POLICY DOCUMENT ANALYSIS: LAQSHYA PROGRAM

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Health Policy Analysis

Health Policy refers to "decisions, plans, and actions that are undertaken to achieve specific health care goals within a society" (WHO) (1) (2) It can be exhibited in the form of laws, bureaucratic edicts, or practice guidelines.(3) Public Policy is defined "as a course of the method of action, selected by the government from possible alternatives to guide and determine present and future decisions."(4)

Health Policymakers are tasked to steer a track between demands and contending interests to generate a realistic response to health problems.(3) The National Health Policy (NHP) is a subset of Public Policy. The main objective of this is to create conditions that ensure good health for the entire population.

There has been increasing interest in knowledge translation to strengthen evidence-based policymaking, which strives to address many of the challenges in translating research to policymakers, closing the 'know-do' gap. Although evidence from research has considerable potential to contribute to effective health policy, there are other factors that can influence policy making, (5) economic, social, and political forces also contribute to a large extend.(6)

Health Policy Analysis is a critical aspect of health policy formation and change, which aims to explain the interactions among ideas, interests in the policy process.(4) The review of documents and guidelines, It is a mechanism by which the evidence bast best practices best practices can be ensured for the promotion of good health. (7) Results from analysis and evaluation of the health policy can provide information to help with the allocation of scarce resources and increase the chances of ongoing funding if there are evidence showing success in achieving its goals, as acquisition of ongoing funding greatly increases the opportunity window of successful policy implementation, thus further

increasing chances of policy impact.(8) Policy Impact refers to “strategies of policy implementation (outputs), changes in individual or health of the population, especially when clinical management policies are applied (outcomes).” (8) The policy analysis can also support policymakers to improve the implementation of the future policy by enhancing the policy document. One approach to achieving enhancements of policy documents is the analysis of internal validity. In this situation, internal validity refers to “the comprehensiveness and clarity of policy statements to demonstrated intended outcomes.” Optimally, the planned outcomes are not always articulated in the health policy documents.(9) The details in the health policy documents that can affect the policy implementation and its success may not be familiar or neglected since its implementation is not the responsibility of the policy writers.

Developing policy document is included in the policy process as one of its part, which should be ethically justifiable, economically rational, socially acceptable, and epidemiologically sound.(10) (11) The purpose of the statement is to enrol commitment by the government, which enables opportunities, obligations, resources, and goals to be recognized in a definite form in written guiding principles as Guidelines, Procedure manuals, or Policy Directives.(9) (4) Policy document analysis, is the analysis of these documents, owning of the fact that a policy coheres to certain principles, namely legislative support, goal clarity, and key stakeholders. The guidance of the implementers regarding the policy documents should be taken: (1) before action, to confirm that the policy could be implemented and can accomplish its goals. (2) during phases of implementation, to observe the progress as anticipated. (3) during evaluation phase, to accommodate policy goals with intended outcomes and allow making essential changes to future policies, as a result expanding their impact. Policy document analysis is a method which is straightforward and is used to evaluate the extent to which the policy confirms to critical principles that influence successful implementation. Carefully

delineating the linkages between closely affiliated policy documents may promote development of future policy that is more rational.

Health Policy for Mother & Childcare: India

India has a decentralized, three-tiered, mixed health care system inclusive of public and private health-care service providers, to provide preventive and curative health care in rural and urban areas. However, secondary, and tertiary care health-care services are mostly provided by private health-care providers concentrated in urban India. India having a federalized system of government, the governance and operational areas of health system have been divided between the union and the state governments.(12) At the national level, the central agency is the Ministry of Health and Family Welfare (MoHFW). In each State, the implementing agency is the State Department of Health and Family Welfare. Each State has its own healthcare delivery system managed by both the public as well as the private sector. While States are responsible for the functioning of the overall healthcare, the Central government is responsible for formulating the country's health policy and implementing the national health programmes.

Health systems and polices at national and state levels play a vital role in determining the way health services are delivered, utilized and their effects on health outcomes. The 1946, Bhore Committee Report, also mentioned as Report on the Health Survey and Development Committee, has been a marker report for India, from which the health system and policies have made headway over the years. In 1983, India for the very first time adopted an official National Health Policy. Earlier, recommendations through the Five-year Plans and various committees were formulating states health activities. Under the Five Year Plans the health ministry constituted schemes with target approach. Each

plan period had a number of schemes and with every subsequent plan added more schemes while only a few were dropped.(13) Over the years, Indian Government has successfully structured three National Health Policies (1983, 2002 and 2017), and planned twelve Five-year Plans (last in 2012-2017), for the betterment of the overall health of the Indian population, through numerous programs and interventions.(13)

After independence in 1947, India took over a health system wrecked by inequality and low coverage and therefore, during the opening years, the health system development focused on equality and expanding coverage. Although, owning to constrained resources, efforts were severely restricted.(14) (15) In 1940s the Maternal Mortality Ratio (MMR) was 2000/1 lakh live births which reduced to 1000 in the 1950s, and the Infant Mortality Rate (IMR) was 189.6/1000 live births.(16)

Under the First Five Year Plan (1951-56), Maternal and Child Health (MCH) services were expanded with skill upgradation of doctors, nurses, and midwives through trainings. However, quality of infrastructure and human resources emerged as a concern, contributing little progress in real terms.(17) By the end of 1960s, IMR had reduced to 161.7/1000 live births.(18) Under the Third Five Year Plan (1961-1966), more emphasis was given on growing population and as a result target approach was introduced for family planning, overshadowing community based MCH services.(19) IMR by now had declined to 141.7/1000 live births.(18)

In response to the commitment to the Alma Ata Declaration in 1978, to achieve "Health for All" by 2000, India formulated its first NHP in 1983, which aimed at reducing MMR from 4-5 to below 2; and IMR from 125 (1978) to below 60 by year 2000.(20) (21) The policy brought back focus on preventive, promotive, rehabilitation and public health aspects of healthcare, through the establishment of comprehensive primary health care services and strengthening coverage and referrals based on principles of equity, and

universality.(22) But since the policy concern was limited to human resource with poor funding and compromised quality of services, the weak implementation kept the performance unsatisfactory.(23)

The Seventh Five Year Plan (1985-1990), for the first time gave priority to maternal health, emphasizing on prevention, promotion, and educational aspects. Quality of care was absolutely segmented as a concern in terms of management, supervision, supplies and training, although no substantial strategy was suggested to address these concerns.(24) By now IMR had declined from 105.6 to 84.3/1000 live births, and MMR had come down to 424/100,000 live births (NFHS-1 and SRS from a period of 1982-1992).(25) (26)

During the 1990s, when the global MMR was 400, in India, it was 600 contributing to 27% of maternal deaths. This not only impacted the quality of life but also adversely affected the contributions the population could make to the country socially and economically.(27) During the same period, the global movements for reproductive rights for women resulted in focusing on overall reproductive health with target free approach in family welfare programming. There was a shift to Reproductive Child Health (RCH) with expanded MCH programming. It was then that in 1992-97, the government launched the Child Survival and Safe Motherhood Program (CSSM) supported by World Bank. The programs child survival component was extended with some new developments to previous child survival activities such as immunization, acute respiratory infection and diarrhoea management, while the maternal component was based on a new perception of preventing maternal mortality through training of traditional birth attendants, setting up of First Referral Units (FRU) for Emergency Obstetric Care (EOC) and disposable delivery kits in MCH services.(19) This perspective was a withdrawal from the old 1970s Maternal Child Health (MCH) high risk approach.(28) Despite all efforts, by 1997-98, MMR had increased to 540/100,000 live births (NFHS-2), while IMR had reduced from 89 (1990) to 67.6 (1998-99) per 1,000 live births.(29) (30) Although, this achievement

was not satisfactory in respect to the desired impact on women and child development and population growth, hence to overcome the problem, a need for a new approach was well felt.

In 1997, The International Conference of Population and Development (ICPD) held in Cairo, recommended to facilitate services for family planning as comprehensive reproductive health care component. In response, the Government of India launched the Reproductive and Child Health (RCH) Phase-I in 1997-2002.(31) The program emphasised on client-orientation, target free approach based on community needs – Community Needs Assessment Based Approach (CNAA), high quality, and integrated services to the beneficiaries. The integrated package of services included services for mothers (during pregnancy, childbirth and postnatal care and, safe abortion services); children (new-born care, immunization, Vitamin A prophylaxis, Oral Rehydration Therapy for diarrhoea, Acute Respiratory Infections and Anaemia); prevention and management of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) and counselling services for adolescent. Meanwhile awareness for the 'quality' component increased substantially and the prospective broadened to include efficiency and quality assurance in the form of norms and standards in the five-year plans.(32) (33) In several states, through schemes such as India Population Project and Health System Development Project implementation of quality improvement initiatives were notable.(34)

During the same period in 2000, India signed the United Nation Millennium Declaration of Millennium Development Goals (MDGs) and committed to reduce MMR by three quarters by 2015, under MDG 4 – Reduce Child Mortality and MDG 5 – Improve Maternal Health. In 2002, the Indian Government evolved revised NHP 2002. The main goals in terms of MCH component of the policy were to reduce IMR to 30/1000 and MMR to 100/1 lakh live births by 2010;(35) decentralize public health system and

strengthen infrastructure, logistics and supply system, surveillance system, referral system, human resources development and capacity building.(36) The interventions helped improving health indicators such as Total Fertility Rate (TFR) and Life Expectancy, but crucial indicators like MMR had stagnated at around 400 per 1lakh live births and IMR at 60 per 1000 live births, respectively.

The MoHFW extended RCH Phase-I to RCH Phase-II under the flagship of National Rural Health Mission (NRHM) in 2005, with an aim to provide accessible, affordable, and quality health care. All the programs were integrated with the emergence of quality improvement strategies. This was the first time when the quality aspect was given recognition in the policy and planning at the national health levels.(37) During this phase apart from focusing on the existing initiatives, several new Intervention were added in the MCH basket, for example, Janani Suraksha Yojana (JSY), a demand promotion and conditional cash transfer scheme to promote institutional deliveries; engagement of Accredited Social Health Activists (ASHAs); Janani Shishu Suraksha Karyakram (JSSK), to eliminate out-of-pocket expenses through free drugs, diagnostics, treatment, free transportation for the sick infants and postnatal mothers and Mother and Child Tracking System (MCTS) were introduced. The government partnered with the professional organizations for the capacity building of doctors in Anaesthesia and Obstetric care, especially caesarean section skills.(38) As a result there was significant improvement in MMR which declined from 280 (2005) to 212 (2009) and from 178 (2010) to 167 per 1lakh live births in the period 2011-13 (SRS).(39)

Quality in Public Health

In the intervention field of quality promotion the Indian Public Health Standards (IPHS) in 2008, were institutes for the upgradation of the health infrastructures.(40) RCH-II

Quality Assurance Guidelines were circulated to form Quality Assurance Committees at district and state level for continuous monitoring of the quality component. For capacity building, technical assistance, and to intensify quality services National Health System Resource Centre (NHSRC) was set up. To address critical gaps in skill sets, standard training modules and treatment protocols were developed, for example, at community level, for community health workers, training modules for skilled birth attendants, emergency obstetric care and home-based new-born care. To address gaps in quality care, with the provision of untied funds, Patient Welfare Committees at facility level were established.(34) (37) Guidelines for implementing Maternal Death Reviews were issued, a strategy to improve the quality of obstetric care and reduce maternal morbidity and mortality.(41) Later, the 11th Five Year Plan (2007-12) permitted setting up National Accreditation Board for Hospitals and Healthcare Providers (NABH), for accreditation of tertiary, secondary private and public health facilities.(42) The Bureau of Indian Standards (BIS) developed ISO certification for healthcare quality management systems in hospitals.(43)

In line with 12th Five Year Plan (2012-17), India adopted Sustainable Development Goals (SDGs) in 2015 to achieve "Universal Health Coverage," and reduce MMR below 70/100,000 and IMR below 25/1000 live births by 2030.(44) To have a profound impact on the maternal and child health situation, the Health Ministry implemented Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCH +A) strategy. In continuation with the strengthening of the schemes

initiated during Eleventh National Health Policy, the government added multiple new schemes to further reduce maternal and neonatal mortality and morbidity.(45) For example, The Pradhan Mantri Surakshit Matritva Abhiyan program 2017, to ensure antenatal care; Mothers Absolute Affection Program, with focus on promotion of breast-feeding practices; establishment of New-born Care Units (NBCUs) and

Special New-born Care Units (SNCUs) and screening programs for adolescent girls. To promote continuous progress towards quality of care in public health facilities, standards, regulations, and accreditation processes were initiated and interventions like National Quality Assurance Standards (NQAS) (2013), Dakshata (2015) a training package for competency enhancement for the providers, Kayakalp (2016) to inculcate the practice of hygiene, effective waste management and infection control, Mera Aspataal (My Hospital) (2016) were launched.(46) According to Sample Registration System (SRS), MMR had declined to 122/100,000 live births and IMR to 34/1000 live births in 2016.(47)

Although, over the years India succeeded in improving some of the health indicators (*Table 1*), with significant gain in accessibility and affordability to healthcare services, the efforts were still not sufficient to meet the targets set under the national goals and international commitments.

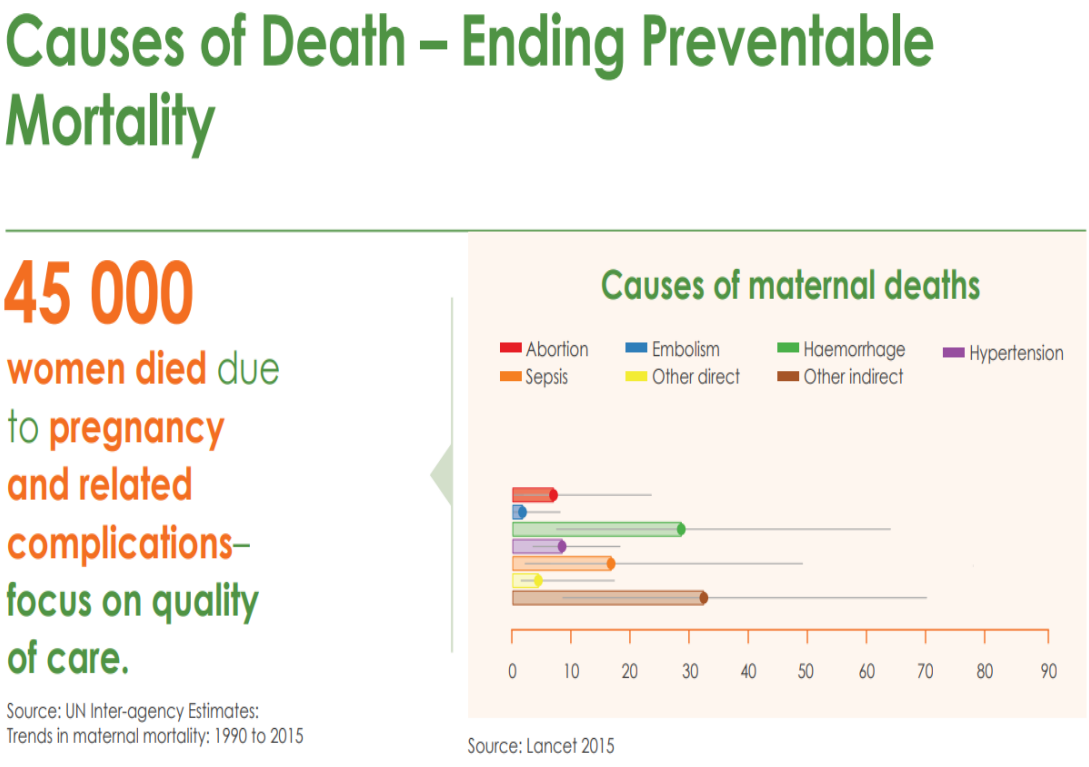
Table 1: Changes in the Health Indicators

Indicators	**"NFHS-1 (1992-93)"**	**"NFHS-2 (1998-99)"**	**"NFHS-3 (2005-06)"**	**"NFHS-4 (2015-16)"**	**Change within 10 years**
Maternal Mortality Rate	78.5	67.6	57.0	41	Decreased by 16
Maternal Mortality Rate	437	540	280	130 SRS(2014-16)	Decreased by 150
Mothers who had at least 3 antenatal care visits for their last birth (%)	43.9	44.2	50.7 37.0 (4 ANC visits)	51.2 (4 ANC visits)	Increased by 14.2

Institution Deliveries (%)	26.1	33.6	38.7	78.9	Increased by 40.2
Births assisted by doctor/nurse/LHV/ANM health personnel (%)	33.0	42.4	46.6	81.4	Increased by 34.8
Mothers who received postnatal care from doctor/nurse/LHV/ANM health personnel within 2 days of delivery for their last birth (%)	NA	NA	34.6	62.4	Increased by 27.8

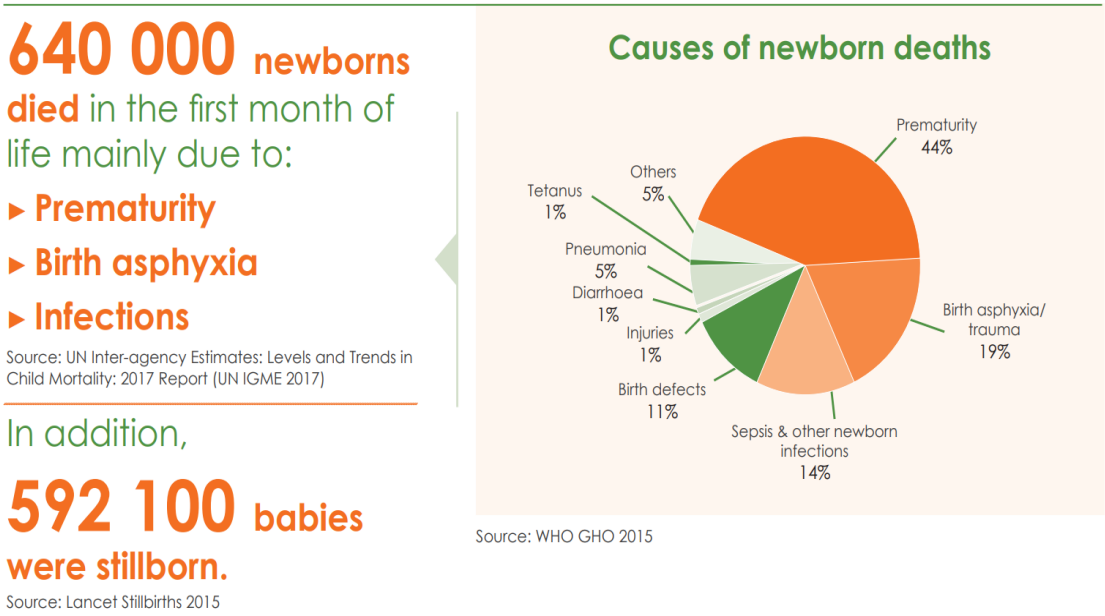
Source: "National Family Health Survey, India"

The surveys, reviews and studies revealed reasons for not achieving desirable outcomes in respect to MMR and IMR despite multiple efforts. They highlighted that the preventable maternal deaths mainly clustered around labour, delivery, and



immediate postpartum period in relation to direct causes and substandard quality of care at every level of health facilities. Over 70% of maternal deaths resulted from complications such as postpartum haemorrhage (30%), hypertensive disorders (10%), sepsis (17%), obstetric complications (5%), and others (33%), while prematurity (44%) asphyxia (19%) and infections (14%) in case of neonates. Lack of skilled manpower, infrastructure, drugs, and equipment's resulted in low coverage of Emergency Obstetric Care, hence compromising quality of services extended by health facilities.(48)

Source: India RMNCAH Fact Sheet, July 2018, WHO (49)



Source: India RMNCAH Fact Sheet, July 2018, WHO (49)

Over the past two decades, the world has been emphasising on reducing MMR and Infant IMR through various policies and initiatives. India has also made several efforts and contributed at large to overcome these challenges.

LaQshya Program

With an improved understanding of the main root causes of maternal and infant deaths, and an aim of achieving the Sustainable Development Goal 3, the MoHFW conceptualised strategy and launched LaQshya program in 2017.

This was the first major policy attempt to address Quality of Care (QOC), through 'Patient-Centric' and 'Respectful Maternity Care' approach around the child-birth and during the immediate postpartum period in Labour Rooms and Maternal Operation Theatres in public health facilities. The LaQshya program targets to achieve 'Zero-defect' clinical care by strengthening key inputs like infrastructure, the layout of labor room and maternal operation theatre, skilled human resources, equipment, and drugs and issues affecting the process of care. To guide the efforts in this direction and to implement internationally accredited National Quality Assurance Standards, the LaQshya guidelines are boosted with already existing endeavours and program guidelines. The Plan, Do Check, Act (PDCA) methodology has been combined with Rapid Improvement Events to help in building a quality culture within the health systems. 'Reward and recognition' have been incorporated in the program to motivate and encourage the stakeholders.(50)

Method of policy analysis: a review

Policy analysis is a recognized research and academic descriptive study, explaining various aspects of a particular policy.(51) The objective of the public policy is to explain the interlinkage between ideas, institutions, and interests, within the policy process through integrative approach . It is a tool that can be utilized to understand the past failures and success of a policy and then accordingly to plan the implementation of the policy both retrospectively and prospectively, to understand past policy failures and success and

to plan the future policy implementation.(52) The application of policy analysis particularly in the health sectors is crucial, especially in developing low-middle income countries.(53) There are two different approaches to conduct Policy Analysis: (1) analysis OF the policy process: in which different aspects of policy formulation are examined, such as problem identification, agenda-setting, decisions making, and policy evaluation and implementation. This approach is used mostly for retrospective work, to generate knowledge. (2) analysis IN and FOR the policy process: this deals with the use of techniques (analytic), research, and recommendations for the various policy processes. This approach as more applicable for dynamic engagement with the policy process. (54) However, over the years less attention is given to HOW to do policy analysis what research design, theories or methods best inform policy analysis.(52)

There are various methods of performing health policy analysis, which include the study of the problem, and also the consequences of using one option above the others in addressing the problem itself. It is supported and focused by using relevant theory, a clear conceptual framework, and different research designs apart from a single case study on specific issues. (1) Theory approach - is defined as a "comprehensive, systematic, consistent, reliable explanation and prediction of the relationship among specific variables, which can be a representation of reality".(53) (55) For example, Kingdoms Multiple Streams Theory,(56) (57) Group Theory (58) (59) and Multiple Implementation Theory - Top-down and Bottom-up approach.(60) (61) (2) Research design is an important aspect of health policy analysis as policy decisions usually require longer-term processes and dynamic evaluation. Generally, studies use both, qualitative and quantitative approaches (Mixed Design), considering the randomized clinical trial the golden standard for medical care studies.(62) (63) (64) Cross-country comparative study approach to compare different country contexts in policy adaptation, evolution and implementation can also be eliciting.(65) (66) (67) (3) Framework approach is an

important tool of health policy analysis. In this the identified question is organized by recognizing elements and their inter-relationships for generating theory, as they don't explain or predict outcomes and behavior. For example, the Stages Heuristic Framework, in which the policy process is divided into four stages: agenda setting, formulation, implementation, and evaluation."(Lasswell 1956; Brewer and DeLeon 1983)."

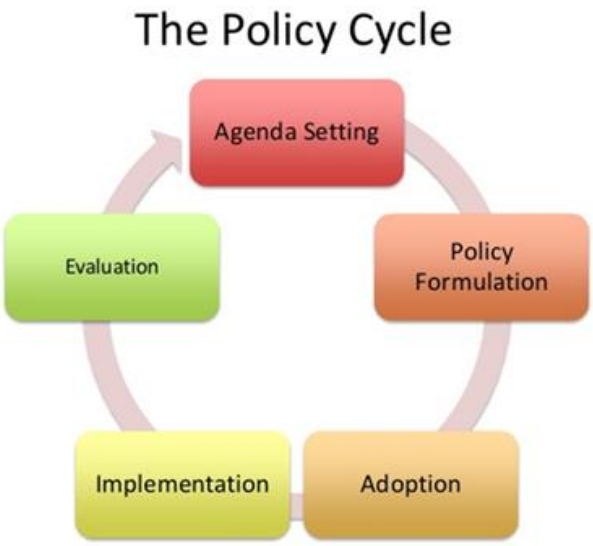


Figure 1:"**Stages heuristic framework** (Lasswell 1956; Brewer and DeLeon 1983)"

Policy Triangle framework (Walt et al, 1994, 2008), which is based on the perspective of political economy, considering how the policy's content, context, process, and actors interact with each other in shaping the policy.(68) (69)

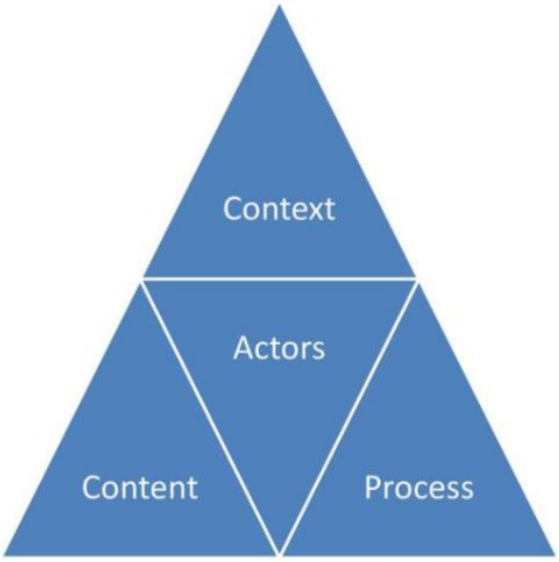


Figure 2: **Policy Triangle framework** (Walt et al, 1994, 2008)

The Social Determinants of Health Framework (World Health Organisation) is used for equitable access of health care (70) (71) and The 3-i Framework (idea, interest, institution), is used mainly in policy development and implementation.(72) (73)

Policy Document Analysis is an approach to analyse the content of policies, their likely success in implementation and impact on intended health outcomes.(74) It is helpful for strengthening future policy development as the analysis determines the limitations, weaknesses and strengths of the current and past policies and also assess the research evidence in policy. However, currently frameworks for conducting policy document analysis are lacking.(75) Quantitative methods systematically quantify the policy information according to predeterminant categories, while the qualitative policy analysis aims to identify key concepts and themes through a systematic process.(74) The most preferred framework for theoretical policy document analysis is the Analysis of Determinants of Policy Impact (ADEPT), based on the concept of von Wright's "logic of events", (76) (77) developed by Trezona et al (75) and Rutten *et al*.(9)

A theory was developed by Gorge Henrik von Wright, a Finnish philosopher, based on the factors that conclude human action and about the reasoning that causes the interplay of these factors (von Wright, 1976). He identified four reasons - wants, duties, abilities, and opportunities, and named them as 'determinants'. The focal point of the hypothesis, was the interaction among the four identified determinants and their different properties, which von Wright called *logic of events*: And he quoted that "As the situations change, creating new opportunities for action, intentions articulate under the already existing wants and duties and within the frame of given abilities, and that every action creates new situations or opportunities that may, in turn prompt subsequent events".(78) (von Wright, 1976).

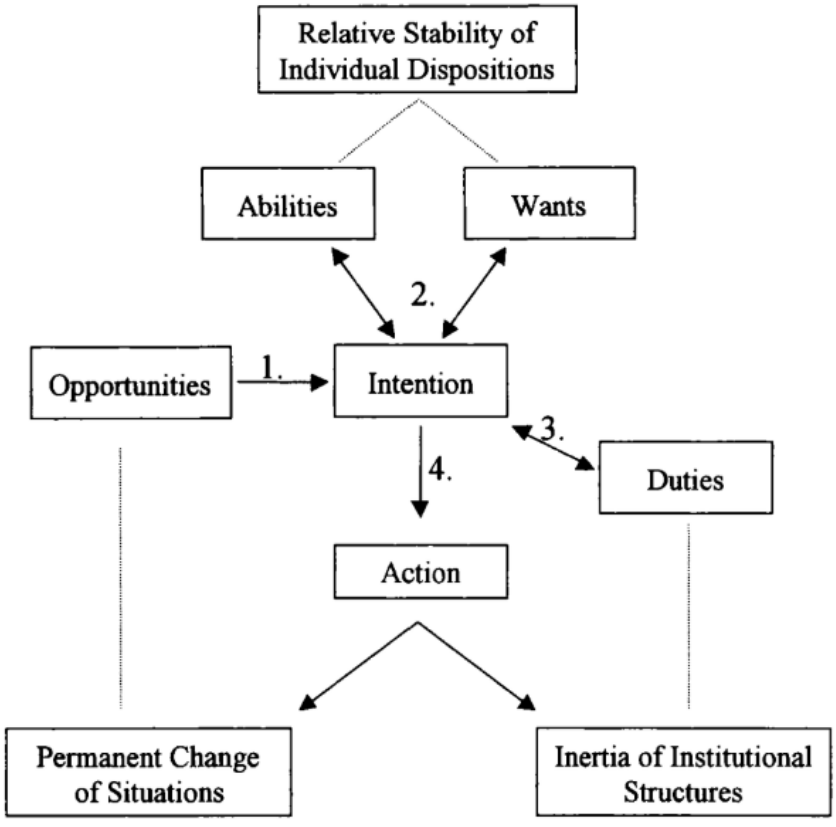


Figure 3: "**von Wright 'logic of events"**. Source: Rütten et al., 2000.

The Analysis of Determinants of Policy Impact (ADEPT) model is an adaption of von Wright's native 'logic of events' theory, for the promotion of health policies. It was formulated in 1996. For enabling the application at organizational/policy level, there was a need of translating the identified determinants from the individual to the aggregated level. This was necessary as the determinants gain complexity in their interpretation when referred in the context of policy action.(79) (80) (81)

Hence, changes were made. Wants re-named as goals; duties as obligations that comprised duties of the policy-makers, policy systems institutional arrangements and effects of that system on the community. Abilities were translated into resources which reflected capacities of policy-makers organizations as well as their individual abilities. The term opportunities remained unchanged and it distinguished three subclasses: organizational opportunities - that emerge due to the changes within the organizations, political opportunities – which appear because of the changes taking outside the organization, such as in political and inter-organizational settings and public opportunities - that come to light from changes in public knowledge, interest and involvement of the population or mass media. Finally, in the ADEPT model, different steps involved in the policy process, such as development, implementation and policy impact can be drawn up as 'dependent variables'. In this context, Policy Impact is defined as "policy output (i.e. the actions taken on the policy level) and outcome (i.e. the health effects on the population level)".(81) ADEPT has been used in policy development and policy analysis in the past and hence is experimentally tested.(77)

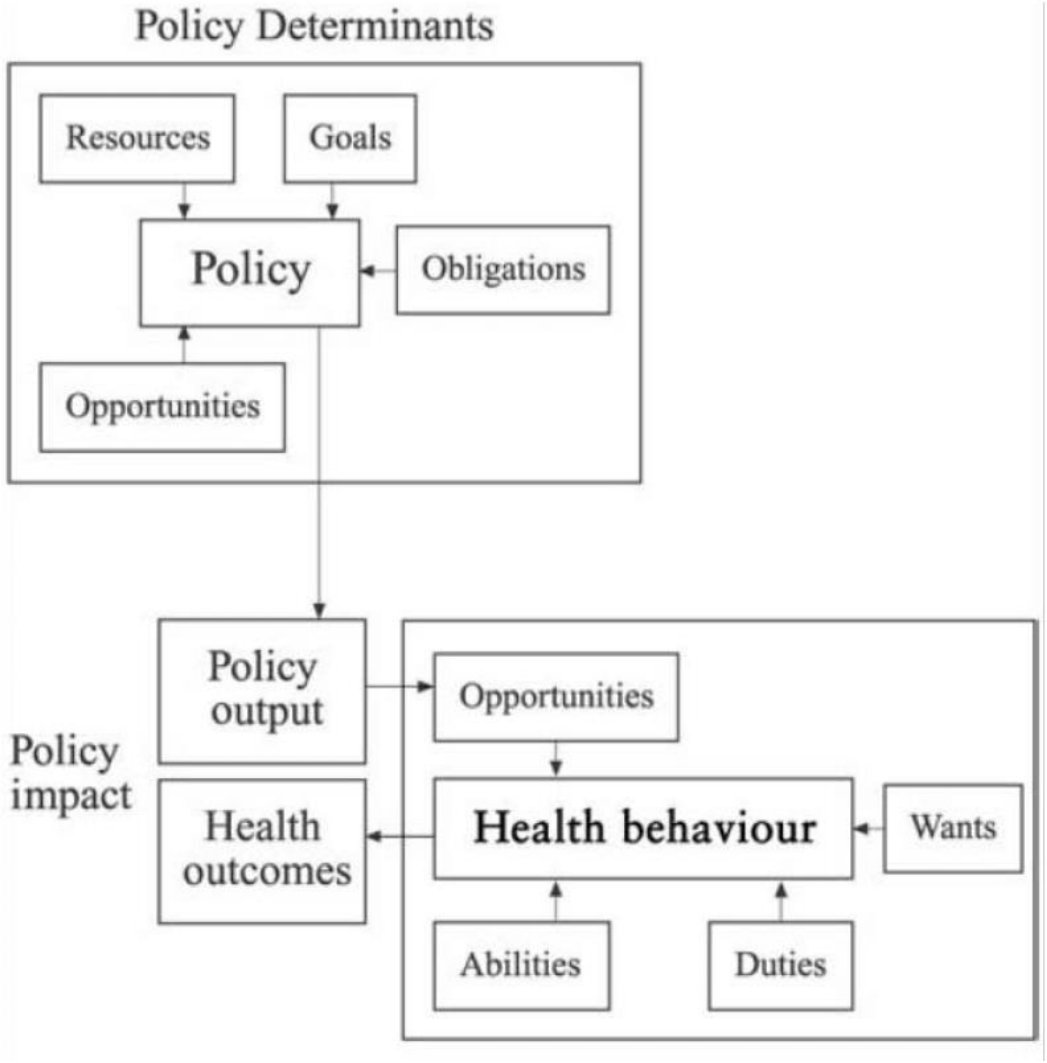


Figure 4:"**logic of events**"

Source: (79)

Table 2. "List of items operationalising ADEPT"

Items
"Policy determinants"
"Goals"
"The goals are officially spelled out"
"The goals are concrete enough"
"The action centres on improving the health of the population"

"Obligations"
"Personally, I feel obliged to do something in this field"
"The action is part of my professional duties"
"Scientific results demand the action"
"We are obliged to the population to act in this area"
"Resources"
"There are enough personnel"
"My organization has the necessary capacities"
"There are sufficient financial resources"
"Organizational opportunities"
"My own involvement has worsened/improved"
"The co-operation within my organization has worsened/improved"
"Political opportunities"
"The political climate has worsened/improved"
"The support from other sectors has worsened/improved"
"The co-operation between political levels involved has worsened/improved"
"The co-operation between public and private organizations has worsened/improved"
"The lobby for the action has worsened/improved"
"Public opportunities"
"The involvement of the population has worsened/improved"
"The population supports the action"
"The media's interest has worsened/improved"
"Policy impact"
"Outcome"

"The action has achieved the intended behavior change in the population"
"Considering cost-benefits, the action was worthwhile"
"Personally, I am satisfied with the results"
"Output"

Source: Rütten et al., 2000a: 73, 83

Method

We chose to evaluate the Policy Document or Guidelines of 'LaQshya Program' to find out the configuration across policy statement and intended outcomes. The framework and the criteria of "von Wright's 'logic-of-events' authenticated by Rütten *et al"* used for this assessment has been taken from the research paper, by K. Katherine, Masoud Mirzaei, Stephen Leeder (2010).(9)

The reason for choosing these pre-defined set of criteria was their easy understanding and convincing interlinking between the 'determinants' of the policy and the policy outcomes. Moreover, it has been proven that this tool is competent for analysing health policies. (8) Rütten *et al*. adapted the logic of events model within the context of health policy to develop a framework for health policy analysis.(82) (76) This framework shapes the determinants as "output of health policies" with components of goals, resources, obligations, and opportunities. This framework was used by Rütten to examine health promotion policies.(82) The utility of this framework is demonstrated in other literature also.(83) Nevertheless, this framework can be adapted for evaluation and document analysis of other policies related to health, as the framework focuses on policy formulation and implementation.

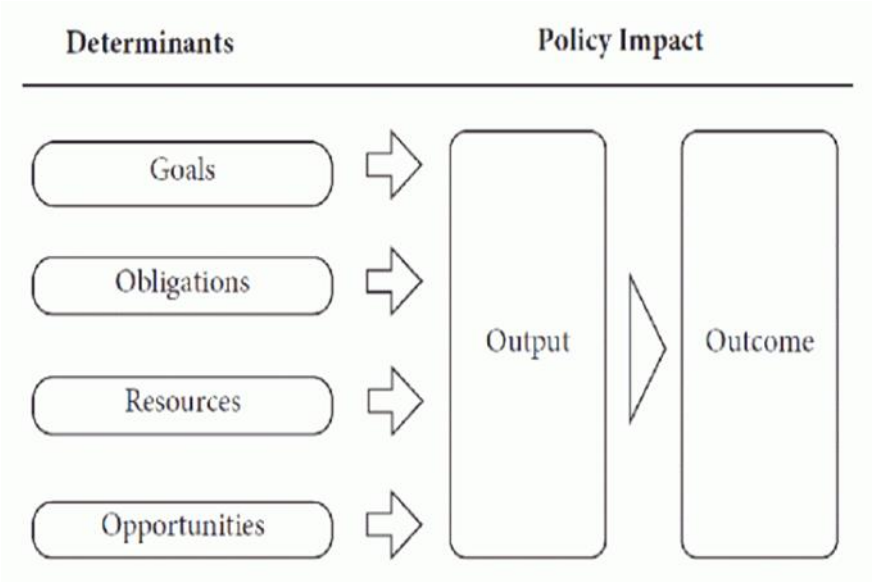


Figure 5:"**The ADEPT model**"

Source: (81)

Table 3: Map of Policy Documents Related to LaQshya Program

"National Health Policies"		
"NHP 1983"	**"NHP 2002"**	**"NHP 2017"**
Five Year Plan		
Seventh (1985-1990) Eighth (1992-1997) Ninth (1997-2002)	Tenth (2002-2007) Eleventh (2007-2012) Twelfth (2012-2017)	The Planning Commission was replaced by Niti Ayogya in 2015
	"National Rural Health Mission" (NRHM) 2005-2012 "National Health Mission" (NHM) 2012-2017	National Health Mission (NHM) 2017-2021

National Programs and GUIDELINES		
• "Child Survival and Safe Motherhood (CSSM)" 1992-1997 • "Reproductive and Child Health (RCH) Phase-I" 1997-2002	• 'Reproductive and Child Health Phase-II' 2005 • "National Accreditation National Board for Hospitals & Healthcare Providers (NABH)" 2006 • "Indian Public Health Standards (IPHS)" 2007 • "Maternal Death Review (MDR)" 2010 ❖ "Maternal Death Review Guidebook" (2010) ❖ "Guidelines for Maternal Death Surveillance & Response" (2017)* • "Child Death Review" (CDR)	• Dakshata Program 2015 ❖ Dakshata Operational Guidelines (2015) (2018)* • Kayakalp Program 2016 • **LaQshya Program** 2017 **"LaQshya Guidelines Labour Room Quality Improvement Initiative" (2017)** ❖ **"LaQshya Quality Improvement Cycles Resource Material" (2018)** ❖ **"LaQshya**

	❖ "Operational Guidelines - Child Death Review" (2014)* • "Reproductive, Maternal, New-born, Child, and Adolescent Health Program (RMNCH+A)" 2013 ❖ "Guidelines for Operationalising First Referral Units" (2004) ❖ "Skills lab Operational guidelines" (2013)* ❖ "Maternal and Newborn Health Toolkit" (2013)* • "National Quality Assurance Program" 2013 ❖ "Operational	**Standard Operating Procedure for District Hospitals" (2018)** ❖ **"Standard Operating Procedures (SOP) for Labour Room and Operation Theatre" (2018)** ❖ **"Maternity OT LaQshya NQAS Assessment Checklist."** ❖ **"Labour Room LaQshya NQAS Assessment Checklist."**

	Guidelines On Quality Assurance (2013)"* ❖ "National Quality Assurance Standards (NQAS)" ❖ "Guidelines for Obstetric High Dependency Units (HDU) and Obstetric Intensive Care Units" (ICU) (2016) (2017)* ❖ "Guidelines for Standards of Labour Rooms at Delivery Points (2016)"* ❖ "Operational Guidelines for	

	Obstetric High Dependency Units (HDU) and Obstetric Intensive Care Units (ICU) (2017)"	
* Guidelines of other National Programs related to LaQshya Program.		

Although, for elaborating the complications of the policy process, several models have been put forward, but no model has come up as superior in respect to simplicity, whose benefits prevail above all others in every circumstances. Instead, the varying weaknesses and strengths of each make some more suitable than others in different situations.(84) In contrast to the health policy process, the models used for policy development are linear in nature, as they outline the process (setting agenda, making decisions, implementation) in a linear manner, while the health policy process rarely has an understanding of this linear style. According to the linear model, "the policy development process is a rational, objective, balanced and analytic one". However, as stated earlier, this model is over simplified, since it describes the complicated policy process in straightforward manner.(85) On the other hand, the 'garbage can' model suggests that "decisions are not

always the result of the logical processes and instead decisions arise from randomly crossing paths taken by participants, opportunities, problems and solutions".(84) An 'Australian Policy Cycle' Model proposes the stages through which the policy development proceeds, that is "issue identification, policy analysis, policy instruments, consultation, coordination, decision, implementation, and evaluation".(86) Adding to the strengths of 'logic of events' model, it recognises the non-static relationship between determinants, which means that the relationship among the determinants varies as the situation changes.(87)

Since the relation between policy documentation and process, was non-linear, a need of amendment of Rütten *et al*. criteria (2003) were felt. After adding and excluding some criteria's, a new framework for analysis of policy document was developed. 16 new criteria (indicated in *italics*) were added. Despite of being strongly relevant to policy context, some of the criteria were excluded from the analysis since assessing them by examining the policy document was challenging. They are marked (**) in Table 4, for example political opportunities.(9)

The explanation given for the amendments made to the "criteria of Rütten *et al"* as follows:

A. "Accessibility" "The document accessibility could be a barrier or facilitator to usefulness and implementation of policy. Stakeholders like senior executives, health service planners and managers, those responsible for direct health service delivery, health providers of care for women with pregnancy and general public are identified as the intended audience for the program."(9)

B. "Policy background" "Policy document encompasses the consideration of scientific results and so the Rütten criterion 'scientific results demand the action' has been incorporated into the section. Sources may be of different types: authority (e.g. person, books, articles),

qualitative or quantitative analysis, deduction (premises that have been established from authority, observation, intuition or all three).”(9)

C. “Goals” “Detailing precise change mechanisms may provoke unnecessary resistance to amendable details and deny achievement of the final goal. Goals should demonstrate consistency, which is associated with dependability. External consistency refers to observations made in other situations that support the policy proposal. Internal consistency refers to inferences logically drawn from the available information.”(9)

D. “Resources” “Rewards or sanctions for spending the allocated financial resource on other programs can affect the likelihood of success of a policy. Organisational capacity criteria were amended to enable assessment.”(9)

E. “Monitoring and Evaluation” “Independent evaluation strengthens the analyses’ credibility. Data collection before and after implementation also increases the credibility of the evaluation.”(9)

F. “Political opportunity” “Assessment of political opportunities is difficult using document analysis. Thus, this criterion was excluded from analysis.”(9)

G. “Public opportunity” “Rütten’s original criteria are difficult to assess using document analysis and have thus been excluded. Other aspects of public opportunities such as stakeholder involvement will be assessed.”(9)

H. “Obligations” “One of the links between goal setting and successful implementation is the development of explicit objectives. It follows that part of this is the clear specification of the obligations of various implementers.”(9)

Other National Health Program policy documents related to LaQshya Program were located

with the help of relevant national health websites and Google. Mapping of documents relevant to LaQshya Program and quality care were lined up to facilitate the analysis and searching (*Table 2*).

Analysis was conducted on the document ***LaQshya Guidelines-Labour Room Quality Improvement Initiative (2017).*** The internal validity of the policy document was evaluated with the help of criteria listed in Table 4. This document was selected because this is a major policy document which deals with reducing maternal mortality, neonatal mortality, and quality care at health facilities by strengthening key processes related to the labour rooms and maternity operation theatres. It also aims at improving quality of care around birth and ensuring Respectful Maternity Care.

Table 4:"Criteria for Analysing Policy Document"

A. "Accessibility"
1. "The policy document is accessible (hard copy and online)"
B. "Policy Background (Source of Health Policy)"
1. "The scientific ground of the policy is established"
2. "The goals are drawn from a conclusive review of literature"
3. "The sources of the health policy are explicit" *I. "Authority (one or more persons, books, scientific articles, or sources of information)"* *II. "Quantitative or qualitative analysis"* *III. "Deduction (premises that have been established from authority, observation, intuition, or all three)"*
4. "The policy encompasses some set of feasible alternatives"

C. "Goals"
1. "*The goals are explicitly stated (The goals are officially spelled out)*"*
2. "The goals are concrete enough (quantitative where possible and qualitative where not) to be evaluated later"
3. "The goal is clear in its intent and in the mechanism with which to achieve the desired goals, yet does not attempt to prescribe in detail what the change must be"
4. "*The action centres on improving the health of the population**"
5. "*The policy is supported by evidence of external consistency in logically drawing a health outcome from the goals and policy outcomes**"
6. "*The policy is supported by internal validity in logically drawing a health outcomes from the goals and Policy outcomes**"
D. "Resources"
1. "Financial resources are addresses (there are sufficient financial resources)"
• *"The cost of condition to community has been mentioned*"*
• *"Estimated financial resources for implementation of the policy is given*"*
• *"Allocated financial resources for implementation of the policy are clear"*
• *"There are reward/sanction for spending the allocated resources on other program*"*
2. "Human resources are addressed (there is enough personnel)"*
3. "Organizational capacity is addressed (my organisation has the necessary capacities)"*
E. "Monitoring and Evaluation"
1. "The policy indicated monitoring and evaluation mechanism"
2. "The policy nominated a committee or independent body to perform the evaluation"
3. "The outcome measures are identified for each of the explicit and implicit objectives"
4. "The data for evaluation collected before, during and after the introduction of the new policy"
5. "Follow up takes place after a sufficient period to allow the effects of policy change to become

evident"
6. *"The other factors that could have produced the change (other than policy) identified**"*
7. *"Criteria for evaluation are adequate or clear"*
F. "Political Opportunity"**
1. "Co-operation between political levels involved (federal, state, area health) has either worsened or involved**"
2. "Support from other sectors (economy, science, justice) has either worsened or improved**"
3. "The political climate has either worsened or improved**"
4. "Cooperation between public and private organizations has either worsened or improved**"
5. "The lobby for the action has either worsened or improved**"
G. "Public Opportunities"
1. *"Multiple stakeholders are involved"*
2. *"Primary concerns of stakeholders recognised and acknowledged to obtain long term support"*
3. "The Media's interest has either worsened or improved**"
4. "The population supports the action**"
5. "There is media's interest**"
H. "Obligations"
1. *"The obligations of the various implementers are specified – who has to do what"*
2. "The action is part of health professionals existing duties**"
3. *"The scientific results are compelling for action**"*
4. "Health professional obliged to the population to act in this area**"
** Excluded criteria * Rephrased or extended criteria (original Rütten criteria)

Table Source: (9)

Results

Table 5. summarises the LaQshya Program policy document analysis using the criteria described in the Method section (Table 4). Criteria were considered 'Fulfilled/Strong' if all the mentioned criteria were addressed, 'Room for improvement' if some criteria were addressed and 'Not fulfilled/Weak' if no criterion was addressed."(9)

A. "Accessibility"

1. "The policy document is accessible (hard copy and online)"

The document was accessible online from The MoHFW website, (https://main.mohfw.gov.in) (Home » NHM Components » RMNCH+A » Maternal Health » Guidelines- MH);(88) NHM website (https://nhm.gov.in);(89) NHSRC website (http://nhsrcindia.org);(90) National Health Portal website (https://www.nhp.gov.in); (91) and freely on 'Google'.

The hard copy of the policy document was accessible to the stakeholders like senior executives of national resource team, state nodal officers and managers, since for them in the 'Preparatory Phase of Activities' of the guidelines, workshops have been included. "…. workshops for national resource team and state nodal officers."(50) It is unclear about the accessibility of the hard copy for the parties at district level, who are directly responsible for providing healthcare services, for instance, health providers in labour rooms and maternity OT, as for district stakeholders only about conveying instructions for conducting various activities has been mentioned. "…. issuing instructions" is mentioned.(50)

B. "Policy Background (Sources of Health Policy)"

1. *"The scientific grounds of the policy are established"*

Yes, the background of the policy is based on the scientific evidences. The NHP 2002 (92) states, "NHP-2002 envisages the identification of specific programmes targeted at women's health". "The various Policy recommendations of NHP-2002, will facilitate the increased access of women to basic health care." This is related to upgradation of primary health centres (PHCs) infrastructure, provision of drugs, trainings to medical and paramedical manpower and simplified rules and procedures for hiring skilled workforce on contractual basis in order to overcome the shortfall of human resources.(92)

The National Health Policy (NHP) 2017 (93) states "There is need to evolve and disseminate standards and guidelines for all levels of facilities and a system to ensure that the quality of healthcare is not compromised." "The policy strongly recommends strengthening of general health systems to prevent and manage maternal complications, to ensure continuity of care and emergency services for maternal health." Furthermore, the policy recommends "creating a robust independent mechanism to ensure adherence to standard treatment protocols, a scheme to develop comprehensive facility development with human resources and specialist skills." Finally, the policy initiatives aim for "measurable improvements in quality of care as the public hospitals and facilities would undergo periodic measurements and certification of level of quality".(93) (94) In addition the guideline states, "…. 'patient-centric' care is expected to be based on the available scientific evidence."(50)

2. *"The goals are drawn from a conclusive review of literature"*

Yes, the goals are drawn from conclusive review of literature. For example, peer reviewed journal articles (both qualitative and quantitative), bring up some of the main issues which need attention for reducing MMR and IMR. (95) (96) (97) (98) (99) (100) (101) (102) These papers clearly highlight that the direct obstetric causes during antepartum and

postpartum period are the main contributors of maternal deaths. For example, postpartum haemorrhage, pregnancy induced hypertension, sepsis, complications during labour and from obstetric surgery . The high burden of mortality was noticed in those areas where the capacity of the health-facilities to provide routine and emergency obstetric care was insufficient in terms of infrastructure, human resources, supplies and skilled healthcare providers. The articles also mention about the ill-treatment the pregnant women are subjected to at the time of labour and childbirth. They face disrespect and abuse, overtreatment and under treatment at the time of birth process.

3. "The sources of the health policy are explicit (Authority, Qualitative or quantitative analysis, Deduction)"

The background of the policy is 'sound", as the sources used by the policy makers are straightforward. The MoHFW, Government of India holds the authority of the document. The qualitative or quantitative analysis was conducted prior to the development of the guidelines as the policy makers quote in their address block of the policy document, about the percentage of institutional maternal and neonatal deaths that contribute to countries Maternal and Neonatal Mortality Rate. "…. approximately 46% maternal deaths, over 40% stillbirths and 40% neonatal deaths take place on the day of delivery."(50)

Expert opinions and observations based on collected data, and intuitions from reference groups like WHO, USAID, UNICEF, Jhpiego, IPE Global, Bill & Melinda Gates Foundation (BMGF), Access Health International, National Health System Resource Centre (HNSRC), Advisors and Consultants from Policy Division, Maternal Health Division, Child Health Division, Quality Improvement Division along with the administrative officials from the MoHFW had also contributed in the development the policy document.(**Annexure 1**)(50)

4. "The policy encompasses some set of feasible alternatives"

Policy Document "A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India" 2013,(103) is yet another example which proves that earlier also MoHFW, MCH Division, had developed evidence based guidelines for, RMNCH+A Program with the help of Developing Partners and External Agencies.

C. "Goals"

1. "The goals are explicitly stated (officially spelled out)"

Yes, the goals are stated explicitly, and spelled out in the policy document. For example, "…. reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery in labour room and maternity OT and ensure respectful maternity care."(50)

2. "*The goals are concrete enough (qualitative where possible and quantitative where not)"*

No, the goals are not concrete enough, as it is not clear how much percentage of reduction in MMR and IMR and in what time period this change is expected to take place after the implementation of the intervention.

3. "*The goals are clear in its intent and in the mechanism with which to achieve the desired goals, yet does not attempt to prescribe in detail what change must be"*

Yes, the purpose of the goal in mentioned clearly, however, the mechanism with which the desired goal is to be achieved is not explained adequately. The reason being that the strategies underlined are not in alignment with the stated objectives. For instance, no strategy is stated in reference to the objective "…. provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility."(**Annexure 2)**(50)

Moreover, the activities related to RMC are provided in an annexure form at the end of the document, instead of mentioning them in detail with the other activities in the 'Intervention Section'. (**Annexure 3**)

4. "The action centres on improving the health of the population"

Definitely, the action of the goal is centred on improving the health of the population since 46% maternal deaths, over 40% stillbirths and 40% neonatal deaths take place during delivery can be prevented through this intervention.(50)

5. "*The policy is supported by evidence of external consistency in logically drawing a health outcome from the goals and policy outcome"*

Yes, the policy is supported by evidence external from the organization, e.g. Indian Health System. It is evident that over the past years, other neighbouring Middle-Income Countries (MICs) like Sri Lanka, Bangladesh, and Malaysia, have been successful in reducing MMR and IMR to a significant level after adopting some of the interventions including in the LaQshya document.(104) (105) (106) (107) For instance, by upgrading quality of healthcare services through good infrastructure, skilled healthcare professionals, sufficient human resources, and supplies; and including respectful maternal care during antenatal and postnatal routine and emergency obstetric care at all levels of health system. In Sri Lanka, the MMR has reduced from 405 in 1955 to 45/1lakh live births in 2005 and from 38 in 2010 to 36/ 1 lakh live births in 2016,(104) (108) while IMR has declined from 68.7/1000 live births in 1960 to 14.4 in 2000 and further to 8.0/1000 live births in 2016.(109) In Bangladesh, MMR has reduced from 434 in 2000 to 186/1 lakh live births in 2016,(110) while IMR has reduced from 40.5/1000 live births in 2009 to 29.3/1000 live births in 2016.(111)

6. "The policy is supported by internal validity in logically drawing a health outcome from the goals and policy outcomes

Yes, the policy is supported by internal consistency. For example, a pilot intervention was conducted in Kerala, India, in 2013, to sustain and accelerate the reduction of IMR and MMR during antepartum and postpartum care in health facilities. The intervention was based on four-pronged strategy (RAFT Model). The RAFT Model is explained as, "R - Review of maternal records (death certificates or autopsy reports of mothers); A- access to quality and respectful healthcare to women; F - funding for infrastructure, medicines, and interventions in labour room; and T - training of personnel" . And it was found that after the adaption of RAFT Model, deaths related to postpartum haemorrhage reduced from 20.4% in 2010-11 to 9.4% in 2015-16, also deaths related to pregnancy induced hypertension declined from 14.1% in 2010-11 to 12.3% in 2015-16. (112) (113)

D. "Resources"

1. "Financial resources are addressed (there are sufficient financial resources)"

Limited aspects of the financial resources are disclosed. What cost to the community would have to bear has not been mentioned. There are no details about the expenditure the government would have to bare in order to improve the multiple indicators related to Morbidity, Maternal Mortality Ratio, and Neonatal Mortality Ratio. Moreover, how much overall financial loss a family, community and the national would have to suffer when a maternal death and a neonatal death occurs has also not been taken into account in the document.

For the execution of the interventions, no prior estimates, and limitations of funds are given. Nevertheless, the allocation of the financial resources for the implementation of the program from the Programme Implementation Plans (PIPs) has been highlighted. It is very clearly stated that "…. states make a robust plan for the initiative and submit their requirements in Annual Programme Implementation Plans (PIPs)." The policy document also suggests list of activities for the budgetary support under section 'Financial

Arrangements' through PIP proposals under National Health Mission (NHM) (**Annexure 4**).(50)

There is no provision of sanctions or rewards for utilizing the grant resources elsewhere as the policy clearly defines about facilitating funds on demand for the requirements specific to fulfil the implementation of this initiative only.

2. *"Human resources are addressed (there are enough personnel)"*

The human resource component is not addressed. There are only recommendations of how much minimum staff is needed in labour rooms and maternity operation theatres (OT) at every level of health facilities according to the case load and prevalent norms (**Annexure 5**).(50) There is also a mention about architects/planning consultants for labour room redesign, but their availability has not been specified. Therefore, it is not clear whether there is sufficient workforce for conducting various activities of the program or not.

3. "Organizational capacity is addressed (my organisation has the necessary capacities)"

The Organizational capacity is addressed. For example, for strengthening and upgrading infrastructure by initiating new constructions, re-designing and standardizing Labour Rooms and Obstetric OTs,(114) Obstetrics High Dependency Units (HDU) in District Hospitals and Obstetric Intensive Care Units (ICU) in Medical Collages,(115) Maternal and Child (MCH) Wing,(116) (117) including adequate equipments, medications, and other supplies as per MoHFW Guidelines to meet the National Quality Assurance Standards (NQAS).(118) (119) (120) From the document it is not clear that how many health facilities across the country had been previously upgraded and certified and how many are expected to get NQAS Certification through this program.

E. "Monitoring and Evaluation"

1. "The policy indicated monitoring and evaluation mechanism"

Yes, an elaborate mechanism of monitoring and evaluation of the program under sections 'Institutional Arrangements', 'Phasing of Activities' and 'monitoring and Reporting' using a standardised methodology is mentioned in the policy document.

An 'Institutional Framework' comprises of Quality Assurance Committee or mentoring groups at all levels (National, State, District, Facility) for monitoring and supporting implementation of the program.

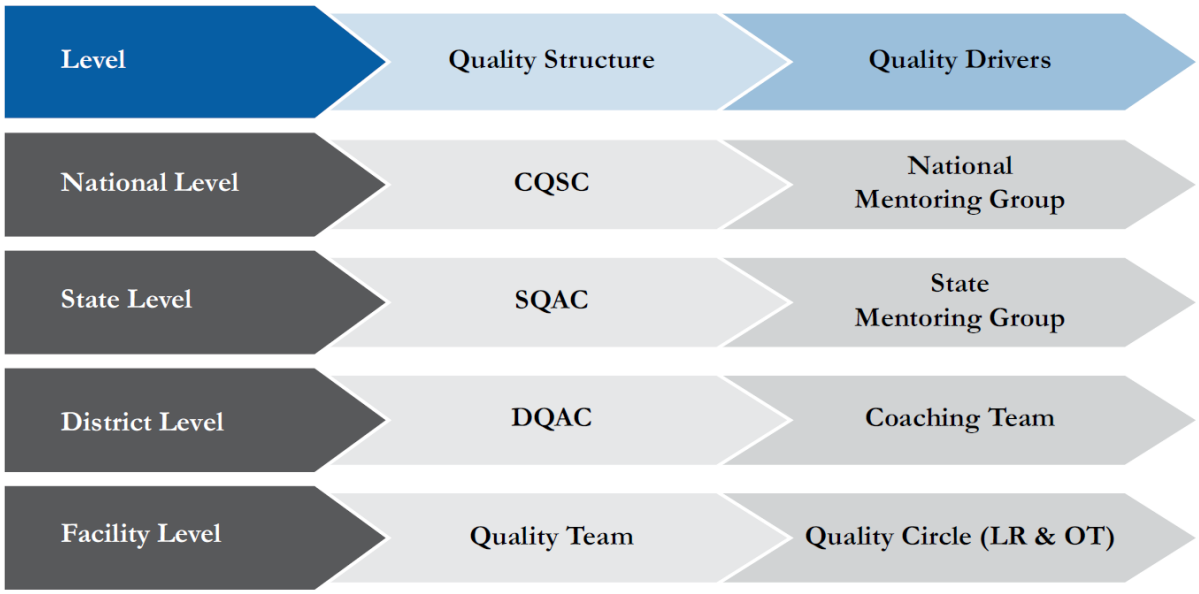


Figure 6: Institutional Arrangement

The 'Phasing of Activities' guides to carrying out program activities in different time bound phases.

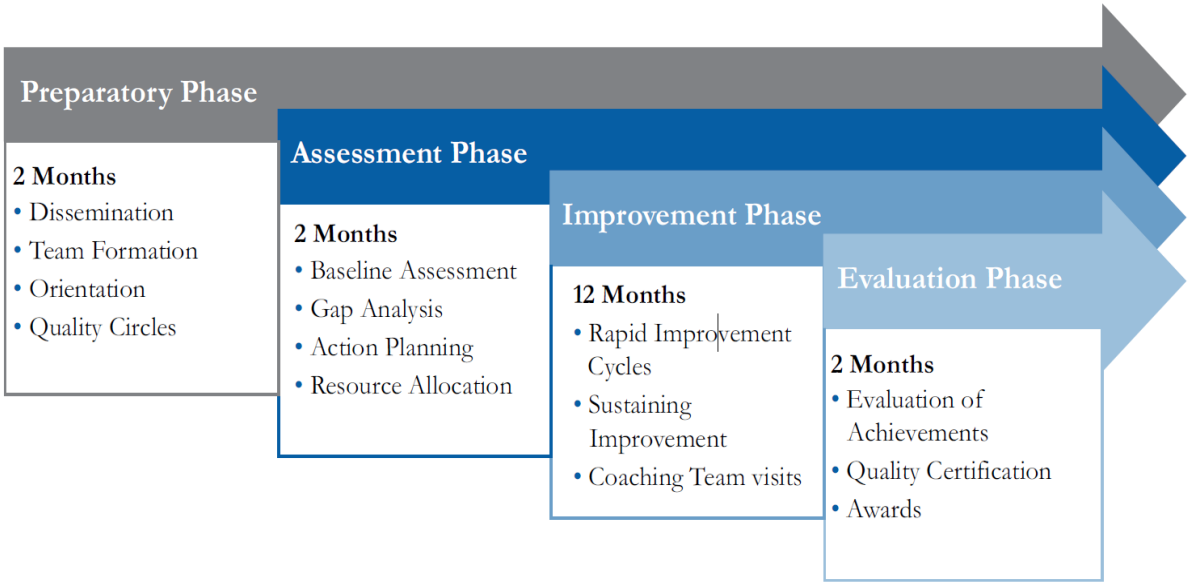


Figure 7: Phasing of Activities

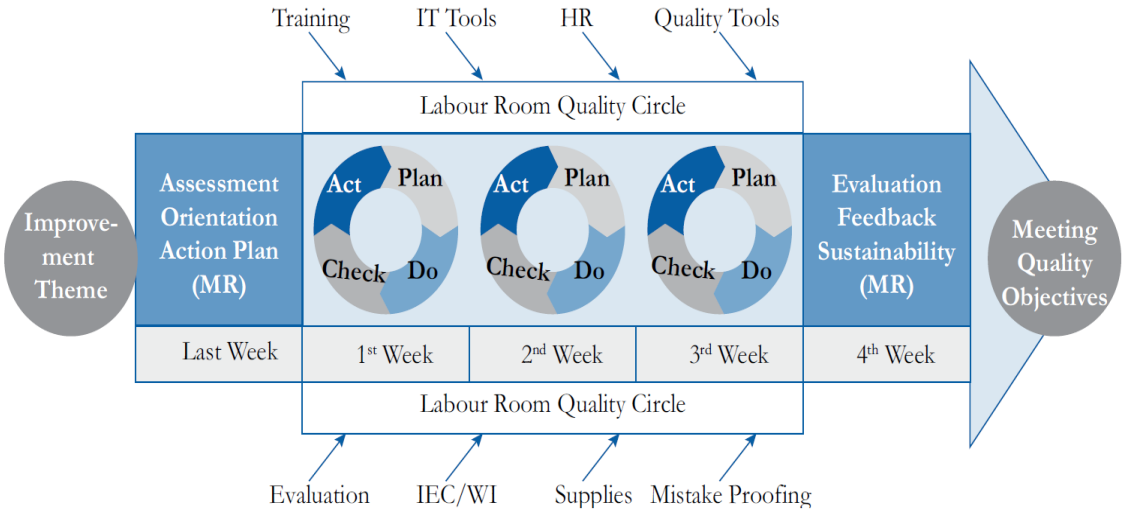


Figure 8: Plan-Do-Act-Analyse Cycle (Quality Cycle)

'Monitoring and Reporting' section describes about continuous monitoring of program activities such as assessments and visits of coaching teams during Assessment and Improvement Phases through a dedicated web-based tracking system. e.g. 'LaQshya Web Portal'.

2. "The policy nominated a committee or independent body to perform the evaluation"

At the National Level, the policy has nominated the "Central Quality Supervisory Committee" (CQSC), while at the State Level, "State Quality Assurance Committee" (SQAC) and External Assessors empanelled with NHSRC would carry out the process of evaluation.(50)

3. "The outcomes measures are identified for each of the explicit and implicit objectives"

Yes, the outcomes measure only for the explicit objectives have been identified, as there are no implicit objectives included in the document. How much percentage of an objective(s) is to be achieved in order to reach the intended outcome are enlisted in detail under two different headings, first in the 'Facility Level Targets for Incentives' (**Annexure 6**) and second in the 'Certification, Incentives and Branding Section'(**Annexure 7**) of the document.

4. "The data for evaluation, collected before, during and after the introduction of the new policy"

The data for the evaluation is supposed to be collected once the new policy has been introduced in the health system. First time data is scheduled to be collected during the 'Assessment Phase' for the baseline assessment and gap analysis. Thereafter, completion of each Quality Cycle (six Quality Cycles at an interval of two months). The Quality Cycles are included in the 'Improvement Phase'. This data is utilized for monitoring and concurrent performance evaluation of quality indicators by the SQAC. Finally, the data is collected in the end of the program, during the 'Evaluation Phase' for evaluating the quality objectives and indicators (Fig 3).

All the data collected is uploaded in the tracking system, known as 'LaQshya Web Portal' which facilitates the evaluation process. The portal also contains all the guidelines, resource material, latest information, and progress reports relevant to the program.

5. "Follow up takes place after a sufficient period to allow the effects of policy change to become evident"

Yes, there is sufficient time given for the follow up to be carried out, and to visualise the results which have taken place in the policy. and to permit the effects of the policy change to be evident. The follow up is initiated in the form of monitoring and surveillance. Once health facility meets the assessment criteria of the Labour Room & Maternity OT Checklists, (**Annexure 8 & 9-Excel Sheets**), it is certified with Quality Certification. The external assessment is conducted by NHSRC, through the empanelled external assessors. The validity of the Certification is 3 years. The health facilities would have to get their scores verified of the scores every year by the State Quality Assurance Committee. (**Annexure 7**)

6. "Criteria for evaluation are adequate and clear"

Yes, the criteria for the evaluation are adequate, clear and are well aligned with the objectives. The evaluation is based on facility level quantitative indicators and quality objectives.

- Qualitative Indicators/Targets – are used for evaluation after completion of each Quality Cycle. These targets are detailed in 'Target Section' (Annexure) and the other set of indicators are used at the time of final evaluation of the program implementation, which are detailed in 'Facility Level Targets for Incentives'.(**Annexure 6**)

- Checklists – for NQAS, the "Labour Room & Maternity OT Checklists", have been developed. These are used as tools for the assessment and certification of the health facilities.(**Annexure 8 & 9-Excel Sheets**)
- Criteria for Incentivisation and Branding – there are different criteria's used as evaluators for providing incentives and branding to the teams working in Labour Rooms and Maternal OTs at Medical Collages, District Hospitals (DHs) and Community Health Centres (CHCs).(**Annexure 7**).

G. "Public Opportunities"

1. "Multiple stakeholders are involved"

Yes, multiple stakeholders have participated in the policy document development of the policy document and for the implementation of the program. Several Developing Partners, External Agencies, and members of the MoHFW were involved. List of contributors is enclosed in **Annexure 1**. Medical Collages, District Hospitals and Community Health Centres, Quality Assurance Committees, and mentoring groups at all levels (National, State, District, Facility) are some of the main stakeholders involved as implementers.

2. "Primary concerns of stakeholders recognised and acknowledged to obtain long term support"

The importance of multiple stakeholders involvement is acknowledged as the document enlists the names of all the contributors, who had helped in the development of the policy document (**Annexure 1**). According to the statements of the policy makers in the document, "The Ministry of Health and Family Welfare, NHSRC and our developing partners have put their heart and soul into the development of these guidelines.", "….for their valuable inputs", "…. proficient team." The included stakeholders were experts from

various departments of MoHFW and non-government organizations.(50)

It is also evident that most of the stakeholders involved in formulating this guideline have been providing their services and supporting MoHFW in developing policy documents for other MCH programs over the years.(121) (116) (122) Technical Supporters like NHSRC would further be helping in the evaluation of the objectives of the LaQshya program by empanelling External Assessors.(50)

H. Obligations

1. The obligations of the various implementers who was to do what

The main commitments of the various implementors are highlighted in a very appropriate manner in section 'Roles and Responsibilities' (**Annexure 10**), elaborated in 'Action Plan' (**Annexure 11**) with respect to phases of implementation and time limitation. The parties to whom implementers are held accountable were also specified.

Table 5: Summary of Result.

Criteria	Fulfilled	Room for Improvement	Not fulfilled
A. Accessibility			
B. Policy Background			
C. Goals			

D. Resources			
E. Monitoring & Evaluation			
G. Public Opportunity			
H. Obligation			

Discussion

Almost three years ago, on 11th December 2017, the MoHFW, Government of India, had launched program LaQshya. A few of the set criteria were accomplished by the policy document **LaQshya Guidelines-Labour Room Quality Improvement Initiative (2017).** Policy background, Public Opportunities and Obligations were the greatest strengths. Considering the magnitude of the project, there are opportunities or scope for the improvement of the policy documentation. Accessibility, Goals, Resources, and Monitoring and Evaluation were some of the areas identified and included in opportunities through the use of the modified criteria of Rütten *et al*.

The criteria may be contemplated as a 'checklist' that allows policy makers to judge how closely policy intentions are reflected in their documents. Moreover, the benchmarks can specifically give an insight of how policy documents may be modified after taking into account lessons learned from the previous experiences of failures and successes. The successful implementation of any program depends on its documentation; hence a strengthened policy can potentially increase the likelihood of desired outcomes.

In terms of Accessibility, the policy document is freely available on multiple government websites, however, anyone who does not already know how to reach for the various sections within these websites and where the document might be found, would have difficulty in finding it. As far as accessibility of the hard copy is concerned, it was not clear whether service providers at district level had accessibility or not, since no formal training in context to the program was scheduled for them. In contrast, an orientation workshop for the national and state nodal officers was planned. Nevertheless, in-cooperating training or orientation program for all the stakeholders involved at every level would have helped in dissemination of concise and accurate information regarding different aspects of the initiative, like the interventions, roles and responsibilities; encouraged their confidence and helped them to adapt faster to the target approach and finally receive a hard copy of the policy document to consult during implementation phase whenever needed. On the whole, training would contribute to a more effective and productive workforce.

A policy can be strengthened by setting suitable goals. The goal stated in the document is clear in its aim and did not strive to reveal their details. Although, according to the Rütten *et al* framework questionnaire, the goal is satisfying some benchmarks of policy analysis, leaving some space of improvement. The goal could be concrete, if stated as 'S.M.A.R.T' (Specific, Measurable, Attainable, Relevant, Time-bound) which would help in specifying how much percentage of reduction in MMR and IMR is intended and in what time period is this change expected to take place to get close in achieving the committed Sustainable Development Goals (SDGs) (3.1 & 3.2) after the program implementation. Furthermore, the language used to describe the desired goal could have been more interconnected and descriptive. This would further help implementers for better understanding and correlating each objective with its outlined strategies and activities during implementation process.

Document conciseness forces one to suspect that the details of the policy document in respect to goal process and statistical analysis have been investigated comprehensively somewhere else, such as in internal documents of the Ministry, and have been excluded intentionally from the policy document owning to briefness. Some example statements from the document are "Majority of the interventions under the initiative have been drawn from the existing programme guidelines such as Maternal Death Review (MDR) and Child Death Review (CDR) Guidelines…." or "…. guidelines are already in place to guide to our efforts in this direction." Therefore, many more guidelines related to other National Programs (*Table 2*) need to be searched externally to get an overall insight of the goal mechanism of the intervention. Therefore, a detailed policy document would be appropriated for better understanding and implementation of the program. With regards to data and statistical analysis, it may be such details are not schemed for public access as the data is not transparent. However, providing entrance to the details related to the policy and its materials relevant to it would be useful for the researchers and external evaluators.

The criteria for the financial resources are not completely communicated in the document. The reason for not mentioning priorly the estimates and limitations of financial resources for the policy implementation may be that firstly, there was no insight regarding how much funds would be needed to successfully implement the program, as the gap analysis of the health facilities was not initiated prior to the program implementation, instead was included as one of the activities in the intervention. Secondly, the government intends to provide budgetary support mainly to bridge the identified gaps under certain headings such as infrastructure, supplies, human resource, trainings, etc and this is feasible only when the gap analysis is completed and the demand is generated after the preparation of the action plan.

Moreover, it is not clear that why there are no provision for paying out of assigned

resources on other projects. This may be due to the fact that since this program is focused to address one of the biggest challenges the government is striving to achieve, that is SDG (3.1 & 3.2) by 2030, by reducing MMR and IMR. The MoHFW intends to put all its available resources for this program exclusively. Furthermore, the allocated financial resources for healthcare are also limited, as India spends only 1.28% (2017) of the its Gross Domestic Product (GDP) on healthcare.(123) Therefore, to avoid financial constraints during the program implementation, allocation of resources to the other programs might have been restricted. Secondly, the budget is being provided through NHM PIPs, were the funds are requested with justification under relevant financial heads to maintain transparency, clarity in allotment and expenditure and to maintain sufficient resources to fulfil the desired outcomes of the programs. And within the PIP there is no flexibility of using grants for any other activity. Under special circumstances, the funds can be re-allocated to other programs only after seeking permission from the MoHFW, NHM Division.(124)

It is unclear about the progress of the program (in terms of recurrent funding, expenditure, human resources, equipment and supplies, and infrastructure) since the 'LaQshya Web Portal' where all program related data is uploaded is password protected and therefore, the data is not available on public domain.(125) Improved access to 'LaQshya Web Portal' would be helpful in finding detailed data for human resources, recruitment status and whether the resources are sufficient or not. Although, the policy recommends the States for independent redeployment or recruitment of new staff in case of shortfall, it is unknown whether there is availability and willingness of the required personnel in the market to join the public health sector. In addition, this information would be useful in planning the future strategies and assignment of resources to execute obligations, which are advanced by incentives and honour.

Almost three years ago, the timeline for implementation and performance evaluation was

set for 18 months. However, till date no data in any form e.g. evaluation report, health survey, journal paper is available to help evaluate the effects of policy change, except for a report of Certification Status which is available at NHSRC website,(126) The Certification Status Report acknowledges that 184 health facilities from 23 states have been certified under NQAS, through LaQshya Program. Out of 184 health facilities, 75 have been certified as 'conditionality'. It is not clear that under what circumstances or criteria these hospitals have been certified as 'conditionality' since the policy document does not mention any such benchmark. (**Annexure 12-Excel sheet**).

Although, Public Opportunities and Obligations meet the Rütten et al framework questionnaire criteria, the process of policy development, or how regular the meetings were held, and during which period of policy process the advice from the stakeholders was obtained is not evident as no documentation regarding any of such procedure is available on any government or developing partners website.

Therefore, with no concrete data, it is impossible to conclude whether the outcomes of the program had any impact on the maternal and child health indicators

This study was endeavoured to evaluate the policy document restraining public and private health service provision for maternal and child health. In addition, this is an attempt to advance the positioning of standards for backdated appraisal of the policy document's internal validity in an Indian context. Moreover, these criteria can also be utilized for future appraisals, and can be helpful in strengthening the health policies during the development phase by priorly reviewing the evaluation phase of the policy proposals.

Conclusion

The Guidelines of LaQshya Program have less strength and more room of improvement with no weakness when assessed against a set of analysis criteria. Since, implementation

of LaQshya Program is dependent on many other parallel ongoing programs, mapping of the documents relevant to LaQshya Guidelines proved to be important in obtaining a complete picture of the policy document. However, document analysis of those programs is also necessary for effective implementation of the LaQshya initiative.

Attachments


Annexure 1 Contributers.docx


Annexure 2 Goal, Objectives and Strate


Annexure 3 RMC.docx


Annexure 4 Financial Arrangements.docx


Annexure 5 Human Resource.docx


Annexure 6 Facility Level Targets.docx


Annexure 7 Certification, Incentive


Annexure 8 Labour Room Laqshya NQAS


Annexure 9 Maternity OT Laqshya NQAS As

Annexure 10 Roles and Responsibilities.d

Annexure 11 Action Plan.docx

Annexure 12 Certification Status.xls

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