also worked on the Hunger Reduction Commitment Index at the Hub and helped develop the Governance Toolkit for Universal Health Coverage in India. Her areas of interest include community action in health and governance aspects of public health. This year she will be pursuing her Master's in Public Health from the London School of Hygiene and Tropical Medicine.

**Mr. V R Raman:**

VR Raman is Principal Fellow at the Health Governance Hub, Public Health Foundation of India's interdisciplinary programme of research on critical aspects of health governance in low-income contexts, linked to capacity building and advocacy. He is a public health and development practitioner with two decades of experience of policy, planning, research, advocacy, training, community mobilization and organization building towards strengthening health and linked systems in several states of India. He has served as Technical Resource Person to the Planning Commission's High Level Executive Group on Universal Health Coverage (2011). He is a founder member, in 2002, and later, Director-in-charge of the Chhattisgarh State Health Resource Centre. He continues to be a Governing Board member of SHRC. He helped planning and setting up of the Jharkhand State Health Resource Centre too, during this period. He is a Governing Board member of Jharkhand SHRC, since its inception. A founder member of the Public Health Resource Network (PHRN- a national level peoples initiative to support capacity building of health systems), he helped setting up its important educational partnerships such as with People's Open Access Education Initiative (People's Uni-for their distance based MPH), and with Indira Gandhi National Open University (IGNOU- for their distance based PG Diploma in District Health Planning and Management). He served as a Mentor to the community health fellowship initiative of PHRN and he is currently member of Editorial Advisory Committee as well as National Coordination Committee of PHRN.

He is an invited faculty to National Health Systems Resource Centre (NHSRC- technical advisory to NRHM) for the national level trainings under ASHA community health worker initiative and for the fast track capacity building of district officials in decentralized health planning. He had been a special invitee to the National ASHA mentoring group as well. His prior engagements have been with the Bharat Gyan Vigyan Samiti and the Kerala Shastra Sahitya Parishad, largely for strengthening literacy as well as education programmes and for science popularisation campaigns.

**Ms. Saroj Sedalia:**

Saroj works with the AMDD program. She is based in Bihar and works on implementation research and public health.

**Dr. Shanti Pantvaitya:**

She is the Executive Director, Programmes, of SNEHA and is currently overseeing all the four vertical programmes and providing technical support to help them achieve the set goals. Dr Shanti has done her MD in Anaesthesiology and worked as medical teacher for 35 years and served as Professor and Head of Anaesthesiology Services at LTMG Hospital for 20 years, where she was instrumental in establishing and coordinating the Emergency Medical Services at LTMG Hospital. She is working with SNEHA since 2003 and significantly contributed towards building partnership with Municipal corporation of greater Mumbai. She has been instrumental in establishing referral network for maternity services among the public health hospitals in Mumbai.

**Dr. Shinjini Mondal:**

Dr. Shinjini Mondal is currently working as a Research Associate, with Health Governance Hub, PHFI. She had done her Master's in Public Health from Tata Institute of Social Sciences and Bachelors in Homeopathic medicine from Delhi University. She has previously worked with PHFI and ICICI Centre for Child Health and Nutrition in areas of community health, child health, nutrition and on health systems strengthening projects. She has an experience of working along with Government health systems as well as in areas of project evaluation, development of evaluations tools and analysis of data.

**Ms. Shruti Chhabra:**

Ms. Shruti Chhabra studied medicine at TN Medical College, Mumbai, followed by Masters in Health Administration from Tata Institute of Social Sciences (TISS), Mumbai. Currently she is doing her PhD in Socio-medical Sciences from Columbia University, New York. She is on their Rosenfield Sexual and Reproductive Health Scholarship, and has received Ratan Tata and JRD Tata scholarships in the past. As a student she interned with NGOs and the public health system in Uttarakhand and Maharashtra to gain an understanding of rural health and health systems. She has worked in different parts of India in different capacities. She worked in Maharashtra with Pathfinder International on preventing Post-Partum Haemorrhage and establishing a continuum of care (referral system) for maternal health, and with the Government of Gujarat in the State Program management Unit (NRHM). She also co-wrote a history of the Gujarat health system for the government in 2010-11. Her research interests are health systems development, maternal health, rights and ethics in health care. Her Masters' thesis was on the ethics of care in medical tourism for assisted reproductive technologies.

**Ms. Sneha Palit:**

Sneha holds an undergraduate degree in Economics from LSR (Delhi University) and a postgraduate degree in Development Studies from IDS (Sussex). Additionally, she also holds a PG Diploma in International Law and Diplomacy. She started her career working as a Research Assistant with Mission Convergence- a Government of Delhi initiative. She was involved in multiple projects including Pilot Social Audit, Urban Vulnerability Survey and the Homeless Survey (Delhi) and Baseline KAP Study to Analyse Voter Profile in Delhi. She has briefly worked with IDS, Spiral Sussex (a Brighton based NGO) and other NGOs like Adharshila and the Indian Cancer Society, primarily in the domains of awareness and advocacy. She is particularly interested in policy analysis and qualitative research centered on issues including governance, participatory spaces for citizen action and social accountability.

**Mr. Solomon Salve:**

Solomon Salve is from India. Solomon completed MSc in Anthropology from University of Pune in 2004. He worked as a researcher from 2004 to 2009 with Centre for Health Research & Development (CHRD) a unit of Maharashtra Association of Anthropological Sciences (MAAS) and a partner in a research consortium led by the London School of Hygiene and Tropical Medicine (LSHTM) called TARGETS (2005-2010) funded by the DfID-UK. His work with CHRD focused around developing

Public Private Partnerships for management of TB, HIV and HIV-TB co-infections. In 2009 he was awarded with the Commonwealth Scholarship for pursuing a PhD at the London School of Hygiene and Tropical Medicine. His PhD focuses on Policy Implementation, wherein drawing on the bottom-up perspective of policy implementation he is analysing the implementation of national policy for involving private sector for TB control in India. Studying at LSHTM has gradually developed his interest in health systems and policy research, particularly using anthropological lens to study complex organisational relations that strengthen the health systems' capacity to control communicable diseases.

**Dr. Sunil Kaul:**

Dr. Sunil Kaul is an MBBS from Pune and he also has a public health degree from the London School of Hygiene and Tropical Medicine. He has been working for more than twenty years in rural years on issues that determine health of poor and tribal communities. He is the Founder of the ANT (Action NorthEast Trust), a NGO based in Bodoland, Assam that works on issues related to rural development. Sunil worked with the Army Medical Corps for ten years and left it to work in rural Rajasthan and Assam. He is an Eisenhower Fellow and an Aga Khan scholar, he has been appointed Advisor to the Supreme Court's Commissioners on the Right to Food and the State Representative to the National Commission for the Protection of Child Rights to monitor the Right to Education.

Working on livelihoods as an important determinant of health, he has been involved with the setting up of aagor daagra afad, a Trust that is run by weaver women for the tribal weavers and has run at a surplus for most of its existence. Aagor has been distributing local wages of more than twenty lakh rupees every year amongst domestic weavers for the past many years. He is also the Managing Trustee of The Ants Craft Trust in Bangalore that helps design and market handmade crafts made by fair trade agencies apart from a retail store that highlights the strengths of northeast mainly through craft.

**Dr Surekha Garimella:**

Surekha Garimella is a senior scientist at the Health Governance Hub, PHFI. She has an interdisciplinary background in Nutrition, Economics and Public Health. She has worked with NGOs and the WHO in the past and has been involved in research and program implementation. She is a former International Ford Foundation fellow.

**Ms. Sushma Shende:**

Sushma Shende is currently overseeing the Maternal and New-born health programme of SNEHA in the capacity of programme Director. She has significantly contributed towards the process of building partnership with Municipal Corporation, for the improvement in quality of care in the maternal and new born health services of the public health system. She has Over 15 years of experience in designing, implementing, monitoring and evaluating health system programmes and development of similar projects in tribal, rural and other urban areas. Sushma has guided successfully, the Strengthening Primary Care component of one of SNEHA's large maternal and new born health projects, namely "the City Initiative for New-born health" spread over a period of five years (2003 to 2008). She is presently, heading a 40 strong team 1) to work with more than 50 government facilities, to establish a formal referral system among the various tiers of the public health network, for managing women in labour in Mumbai. 2) to continue the work initiated by the UK Department for International Development funded program to scale up ante natal care facilities through the government system in 30 vulnerable slum pockets. She holds a Masters in anthropology, has presented papers on Maternal and New born health in no of national and international conferences.

**Dr T Sundararaman:**

Dr Sundararaman shifted to the field of Public Health from his previous position as professor & HoD of Medicine at Jawaharlal Nehru Institute Post Graduate Medical Education and Research (JIPMER). He had been instrumental in several pioneering health and development initiatives across the country. His role was central in setting up the State Health Resource Centre in Chhattisgarh, a model

Institution known for several pioneering health system initiatives like the Mitandin CHW programme, wherein he was the founding director. Previous to his Chhattisgarh stint, he initiated community health programmes in several states such as Tamil Nadu, Pondicherry, Bihar, Uttar Pradesh amongst others. He is one of the founders of Peoples Science Movement and Peoples Health Movement in India. During his Chhattisgarh Tenure, he had also supported the Madhya Pradesh and Andhra state governments in developing their medium term health strategy and the West Bengal Government in planning the Kolkata Urban Health Systems Project. Dr Sundararaman is founding director of the National Health Systems Resource Centre that acts an additional technical capacity to the Ministry of Health and Family Welfare, and he continues in this position since 2007. He has worked extensively in the area of health human resources. He has authored several reports, books and publications on different public health topics.

**Dr Venkatesh Narayan:**

Dr Venkatesh Narayan is currently a fellow in the Wellcome trust research capacity building grant on Health policy & systems research. Also he is a member at PHFI's interdisciplinary programme of research on critical aspects of health governance in low-income contexts, linked to capacity building and advocacy. He is a medical graduate (MBBS) from Maharaja Sayajirao University, Baroda & Masters in public health (MPH) from Achutha Menon Centre at Sri Chitra Tirunal Institute of Medical Sciences & Technology, Trivandrum. He did his MPH thesis with MDRF (Madras Diabetes Research Foundation) on physical activity in rural Tamil Nadu. Prior to joining PHFI, he was working as the state technical project coordinator with CARE in the BMGF 'ananya' family health initiative at Patna. For about two years, he has worked with UNICEF in Bihar as a divisional health coordinator & provided techno-managerial support to the government health & administrative officials in Maternal & child health programs.

**Dr Vishwas Mehta:**

Dr Vishwas Mehta is an officer of the Indian Administrative Services, of 1986 batch. He has held several key positions with State Government of Kerala and Rajasthan, including the Principal Health Secretary portfolio in Kerala. Held several responsibilities at national level, he is currently the joint secretary to Ministry of Health, Government of India responsible for human resources for health. He has a PhD from MS University, Udaipur, Rajasthan and an advanced degree in public administration from the Maxwell School of Public Administration at University of Syracuse, USA, in addition to his Master's degree in Geology from Punjab University and Post-graduation in management studies. He has written articles on "Health research needs on achieving MDGs" and has authored books on management studies. He has presented widely on topics such as Kerala's health model, nursing development, HRH challenges in India in several national and international forums.