Summer Internship Report

At

Piramal Swasthya Foundation



(May 1st – June 30th, 2025)

By

Kokil Agrawal (PG/24/030)

Mentor Dr. Sumant Swain

PGDM (Hospital and Health Management)

2024-2026



International Institute of Health Management Research, New Delhi

Certificate of Approval

The Summer Internship Project titled "**Effectiveness of Compassionate Leadership Intervention in Public Healthcare for Improving Health Outcomes in Bihar: A Rapid Review"** at **"Piramal Swasthya"** is hereby approved as a certified study in management carried out and present in a manner satisfactorily to warrant its acceptance as perquisite for the award of Post Graduate Diploma in Health and Hospital Management for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein but approve the report only for the purpose it is submitted.



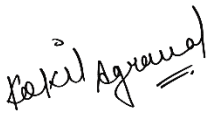
Dr. Sumant Swain

Assistant Professor

IIHMR, DELHI

ACKNOWLEDGEMENT

My internship with Piramal Swasthya Foundation in Bihar was an incredibly rewarding experience. It provided a wealth of opportunities for learning and professional growth. I'm incredibly grateful to have been a part of it. I had the privilege of working with some amazing people throughout the internship. I'd like to express my sincere gratitude to **Dr. Tanmay Mahapatra (Director, Data and Learning, Piramal Swasthya Management and Research Institute), Mr. Nayakanti Srinivas Reddy,** and **Mrs. Suchi Sree Akhouri** for their invaluable guidance, support, and for providing the resources I needed to succeed with my project. Their insightful decisions and willingness to help made a real difference. Thanks, are also due to **Md. Irshad Ali** for his supervision, and to **Mr. Saurabh Kumar, Mr. Kunal Roy and Mr. Ashish Kashyap** for their assistance and data analysis guidance. I'd also like to extend my deepest gratitude to **Dr. Sutapa B. Neogi (Director, IIHMR Delhi), Dr. Sumesh Kumar (Associate Dean Academics and Student Affairs, IIHMR Delhi) and Dr. Sumant Swain (Associate Professor, IIHMR Delhi)** at IIHMR Delhi. Their careful and insightful guidance throughout my studies has been incredibly valuable to my development in theory and practice. This internship has been a major stepping stone in my career. I'm committed to using the skills and knowledge I gained to their fullest potential, and I'll keep working to improve them as I pursue my career goals. I hope to have the opportunity to collaborate with all of you again in the future.



Sincerely,
Kokil Agrawal
PG/24/030

(Completion of Summer Internship from Piramal Swasthya)

The certificate is awarded to

Name: Kokil Agrawal

In recognition of having successfully completed her internship in the department of

RMLE

and has successfully completed

her Project on Title of:

Effectiveness of Compassionate Leadership Intervention in Public Healthcare for Improving Health outcomes in Bihar: A Rapid Review

Date: 30/06/2025

Organization: Piramal Swasthya Management and Research Institute

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish her all the best for future endeavors

Organization Supervisor



Director Data & Learning

Core Team Member

Research and MLE

FEEDBACK FORM

(Organization Supervisor)

Name of the Student: Kokil Agrawal

Summer Internship Institution: Piramal Swasthya Management and Research Institute

Area of Summer Internship: Effectiveness of Compassionate Leadership Intervention in Public Healthcare for Improving Health Outcomes in Bihar**.**

Attendance: Perfect adherence to Internship norms.

Objectives met: Learnt Literature Review, Evidence Table Generation, Epidemiological Concepts, Reference Management Data cleaning and Management, Variables, Descriptive Analysis, Determining the Themes and Sub-themes and Thematic extraction of Information from Qualitative Data.

Deliverables:

- Desk Review on Effectiveness of Compassionate Leadership Intervention in Public Healthcare for Improving Health Outcomes in Bihar.
- Generate Evidence Table
- Literature Review
- Field Visit
- Health and Wellness center visit
- Acquire a basic knowledge in S.A.S.
- Worked on project titled “SOGI”

Strengths:

During this period, she displayed very good adherence to protocols, ready wit, learning spree, punctuality, clarity of understanding, proactiveness, teamwork, commitment, sincerity and diligence with analytical progress. Based on her learning abilities and efforts, it appears that, given the level of effort and aptitude she has, if given chance she can become a very strong performer in the public health research and implementation sector of India.

Suggestions for Improvement:

Scientific writing, programmatic knowledge, advance analytics.

Signature of the Officer-in-Charge (Internship)

Date: 26/06/25

Place: Patna

FEEDBACK FORM

(IIHMR MENTOR)

Name of the Student: Kokil Agrawal

Summer Internship Institution: Piramal Swasthya Management & Research institute.

Area of Summer Internship: Effectiveness of Compassionate leadership intervention in Public healthcare for improving health outcomes in Bihar.

Attendance: Perfect adherence to ~~Apprenticeship~~ norms.

Objectives met: Learnt literature review, Evidence Table Generation, Epidemiological concept, Reference management, Data cleaning & Management, Variables, Descriptive Analysis Defining the themes & Subthemes & Thematic extraction.

Deliverables: DESK Review
Generate Evidence table
Feild visit
Acquire basic knowledge in SAS

Strengths: During this Period, she displayed very good adherence to protocols, ready wit, learning spree, punctuality Clarity of understanding, Proactiveness, team work, Sincerity

Suggestions for Improvement:
Scientific writing, Programmatic Knowledge, advance Analytics

Signature of the Officer-in-Charge (Internship)

Date: 16/7/25
Place: Delhi

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ACRONYMS/ABBREVIATIONS

LMICs- Low middle income countries

HCP- Health care professionals

NHS- National Health Services.

UHC-Universal Health Coverage

KPI- Key Performance Indicators

RMNCHN- Reproductive, Maternal, Newborn, and Child Health and Nutrition

PTTB- Personal Transformation Training Based Interventions.

AMTSL-Active Management of the Third Stage of Labor

ORGANIZATION PROFILE

Piramal foundation is the philanthropic arm of the Piramal group. It develops innovative solutions to resolve issues that are critical roadblocks towards unlocking India's economic potential. India has embarked on the journey towards ensuring Universal Health Coverage and Piramal Swasthya is contributing with its experience & expertise of building innovative solutions that impact at scale. Piramal Swasthya is focused on bridging public healthcare gaps by supplementing and complementing Government of India's vision to meet Universal Health Coverage. Piramal Swasthya is one of the largest not-for-profit organizations in India – in the primary public healthcare space with a focus on Maternal Health, Child and Adolescent Health, Non-communicable Diseases. Piramal Swasthya has over a decade-long experience in operating several healthcare innovations at scale, which are addressing the primary healthcare needs of most underserved and marginalized populations across India. Piramal Swasthya is operational in 21 States in India through 35 innovative public healthcare delivery programs and has served more than 112 million beneficiaries so far. Piramal Swasthya employs 2500+ employees (including over 250 medical doctors) who work with Seva Bhav. The Group's core values of Knowledge, Action, Care and Impact guide the organisation in carrying out its responsibilities towards society. The Foundation believes in collaborating with like-minded partners to bring positive changes in the society. It nurtures projects that are scalable and ensure delivering sustainable impact. The Foundation currently works across 21 states, mostly in partnership with state governments. It has developed innovative approaches and programs in every vertical and has built strong partnerships with governments, technology partners and international organizations (including with Michael & Susan Dell Foundation, Harvard Graduate School of Education and World Diabetes Foundation). The projects are implemented through Piramal Swasthya, Piramal Sarvajal and Piramal Foundation of Education Leadership.

CORE WORK:

INNOVATION AT SCALE:

- Remote health advisory and intervention platform
- Community outreach platform.
- CSR partnerships.

ENDING PREVENTABLE DEATHS

- Tribal health program: unique model aiming at ending preventable deaths.
- D.E.S.H (Detect early and save him/her)- focused on screening and early detection of cancers.

BUILDING SUSTAINABILITY FRAMEWORK

- Aspirational districts transformation program
- SATH (Sustainable Action for transforming human capital) program.
- A.M.R.I.T (Accessible Medical records via integrated technologies) – A public good: Health and Wellness technology platform

OBSERVATIONAL LEARNING

My two months as an intern at the Piramal Foundation allowed me to get a deep dive into the exciting world of public health. Renowned for its dedication to improving community health via outreach, research, and education initiatives, the Piramal Foundation offered a stimulating environment that supported my growth on the personal and professional fronts. In two months at the Piramal Foundation, I gained a rich blend of theoretical knowledge and practical skills. This transformative experience was truly enriching.

Weekly sessions on SAS software, data management, literature reviews, research methods, and Excel greatly expanded my skill set. These sessions proved to be very helpful, introducing me to new ideas and methods essential for efficient public health research and data analysis. The SAS software classes equipped me with crucial skills for handling large datasets, including data cleaning, statistical analysis, and manipulation. The research methodology workshops provided me with a solid foundation for conducting ethical research by delving into study design, data collection techniques, and ethical considerations. In addition to classroom learning, I embarked on field trips to health and wellness centre and participated in Maternal Women of Reproductive age (MWRA) survey which focuses on Family planning, early marriages and reproductive health of women.

These visits allowed me to bridge the gap between theoretical knowledge and real-world practices. I observed firsthand how these facilities function and whether they adhere to established guidelines. One of the major assignments during my internship at the Piramal Foundation was conducting a comprehensive literature review. My topic was the "**Effectiveness of Compassionate Leadership Intervention in Public Healthcare for Improving Health Outcomes in Bihar: A Rapid Review"** at **"Piramal Swasthya"**. This research topic is especially relevant and important because Bihar, like many other states, faces major challenges in its public healthcare system, including workforce stress, patient dissatisfaction and gaps in leadership quality. After doing a thorough analysis of the current research, I found this research deeply engaging because it connects human values like empathy and kindness with practical outcomes such as improved health outcome and citizen trust.

Furthermore, I had the opportunity to contribute to the Qualitative study going on "SOGI" project, an innovative initiative aimed at empowering women and equipping them with essential life skills. We conducted transcriptions, labelling, thematic analysis, and colour coding of interviews and field data. Through this process, we identified key themes such as women's livelihood, lack of awareness among providers, social stigma, and the need for inclusive policies and training.

This study was deeply insightful and thought-provoking. I found this study truly inspiring because SHGs not only help women earn money but also build their confidence, decision making power, and social status. This experience made me realize that economic empowerment is a powerful way to bring social change. It also made me realize the importance of inclusive, non-judgmental, and compassionate care, and the role of healthcare workers in creating safe spaces for all individuals, regardless of gender or sexual identity.

This comprehensive report explores each aspect of my internship experience. It emphasises the jobs and projects I worked on, the useful skills I picked up, and the significant impact this experience had on me. In addition to expanding my knowledge this internship gave me valuable experience that will help me in all my future public health related endeavours.

LEARNINGS FROM SESSIONS CONDUCTED

My journey began with an orientation session where I was introduced to the organization's mission, values and key projects they are working on. The interns were given chance to introduce themselves which made the session friendly. After that, the director, Dr. Tanmay Sir gave a perceptive speech outlining the goals of the Piramal Foundation and highlighting its dedication to enhancing community health. He gave us a thorough rundown of all the things we would be doing over the course of the next two months, emphasising the combination of theoretical instruction and real-world application that was in store for us. After that, we received a briefing on our duties and responsibilities, with an emphasis on the secondary research projects we would be working on. Every intern was given specific public health-related subjects to work on. We were each given a mentor to make sure we had enough support and direction. These mentors, highly skilled in their fields, would offer constant feedback and support while we overcome any challenges. I was assigned a mentor, Dr. Shuchi, who provided guidance and support throughout my internship. The field visit schedule was also provided which allowed us to apply what we had learned in class to actual situations. The purpose of these trips was to provide firsthand knowledge of community health efforts. We felt excited and well prepared for the adventure ahead after having our questions and concerns answered during the Q&A session that wrapped up the orientation day. This initial day not only oriented us to the logistical aspects of the internship but also inspired us with the foundation's impactful work and our role in contributing to it.

Sessions on Research Methodology

There were regular classes on research methodology which were conducted by Dr Tanmay Mahapatra Sir and his gentle teaching style made all the material easy to understand. The research methodology classes were instrumental in developing a thorough understanding of study designs and key concepts crucial for conducting robust research. The sessions meticulously explored various study designs, emphasizing their differences and implications. We started with observational studies, where we learned to observe phenomena in their natural settings without intervention. In contrast, experimental studies involve manipulating variables to establish cause-and-effect relationships through randomized controlled trials (RCTs) or quasi-experiments. Interactive discussions highlighted the importance of randomization in experimental design to minimize biases and ensure that all participants have an equal chance of being assigned to different groups. This process helps control for confounding variables and strengthens the validity of research findings. A critical aspect covered in these sessions was understanding biases that can affect study outcomes. We examined selection bias, measurement bias, and recall bias, among others and discussed strategies to mitigate these biases to enhance the reliability of research results. Furthermore, advanced concepts such as temporal ambiguity,

biological plausibility and the ecological fallacy were explored. We studied the formulas for determining incidence rates and prevalence rates, which are measures of occurrence. The knowledge of disease burden and the development of public health strategies depend on these computations. Complete explanations of the data collection procedures were given, along with comprehensive explanations of all significant methodology topics and frequent discussion sessions were also held.
All things considered, the internship gave me a thorough grounding in study design and important research ideas. My exposure to various study designs, comprehension of biases, and calculations related to measures of occurrence have furnished me with the knowledge and expertise required to carry out detailed research in the field of public health.

Sessions on Data Cleaning & Management

We were given classes on data cleaning and management in also and as we know that any research project's integrity and effectiveness depend heavily on effective data management, and the thorough instruction I received really improved my Excel skills, which are critical for working with research data. I gained knowledge of complex techniques to reduce mistakes made when entering data, like making use of Excel's data validation standards to ensure accuracy. Furthermore, I received training on how to spot and fix discrepancies in datasets by using conditional formatting, CONCATANATE and IF in Excel to resolve missing values, clean up data, and standardise formats. The use of Excel for effective data storage and retrieval was another topic covered in the course. I gained knowledge on how to create and structure spreadsheets that arrange data logically and facilitate analysis and navigation. Additionally, I learned how to use Excel to secure data by establishing cell-level permissions to preserve confidentiality and password protecting spreadsheets and workbooks. I also learned how to use Excel's basic formulas and functions for data manipulation, as well as how to create pivot tables for summarising and analysing huge datasets.
These thorough Excel abilities have given me the ability to successfully organise and handle research data, ensuring high-quality data for analysis and strengthening the validity and dependability of research findings.

Sessions on SAS Software

The theoretical foundations and practical uses of SAS data analysis were discussed in these classes. We gained knowledge about how to use the SAS interface, carry out fundamental commands, and use coding strategies that are necessary for importing, manipulating, and cleaning data. During the training, we learned how to compute important descriptive statistics including mean, median, standard deviation, minimum, and maximum values using programmes like PROC MEANS and PROC UNIVARIATE. We also looked into using PROC FREQ to create frequency tables for data that is categorical. The PROC PRINT procedure, which is necessary for displaying data in a comprehensible and organised style, was thoroughly explored in SAS lectures. Especially after data cleaning and processing procedures, PROC PRINT gives users an easy way to see and validate data by listing the contents of an SAS dataset. The PROC CONTENTS technique, which is essential for analysing the properties and structure of SAS datasets, was thoroughly discussed in our classes. We also learned about using DATA step in which we get to know about how to APPEND, MERGE, DELETE, DROP AND

how to add a NEW VARAIBLE. We were given hands-on assignments that required us to independently build SAS code and produce thorough data summaries and visualisations in order to solidify our understanding. Our ability to use SAS for descriptive statistics was much improved by these practical exercises and the ongoing feedback from our mentors, ensuring that we could analyse and interpret difficult data sets accurately.

Sessions on Literature Review

The literature review classes were crucial in providing us with the deep understanding and abilities we needed to perform comprehensive and systematic assessments of previous research during our internship. Every step of the literature review process was thoroughly explained to us, from creating specific research questions to choosing the right databases and search techniques. A significant focus was placed on PubMed, a widely used database where we learned its interface. It highlighted how important it is to use Medical Subject Headings (MeSH) terms.This allowed us to create specific search queries that minimised noise and found relevant research. In order to focus our searches on study types, publication dates and other factors. we also explored the use of filters and search strategies inside PubMed. Understanding these filters was crucial in ensuring that our literature reviews were both thorough and targeted to our specific research needs. With all of these insights, I was able create an evidence table of papers that were related to my topic and my mentors were always available to assist me when I needed it. Through regular practice and feedback from instructors, we honed our ability to extract meaningful insights from the literature and present them in a clear and structured manner. All things considered, the literature review classes provide an organised structure and useful tools that are necessary for carrying out evidence-based research. They gave us the skills to successfully synthesise findings, navigate complex databases, and assess research articles critically. These abilities are essential for any researcher hoping to advance their subject by enhancing current understanding and influencing evidence-based practice.

Session on RMNCH+A

During the session, we learned about important issues related to mother and child health. First, we understood what high-risk pregnancy means that is when a woman has more chances of problems during pregnancy or delivery, due to reasons like being too young or old, having low blood levels (anemia), high blood pressure or past complications. We also learned about BEmONC and CEmONC services. BEmONC refers to basic emergency obstetric newborn care, which includes administering medication, assisting with labor and preserving newborns. CEmONC refers to comprehensive emergency obstetric newborn care, which includes C-section and blood transfusion procedures as well as all BEmONC services. After that we talked about the IPHS guidelines which are rules that the government made to make sure that all health centers like PHCs and CHCs have the right buildings, staff and equipment to provide good health care. We also learned about IYCF guidelines, which tell us how to feed babies and young children. These include starting breastfeeding within one hour of birth, giving only breast milk for six months and giving healthy food along with milk after six months. Lastly, we studied the RMNCH+A 5x5 matrix, which covers care for five groups reproductive age women, pregnant mothers, newborns, children and teenagers. Additionally, it focuses on enhancing five areas: personnel, medicines and supplies, service delivery, community assistance and data

management. This session helped us understand how all these parts work together to improve the health of mothers and children in our country.

Field Visit Report: Health and Wellness Centre, Bihar

Date of Visit: 07/05/2025

Location: Parsa Block, Saran District, Bihar
Panchayat: Bali
AWC No. :126141
Facilitator: Uttam Sir and Abir Sir

1. Introduction

The Health and Wellness Centre in Parsa is one of the health facility setup under the Ayushman Bharat scheme that will provide essential and comprehensive primary healthcare to the rural population. The visit has been undertaken to evaluate the infrastructure, services and staffing and functionality of the centre.

2. Objectives of the Visit

- Observation the infrastructure and facilities available at the HWC.
- Assess the range and quality of healthcare services provided.
- Review staffing patterns and their adequacy.
- Identify challenges faced by the centre and suggest improvements.
- To observe the process of VHSND

3. Observations

a. Infrastructure

- The HWC is currently operating from a **single-room structure**, which is inadequate for the comprehensive primary healthcare services it is expected to deliver.
- The space serves for multiple purposes like consultation, medicine storage, and patient waiting area and ultimately leading to overcrowding and lack of privacy.
- Basic facilities like electricity and clean water are available but limited; there are no dedicated areas for immunization or maternal care.

b. Services Offered

During the visit, the following services were actively provided are:

- **Antenatal Checkups (ANC):** Basic ANC services including blood pressure measurement, weight monitoring, Height Measurement , blood glucose test and iron-folic acid distribution were observed.

- **Immunization:** Routine immunization sessions for children were being conducted, supported by ASHA and ANM workers.
- **Basic Diagnostic Services:** Simple diagnostics like blood pressure, haemoglobin, and blood sugar tests were available.
- **Essential Medicines:** A limited range of free essential medicines was being distributed.

c. Staffing

1. The centre is managed by a Community Health Officer (CHO) and supported by an Auxiliary Nurse Midwife (ANM) but there is No CHO present that time during the tenure of visit.

2. There is no laboratory technician posted at the centre and basic test are performed without using hand gloves and other essential precautions during the test like hand sanitization.

3. one ANM, one ASHA and one male worker was present.

4. Services Observed During Visit

During the visit, **five patients** were attended at the centre:

- **Three Antenatal Checkups (ANC):**
    - All pregnant women were given routine ANC checkups including weight and blood pressure monitoring
    - Each was provided with **calcium tablets** and **iron-folic acid (IFA)** supplementation.
- **Two Immunizations:**
    - **First child (7 months old):** Received **Penta 2** during this visit. The child had a **delay of 2 months** and **Penta 3** was scheduled for the next visit.
    - **Second child (4 months old):** Received **Penta 3** on time following the immunization schedule.
- **Demonstration:**
    - By Uttam_Sir "How to maintain Child weight-height graph in MCH card."

d. Patient Footfall:

- The centre caters to approximately 8-10 patients during each VHSND , primarily women and children. But centre open only 2 times a week.
- Common ailments treated include respiratory infections, gastrointestinal issues.

4. Challenges Identified

- **Staffing Shortages:** The absence of a full-time medical officer limits the range of services.
- **Infrastructure Gaps:** Lack of dedicated spaces for specific services hampers efficiency.
- **Supply Chain Issues:** Occasional shortages of essential medicines and diagnostic kits.
- **Community Awareness:** Limited awareness among locals about the services offered, leading to underutilization.
- **ANM doesn't properly guide patients (pregnant women) about dietary habits, benefits of IFA ca2+ tablets and also importance of immunization.**

5. Recommendations

- **Recruitment:** Appoint a full-time medical officer to enhance service delivery.
- **Infrastructure Development:** Upgrade facilities to include dedicated rooms for maternal care and diagnostics.
- **Supply Chain Management:** Ensure a consistent supply of medicines and diagnostic tools.
- **Community Engagement:** Conduct awareness campaigns to inform the community about available services.

6. Exit Interviews

Two exit interviews were conducted:

a. Preeti Kumari – 3rd ANC Visit

- She received the basic ANC checkup and medicines.
- However, **no information** was provided about:
    - **Handwashing practices**
    - **Toilet use and sanitation**
    - **Condom usage or spacing methods**
    - **Blood testing for anaemia/infections**

b. Rajni – Child Vaccination (4 months old)

- She was satisfied with the immunization service.
- But again, **no health education or counselling** was provided about:
    - **Hygiene and sanitation**
    - **Family planning methods**
    - **Nutritional advice or infection prevention**

  Both patients reported an **"okay" experience** but lacked awareness due to missed opportunities for health education and counselling.

c. Exit Interview With ANM:

- Basic questions about work description.
- Personnel details about ANM.
- Regarding family planning work.
- Regarding various ANM apps like ANMOL app.
- Regarding child nutrition.
- Regarding ABDM importance.

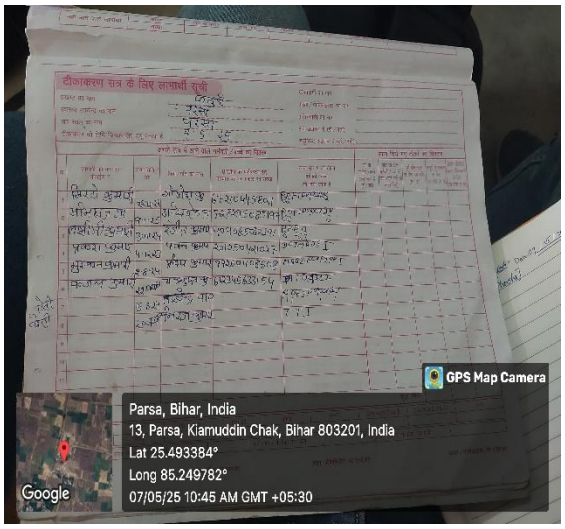
7. Conclusion

Despite serious infrastructure and staffing limitations, the Health and Wellness Centre in Parsa continues to provide critical services such as antenatal care, immunization, and basic diagnostics. However to truly meet the objectives of Ayushman Bharat, investments in infrastructure, staffing and outreach are urgently needed.

8. Pictures










VITAMIN A
PAEDIATRIC
ORAL
SOLUTION IP
Bihar Govt.
Supply
Not for Sale


GPS Map Camera
Parsa, Bihar, India
13, Parsa, Kiamuddin Chak, Bihar 803201, India
Lat 25.493377°
Long 85.249807°
07/05/25 03:16 PM GMT +05:30
Google


GPS Map Camera
Parsa, Bihar, India
13, Parsa, Kiamuddin Chak, Bihar 803201, India
Lat 25.493488°
Long 85.249818°
07/05/25 12:54 PM GMT +05:30
Google


GPS Map Camera
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13, Parsa, Kiamuddin Chak, Bihar 803201, India
Lat 25.493304°
Long 85.249869°
07/05/25 03:33 PM GMT +05:30
Google

Field Visit Report: Survey on Maternal Women of Reproductive Age

Date of Visit: 09 June 2025
Location Visited: Nawada, Bihar
Organization: Piramal Foundation
Facilitator: Mr. Rantosh Kumar sir (Sr. Analyst MLE), Mr. Mithilesh sir (Sr. Analyst MLE) and Mrs. Archana ji (interviewer)

Purpose of Visit:
To observe and conduct spot checks of the ongoing maternal and reproductive health survey among women of reproductive age using the Survey CTO Collect App.

Key Observations:

1. **Interview Process:**
   Observed two interviews. Initially, respondents were hesitant to share information, especially on sensitive topics. However, as rapport was built, they became more open and cooperative.

2. **Awareness of Contraception:**
   Women were generally aware of contraception methods such as Copper-T, injections, pills, and condoms, primarily provided by the local ANMs.

3. **Family Planning Challenges:**
   While most women expressed a desire to limit childbirth to two children, many reported being pressured by their husbands to have more children.

4. **Early Marriage:**
   All three respondents were married between the ages of 15-16, reflecting the persistence of early marriage in the region.

5. **Lack of Awareness:**
   Despite knowing of contraceptive tools, none of the respondents were fully informed about family planning services or their rights.

Observations during spot check:

- Concern is Taken for Respondent Comfort- Interviewer greets politely, ensures respondent feels at ease.
- Good Probing is Practiced
- All Questions are Asked (No Skipping)
- Right-Hand Rule is Followed- Household/participant selection follows the right-hand rule method.
- Confidentiality is Maintained- Interview is conducted privately; avoids reading aloud sensitive data.
- Interviewer is Thorough with Questionnaire- Familiar with questions; does not read awkwardly or fumble.

- Uses Language of Common Understanding- common language is used which is easy to understand.

Constraints Faced and Actions Taken:

Constraints	Actions Taken
Sexual and reproductive health remains a taboo, making open discussion difficult	Ensured ethical clearance was in place
Difficulty accessing female respondents due to cultural norms	Interviewers received training and built rapport with families

Recommendations:

1. Launch targeted health education campaigns through community centres, women's groups, and digital platforms to increase awareness.
2. Involve men and community leaders in conversations on reproductive health to foster supportive environments.
3. Train healthcare workers in sensitive and non-judgmental communication skills.

SOGI Project – Qualitative Study Report

State: Bihar and Rajasthan
Date: 12-05-25 to 4-06-25
Organization: Piramal foundation

1. Introduction

This qualitative study was conducted under the SOGI (Sexual Orientation and Gender Identity) initiative to explore the livelihood experiences, challenges and perspectives of individuals from sexual and women disparities in livelihood in the states of **Bihar** and **Rajasthan**.

The objective was to gain a deep understanding of regional sociocultural contexts, discrimination, healthcare access, safety and policy implications affecting SOGI populations.

These barriers are deeply rooted in factors such as gender, caste, geography, and socio-economic status. They are further compounded by the widening digital divide, which restricts women's access to digital services, skilling programs and livelihood platforms that are increasingly central to economic participation.

1.1 Objectives of the Study

- To map the **current status of livelihood** opportunities available to rural women and girls.
- To identify the **unmet needs and challenges** they face in accessing services, entitlements, and digital skilling opportunities.
- To assess how government programs, especially SRLM, are **addressing these barriers** and where systemic **gaps remain**.

2. Methodology

2.1 Study Design

The study adopted a qualitative, immersive methodology aimed at gaining a deep, contextual understanding of community experiences, perceptions and interactions with local governance and development processes. Rather than relying on quantitative data, the approach focused on capturing narratives, insights and lived realities through direct engagement.

2.2 Data Collection

- **Participants:** SHG leaders, community men and women and govt. officials
- **Tools Used:** in-depth interview and FGDs for local context.
- **Languages:** Hindi and local dialects (Maithili, Bhojpuri, Rajasthani)

2.3 Transcription & Translation

All interviews and discussions were transcribed verbatim in the original language and then translated into Hinglish.

I:जो बेशक अपनी मर्जी से शादी करते हैं या करना चाहते हैं, उनके बारे में आपके क्या विचार है? चाहे वह जाति, धर्म या आर्थिक स्थिति से जुड़ा?

R; जाति देखकर ही करना चाहिए, नहीं तो नहीं करना चाहिए, अन्य जाती नहीं।

I:स्वतंत्रता पुरुष और महिलाओं के लिए समान होनी चाहिए या पुरुषों के लिए अलग महिलाओं के लिए अलग।

R:पुरुष महिला दोनों के लिए बराबर बात एक है।

I:आपका समुदाय में कम उम्र में यह जबरदस्ती की गई शादी को कैसे देखा जाता?

R:अब के समय में ऐसा नहीं होता है। ना कम उम्र में शादी होता है ना जबरदस्ती शादी।

2.4 Labelling and Coding

- Each transcript was labelled with unique participant IDs and location tags.
- A manual coding approach was used.

Q501 Do you think that women's safety, and fear of violence against women's affect their participation in livelihood opportunities? If so, how? Probe: workplace safety issues, safe roads, transportation facilities, etc	Safety concerns limit participation; group travel, safe transport, and local venues help, no
Q502 Do you think sanitation and hygiene related issues affect women's participation in livelihood opportunities? Probe: poor hygiene facilities, lack of awareness on sanitation and hygiene practices, etc.	No, Yes, attention paid specifcially to the availability of proper sanitation facilities at training centers.
Q503 Do you think menstruation has an impact on a women's participation in educational and livelihood opportunities? Why or Why not? If yes, are there any steps taken to address the problem?/ Probe: What additional support do you think can be provided to overcome such barriers?	Yes, has an impact. No, does not have an impact, Awareness campaigns, Distribution of hygiene products and kits, special leaves
Q504 How does access to safe and reliable transportation affect women's participation in livelihood opportunities under NRLM/SRLM?oProbe: Are there specific challenges related to mobility in your intervention area?/oProbe: What measures, if any, have been taken to improve women's access to safe transport?/	**Yes,** ***No*** **,** Should provide transport, organize training locally, provide safe accomodation, link helplines in Pink buses, redressal mechanisms
Q506 What facilities (e.g., toilets, water) are available to support women's participation in NRLM/SRLM activities?/	Toilet, Drinking water, help desk. Trying to pilot creches, Some things not available
507 Has NRLM/SRLM taken steps to ensure the safety and security of women participating in these programs? If yes, what are they	One stop centers, Didi Adhikaar Kendra, Mahila helpline, Mahila Police thana, Trainining during daytime, Close to women's home
Q508 What support systems are available for women who face any form of violence in your area?/	One stop centers, Didi Adhikaar Kendra, Mahila helpline, Mahila Police thana, Emergency funds for survivors, government support,internal cell,

2.5 Thematic Extraction & Colour Coding

Themes were extracted inductively based on the frequency, emotion, and depth of recurring patterns.
Colour coding was applied for clarity:

309 Has participating in NRLM/SRLM programs influenced women's role in household decision-making? If so, how.Probe: children's education, or household purchases etc. Can you share any example, or some success story based on your experience	310 Do you see any gaps in NRLM/SRLM programs in supporting women's livelihood opportunities? If yes, can you tell us about those gaps?/ oProbe: challenges in program design, implementation, or outreach etc	311 In what ways can NRLM/SRLM programs be improved to better support women's livelihood opportunities.oProbe: scope of convergence, specific training, access to capital, or networking opportunities etc	312 How and in what ways, is digital literacy and technology important for women's livelihood?/	312_A: Are any tech-based trainings or capacity building sessions organised for the women?	313: What role does climate ch livelihoods, and what adaptati
es, change is seen in decision making	Haan to mujhe lagta hai ki I think kuchh area hai vahi advanced training area hain we should focused more I mean obviously jo food processing hain agriculture hain commercial sector hain apperal hain jo advanced focused hain in chijon me vo achha kar hi rahi hain but jo hai kafi focus hua hai uspe but going forward I think at might be more recruitment agar vo advanced course me industries 4.2 me mahilayon ka hai jo contribution badhe aur hamare infact ye hua ki educational system aur vocational ecosystem vala courses hai to meet to come together we meet to participate of woman in ITI in technical institute	hum, they are doing lot this its not only SRLM or NRLM needs to work in tendum with industries department aur phir bihar contact BSDM jo bhi state ke liye mission hoga so that you know the kind of training kind of capacity building so ek hi framework ke hisab se mapti customize ho hai jaisa jaisa jo hai work ho rahi hai jo opportunities nikal ke aa rahi hai uske hisab se any infact that is true not only woman beneficiary true for all skilling factory jo supply crate ho rahi hai vo demand ke hisab se creat ho jo	Without Digital literacy think about it is also important on the personal growth abhi 21 century jo hai abhi aap jo online karten hain ya karna chah rahi hai untill unless digital literacy with you jo government ke scheme ko access karna hai aapko aadhar card update karan hai whatever any case vo sari suvidha online hi hai. I was certain amount of digital literacy & you will actually accept Insect manage time varne aap unhi lino me unhi usme fasen rahenge so that any ways yur reduce of productivity . Absouletly, aap dekhenge ki wall ki painting hoti hai jo conventaly hamne dekhe the chote me vo painting vo le ke baithen hain do din 3 din kar rahen hain leke baithe hain she my fertiliser		So,there are sector jahan par i posibly kam hoga agriculture i climate change hota hi hai livli I guess kabhi fluid hai kabhi sul training hoti hai kaise aap drow harvesting ke process ko maka happening agriculture departn kendra hai jo unke through trai happening so usme to I fill ki cl banki renawble energy ki baat bhi kafi sara bhi attraction hai. hamara kafi sara investment on bihar vo renewble energy gr

For ex-

- **Red** – Discrimination & Violence
- **Green** – Healthcare Access

- **Blue** – Identity & Expression
- **Yellow** – Community & Support
- **Purple** – Institutional Response

3. Key Findings

BIHAR – major themes

-Introduction and Livelihood

Women are mostly uneducated due to poverty and primarily engaged in domestic tasks like cooking, cleaning, and childcare. Only a small number participate in SHG-led activities such as goat rearing, door-to-door marketing, tailoring, or tuition.

"Pariwarik zimmedariyon ke chalte rukna pada" / "Silai, bunai aur ghar ka kaam karti hoon" / "Jeevika ke madhyam se samuh bana hai"/ "The men only take care of the outside work"/ "They are responsible for maintaining the household"

-Income and Economic Independence: Verbatims – "Mahila nahi kamati hai isliye vo nahi karti" / "Khud ka paisa nahi hota" / "Thoda bohot kama lete hain silai se"/ "kabhi mera pati bimar ho jayega to hum kiske pass jayenge paisa to hona chahiye na utna"/ "Jab jo jarurat hota hai na …wife bhi leti hai ..hum bhi lete hai dono lete hai.."

-Mobility, household decision-making, and gender roles: Verbatims – "Pariwar ke bade log faisla lete hain" / "Bahar jaane ke liye poochna padta hai"

RAJASTHAN- major themes

-improvement in women education – "aurat apna kamayegi to kisi kea age haath nahi failana padega"

-benefit from Self help groups- "loan milta jata hai shg ki madat se"

-Equality in Choice Should Exist - clear support for gender equality, asserting that both men and women should have the same rights in choosing life partners

What does safety mean to you (at personal, household and community level)? How safe do you/women/girls feel in your community/workplace/school/college/market place etc? •Probe: Are there	Do you believe women in your community have the similar access as men?	Family property	Protection from domestic violence (DV)?	Denying forceful dowry	Why do you think this is the case or not the case?
Ask if Q100=1	Ask if Q100=2	Ask if Q100=2	Ask if Q100=2	Ask if Q100=2	Ask if Q100=2
Q801	Q802A	Q802B	Q802C	Q802D	Q803
Women safety:					
No. of women feel safe in their community and work place "Ha hamlog apne aap ko safe mahsoos karte hai hame lagta hai ki agr ham thik hai to sab thik hai "	**Gender Eqality :** mostly men give support towards equality and there should be equal rights in terms of education ,emplyoment etc. but they also feel their is some lacking behind women eqality "हा बिल्कुल" "पूरा तो नहीं कहा जा सकता है। अति 80% बोल सकते हैं।कुछ हुआ है, कुछ तो नहीं है।" / " Modern yug mein mahilayon ko kaam karne ka aur decisions lene ka adhikaar milna chahiye. Auraton ka apna adhikaar samajhna aur bolna naye yug ki maang hai." but women don't feel their is equality "nahi samaj hain a tgoda samaj se darr ke rehna padta hai ki kon kya bol dega"				
And no of women also feel unsafe ,fear of kiddnaping and also have fear to go outside in the night "अपनी इज्जत देख करके डर लगते हैं। जो कोई बाहर निकले तो कोई ऐसा ना कह दे। लड़की है, कोई औरत है, लड़का सब छेड़खानी ना करे"	**Property rights :** mostly they feel their should be equal rights "महिला संपत्ति में तो बराबर का अधिकार मिलना है।Ha hona chaiye" some of them feel women have no rights over property "kanuni तौर पर है।; ऐसा तो कुछ नहीं है, हाँ लड़की आएगी जाएगी पर दूसरा कुछ नहीं,"				
"ये की झगड़ा हो रहा ये मार्केट, ये सब।"	Domestic violence : mostly said their is no equal rights over domestic voilence "nahi hai jaise ham dekhte hai hinsa hai." some of them said they hai rights "haan" "hai" "ye nhi ki gharelu hinsa mahilaon ke sath hi hoti hai purus ke sath bhi hoti hai"				

Training Report: Maternal Women of Reproductive Age Survey

Duration: 3 Days

Purpose: To equip data collectors with the necessary skills and knowledge to conduct high-quality and sensitive data collection for the survey focusing on women of reproductive age (15-49 years).

1. Objective of the Training

The primary objective of this training was to prepare field investigators to conduct interviews with women aged 15–49 years in a respectful, ethical and effective manner. This included ensuring accurate data collection, maintaining confidentiality and handling sensitive topics with empathy and professionalism.

2. Training Content Overview

Day 1: Introduction & Ethical Considerations

- Overview of the Survey: Purpose and importance of understanding maternal and reproductive health indicators.
- Informed Consent: Emphasis on voluntary participation, reading consent forms clearly and ensuring respondents fully understand their rights.
- Confidentiality: Guidelines on protecting respondents' personal information and maintaining privacy during interviews.
- Right-Hand Rule: Training on systematic household selection using the right-hand rule to ensure randomization and reduce selection bias.

Day 2: Survey Tool & Data Collection Techniques

- Introduction to Data Collection Tool: Walkthrough of each section of the questionnaire and digital app (SurveyCTO).
- Anganwadi Linkages: Understanding the role of local Anganwadi centres and their registry in identifying eligible respondents.
- Probing Skills: How to ask follow-up questions without leading the respondent, using local language and culturally appropriate expressions.
- Tone and Voice Modulation: Use of a polite, non-judgmental tone while asking sensitive or personal questions.

Day 3: Sensitive Topics & Field Readiness

- Sexual and Reproductive Health Questions: Techniques to ask about sexual health, contraception, menstruation, sterilization and sanitation (e.g., availability of toilets).
- Early Marriage & Family Planning: Understanding the social context and how to discuss topics such as early marriage and contraceptive use with empathy.
- Mock Interviews & Role Plays: Practical exercises to simulate real-life interviews, including managing difficult conversations.

- Field Protocols: Instructions on approaching households, ensuring female privacy and navigating local community norms.

3. Methodology

The training involved interactive lectures, role-playing, group discussions and hands-on practice with the data collection tool. Trainers emphasized real-world challenges and shared tips for effective communication and ethical field conduct.

4. Key Outcomes

- Data collectors developed a clear understanding of the questionnaire and were able to navigate the digital tool confidently.
- They practiced and demonstrated ethical interviewing practices.
- The team showed improved sensitivity and skill in discussing topics related to reproductive health and family planning.

5. Conclusion

This training successfully prepared the data collection team to engage with women of reproductive age in a respectful, informed and effective manner. Emphasis on empathy, confidentiality and accurate data collection will support the quality and credibility of the survey results.



Desk Review

TOPIC: **Effectiveness of Compassionate Leadership Intervention in Public Healthcare for Improving Health Outcomes in Bihar: A Rapid Review**

BACKGROUND

Health systems are dynamic and complex and need to be sensitive to the evolving dynamics of demographic, epidemiologic, and social changes. Adaptation to these needs in settings with limited resources demands greatly skilled, adaptive public health leaders (1).

Public healthcare in Bihar is vital in reaching millions of people, especially rural and poor populations. While there has been important progress in services e.g., through the Ananya program, which focused on maternal and child health (2).There remain numerous patients who have poor experiences, long waits, and are disrespected or not listened to when they come in for care. These are not just issues about medical treatment, but about how healthcare professionals communicate, lead, and treat patients and each other.

Perhaps the most critical piece that is so often overlooked is leadership. When healthcare teams are being guided with compassion, empathy, and respect "compassionate leadership" as scientists call it staff feel more confident, and patients are more likely to have a good experience. Global reports indicate that compassionate leadership enhances employee morale, reduces burnout, and leads to enhanced care (3, 4).In fact, compassion has been seen as a universal value in healthcare, although practice varies by culture and setting.

There has been some evidence that has actually shown, in fact, that as leadership becomes more collaborative and empathetic, the care improves (5). Most of these studies are from high-income countries or aren't drawn from real-world government systems within states such as Bihar. Relatively little research has sought to test what happens when we try out building compassionate leadership in the real-world intervention environments of India's public health.

Also, while there are a few measures to quantify a phenomenon like patient satisfaction or staff behaviour, they hardly take into consideration affective or empathetic aspects, and few are suited for local utilization (6).

As India shifts towards universal health coverage, the need arises not just to structure health systems better but also to transform them culturally. Empathic leadership offers a pragmatic, context-sensitive approach to address this twofold need in Bihar's public health system (2).

RATIONALE

In Bihar's state health care system, the majority of the health workers are trying their best but under difficult circumstances, with less resources, and huge pressure. As a result, patients do not always feel cared for. They may wait for hours, be superficially treated, or feel that their concerns are not being listened to. While efforts like the Ananya program have improved technical care(2). we still don't have a total picture of how leadership style influences patient treatment or how employees perform their job.

Throughout the world, there is growing evidence that compassion-focused leadership leaders listening, motivating staff, and valuing people is not only enhancing staff morale but also patient care (3, 4). When health workers are valued and supported emotionally, they will tend to be more compassionate to patients and work better in collaboration. But in India's public health settings, especially in impoverished states like Bihar, this form of leadership has not been studied in depth yet.

Some research (5) has compared team-based leadership in hospitals and found it can improve care, but much of that is from wealthier countries. There are other reviews (6) that find most tools for assessing patient satisfaction fall down when it comes to the emotional elements of care, i.e., how valued or heard the patient perceives themselves. That is to say that we do not yet have good evidence on how leadership behaviours like compassion or empathy influence actual experience in Bihar's public hospitals and clinics.

This is study matters because I am looking at whether training and supporting public healthcare leaders to be more compassionate can lead to better experiences for citizens and, ultimately, better health outcomes. This kind of research has the potential to change not just how leaders work, but how healthcare feels for everyone involved i.e. staff, patients, and communities.

OBJECTIVE

To assess the effectiveness of a compassionate leadership intervention in public healthcare settings in Bihar with respect to its impact on improving health outcomes.

METHODOLOGY

This study adopts a desk review as its core methodological approach. It involves a systematically reviewing and critically analysing of existing academic literature and relevant reports on compassionate leadership in public healthcare, with a focus on India and comparable low and middle-income countries (LMICs). The aim is to understand the role and effectiveness of compassionate leadership in shaping citizen experience, improving interpersonal relations within health systems and enhancing health outcomes. Insights from the desk review will be used to identify knowledge gaps and propose evidence-based recommendations adjust to the public health context of Bihar.

Data collection

A detailed search was carried out using reliable academic sources like PubMed and Google Scholar. The search used keywords such as "compassionate leadership," "healthcare leadership," "India public health," "citizen experience," "Bihar healthcare system," "LMICs and leadership," "patient-centered leadership," "doctor-patient

relationship," "healthcare management in India," and "leadership training in hospitals." From this a total of 18 research papers were found. After reviewing the content and relevance of each 14 papers were shortlisted. Out of these, 11 were studied in depth for detailed analysis and insights.

Inclusion Criteria:

• Articles from 2010 to 2025

• Research on leadership practices in healthcare

• Reports that have quantifiable outcomes (citizen experience, staff morale, health outcomes)

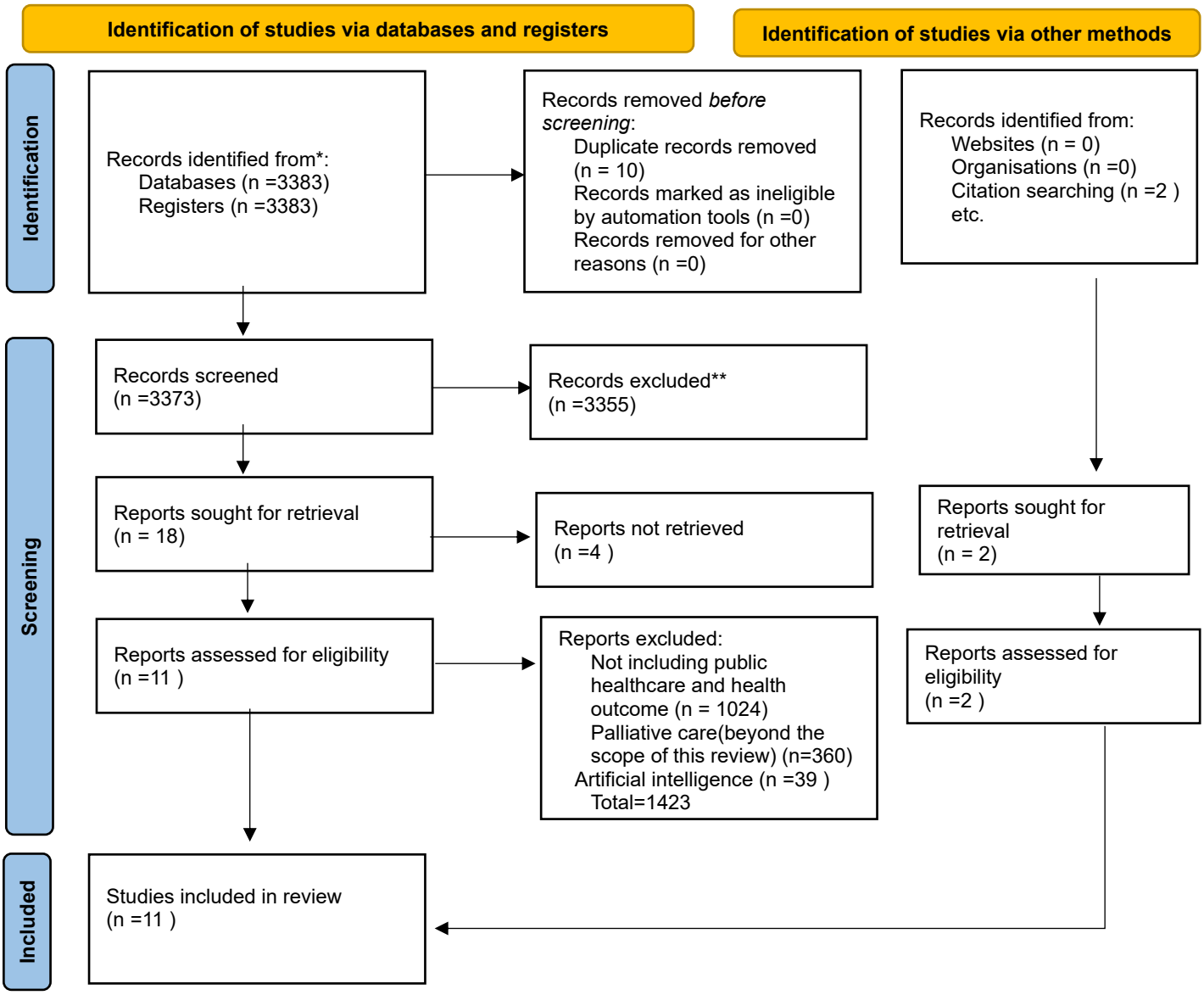
• Research done in India or LMICs and outside India

Exclusion Criteria:

• Not peer-reviewed or of poor methodological quality

• Articles of no relevance to healthcare systems or compassionate leadership.

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).
**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

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Key findings of the topic: Effectiveness of Compassionate Leadership Intervention in Public Healthcare for Improving Health Outcomes in Bihar: A Rapid Review

Compassionate leadership

A human capacity for empathy with the suffering of others and a desire to act upon it through culturally sensitive and acceptable caring interventions that consider both the cultural origin of the patients and carers, as well as the care environment (4).

OR

Compassion is patient-centred practice, which includes understanding and empathizing with patients, having open communication and trust between the patients and HCPs. Compassionate HCPs relate to the patients, listen to their concerns and care for them. Through this they can have a better understanding of possible risks, minimize medical errors and establish trust from their patients (3).

Currently compassionate leadership lacking in India and situation beyond India.

1.In high-stakes public health systems with high levels of pressure, empathetic leadership has become a core element of humane and efficient delivery of healthcare. Empathetic leadership has come to be considered a strategic ability rather than a "soft skill" globally. It is associated with:

-Increased morale and performance of teams

-Better patient experience and trust

-Reduced employee burnout and turnover

- better health outcomes in complex care environments

In the UK, for example, the NHS has embedded the concept into leadership development via the NHS Leadership Academy and Schwartz Rounds, where there is a focus on emotional intelligence, active listening and participatory governance. Findings from studies conducted in Canada, the UK, Iran, and Australia(4, 5) show a positive relationship between compassionate leadership and improved clinical outcomes, team

cohesion, and citizen satisfaction. More psychometrically evaluated and standardized measures of compassionate leadership can now be added to management models.

2. India's context: the Compassionate leadership gap continues to be lacking and fragmented in India, especially in the public health system. The "human interface" of leadership and service delivery is often neglected even as the nation has a robust policy thrust towards Universal Health Coverage (UHC) via initiatives like Ayushman Bharat. (1)

2.1 Previous India Evidence (Darmstadt et al.'s (2020) transformative interventions in Bihar i.e., the Ananya program, which streamlined service delivery through systemic change are referred to in evidence table. Compassionate leadership was not always explicitly built or tracked by these interventions. Leadership improvement was secondary, not the focus area.

Similarly, (6) reviewed patient satisfaction tools but found that most of them lacked rigorous psychometric testing, especially in Indian settings.

This shows that there are no standardized measures for assessing citizen-focused leadership behaviour or compassion-based performance. The Indian public health sector lacking in leadership development initiatives aimed at compassion, empathy or relational competence. Employee motivation and relational governance are not present sufficient priority in the task-oriented and administrative management hierarchy.

2.2 Structural Barriers in Indian Public Health- the greatest hindrances to the development of compassionate leadership are:

- Overloaded systems without sufficient staff or infrastructure.
- Top-down chains of commands suppressing participatory decision-making
- Absence of formal leadership development frameworks in government service
- Norms of culture that are against disfavouring emotional vulnerability within professional hierarchies
- Compassion KPIs that are absent in monitoring or evaluation systems

3. Bihar's International Comparison and Implication Across LMICs (e.g., Pakistan, Iran, Ethiopia): compassionate leadership is increasingly being adopted in system reforms particularly maternal health, HIV/AIDS initiatives, and community-based care (3) argue that transformational leadership types like compassion facilitate healthier patient involvement, satisfaction, and provides resilience.

But plenty of evidence exists from high-income countries or cross-country studies (4) where leadership abilities and infrastructure are better developed. Even though these frameworks can act as a basis for adaptation they may not necessarily be universally applicable in Indian contexts such as Bihar.

What is the impact of absence of compassionate leadership have on healthcare system?

Strong leadership within the healthcare system is essential for providing quality care and ensuring patient safety. Lack of leadership qualities can lead to significant effect on the healthcare system(3). For example, Ernest Amory Codman was a surgeon at Massachusetts General Hospital in Boston who dedicated himself to tracking each patient during their complete treatment journey. He pinpointed errors in the diagnoses and treatments and matched them with the outcome to suggest and make changes. His suggestions were turned down by his peers, and he left the job to go on and establish his own hospital called the 'End Result Hospital'. From 1911 to 1916, Codman's hospital discharged 337 patients, during which time he recorded 123 errors that were categorized into various types of medical errors. He admitted his errors and made them public in the annual hospital report so patients could review the quality of care they had received. His suggestions and recommendations were rejected by the medical profession, but his resolve and leadership kept him going, even earning him the title of 'martyr of quality.

It has been shown from time to time that poorly led physicians can have a negative influence on the quality of care that they provide. Poor leadership has been shown to lead to communication issues among healthcare professionals, making decision-making more complex and even risking patients. Physicians who fail to provide patient safety and quality initiatives, and fail to evolve with changing healthcare needs, can result in staff burnout and high rates of employee turnover. Combined effect of compassion and leadership on quality and patient safety Transformational compassionate leaders will be likely to engage their employees in prioritizing the care of patients and preventing medical errors. Compassionate transformational leaders will likely also foster open communication, feedback, and ongoing improvement, which further add to patient safety and the quality of health care.

Combining compassionate care with transformational leadership increases patient satisfaction, outcome and overall healthcare superiority.

Compassionate care is all about caring for the patients, listening to them and understand their physical as well as emotional well-being. Compassionate care leads to improved communication and treatment Approaches to developing a quality culture and patient safety through compassionate leadership. Developing a culture of compassion and leadership that focuses on patient safety and care quality takes ongoing efforts and dedication.

This information is supported by (3).

• Begin at the top so that top leadership, executives, administrators and department heads all are committed to the essential values of compassion, patient safety and quality care. Embedded in the organizations values in what and how they do things.

• Offer training programs that touch on transformational leadership, empathy and the way these impact patient safety and healthcare quality. Empathy, active listening, and conflict resolution are the most critical elements of these training programs.

•Provide staff members a sense of ownership for patient safety and healthcare quality initiatives which inspire them to communicate freely and without fear of consequences they can express concern. On a regular basis invite staff, patients and families to give feedback freely. To determine what area needs improvement, document and analyse the feedback gathered properly.

•Create a caring work climate in which multidisciplinary groups talk and cooperate well to achieve patient safety and quality measures. This can be done by creating a proper role of individuals in teams, continuous training programs, weekly team meetings and ensuring teams possess suitable resources in terms of time, expertise and technology to effectively perform their functions.

• Foster an attitude of continual improvement will Encourage employees to report incidents, near misses, adverse events and system flaws and take action. Based on the feedback and lessons learned organisation should periodically review and update policies. Recognize employees those who demonstrate outstanding commitment to patient care and healthcare quality.

•Develop key performance indicators (KPIs) for patient safety and healthcare quality. Monitor these KPIs time to time to check for trends, success and areas of improvement.

•Take leaders and employees to account if they hold the values of compassion, patient safety and quality care.

Impact on Healthcare Teams & Colleagues

- Enhanced collaboration as Trust is fostered by compassion. Workers are more likely to cooperate and support one another.
- Less fighting: Compassionate, straightforward communication ends disputes before they become harmful.
- Better learning environment: Members of the team can raise questions, own up to mistakes and foster a professional environment.

AREA OF CONCERN

- Compassion is sometimes mistaken as a weakness. Certain co-workers may think that compassionate leadership is too "soft" especially during times of crisis.
- Perception of unequal treatment: Some people might think a leader is being unfair if they show empathy to a select few.

"That's compassionate leadership not magic, simply humanity with structure."

-*Rasmus Hougaard and Jacqueline Carter*

Compassionate Leadership for High-Population, High-Mortality State like Bihar & UP, India.

Bihar is India's most populated and underserved state with unduly high maternal and neonatal mortality rates. "Compassionate leadership" is not uniformly applied in all the studies, but most of them capture its spirit: sympathetic mentoring, collaborative teamwork and empowering frontline providers. These programs are implemented to address Bihar's public health issues at the systems level in the areas of Reproductive, Maternal, Newborn, and Child Health and Nutrition (RMNCHN).

Uttar Pradesh India has implemented a unique training program for government physicians serving in public health. IIM Lucknow conducted a training in collaboration

with John Hopkins University to enhance the effectiveness public health services. The program consisted of classroom teaching, an interactive group project and a presentation focusing on leadership, communication, teamwork and problem-solving in public health. The training was of short-duration and some subjects such as government rules and hospital management were not covered. Some officers were unable to fully implement the skills due to lack of staff, authority and support from their organizations. Participants suggested a two-stage model of training: initial basic training for everyone followed by an advanced course for interested individuals. The research demonstrates that providing leadership training to medical officers can enhance public health services i.e. Mean test scores improved significantly from 53.31 to 59.56 ($p = 0.003$) but for greater impact the training should be longer, hands-on and backed by changes within the health system. (1)

Main Findings:

Effect of compassionate leadership

- Humanized Supervision & Mentorship- interventions by nurses such as AMANAT greatly enhanced clinical quality of care, provider confidence, and maternal care policy adherence (7).
- Participatory Team-Based Models- The Team-Based Goal Setting Initiative (TBGI) enhanced psychosocial work cultures, job satisfaction and accountability (8).
- Statewide Systems Leadership - Ananya Initiative of large public-private leadership frameworks that encouraged service delivery amongst 28 million population from 8 districts (2).
- Empowerment through Simulation and Feedback- Simulation training empowered nurses to feel more confident and practice-ready in actual situations with high-risk cases (9).
- Data-Driven and Adaptive Leadership -Implementation science approach to QI interventions identified data-driven decision making and learning cycles to improve effect and frontline engagement (10).

Impact of compassionate leadership training on leadership skills of health providers and hospital performance as well as patient experience subsequently: case study from Bihar

- Leadership competencies were higher among health providers who received training on Compassionate leadership skills & Personal transformation as opposed to those who did not.

- District Hospitals where training was conducted (as opposed to not), we found improvement in :
  - ✓ Personal leadership skills.
  - ✓ Social leadership skills
  - ✓ People leadership skills
  - ✓ Overall Leadership Competencies

- **Patient experience** (while interacting with the providers) **was better Based on - relatively higher proportion of patients receiving respectful treatment, Prompt attention giving adequate time, open & clear communication, allowing questions, detailed explanation of procedure, etc. at DHs where training was conducted as opposed to not at District Hospitals** where Compassionate leadership & Personal Transformation **trainings were conducted**

- Health facilities where trainings were conducted:
  - ✓ Experience while **interacting with doctors was better than with the nurses**
  - ✓ **Being greeted respectfully & warmly, prompt attention-giving adequate time, concerns heard actively, having open & clear communication, opportunities to ask questions, answered all questions, being empathetic to patients was found to be higher** in facilities with trained providers.

- Overall, PTTB interventions are positively associated with **improved consistency and quality of service delivery** in both maternal and newborn care, though further efforts are needed to scale underperforming practices to universal levels.

- **Enhanced adherence to key delivery practices** was observed in PTTB-intervened facilities, especially in components of AMTSL and newborn care, reflecting improved clinical protocols following capacity-building efforts.

- **Noteworthy (maximum) changes** were seen in:
  - ✓ **Perineum support**
  - ✓ **Cord pulsation checks**, indicating targeted improvements in often-overlooked areas.
  - ✓ **Timely uterotonic administration** (both pre-delivery and within 1 minute of delivery) and abdominal examination done before delivery showed marked improvements, reinforcing better compliance with active management of the third stage of labour
  - ✓ In **early newborn care**, **clean cord cutting**, **drying**, and **wrapping** practices saw **modest but meaningful gains**, indicating enhanced immediate postnatal care routines.
  - ✓ **Controlled cord traction** and **skin-to-skin contact** were already high across facilities but saw incremental improvement in PTTB districts, suggesting reinforcement of existing good practices.

Gaps Identified in Current Literature

- Lack of Long-term Impact studies - Few had post-intervention long-term follow-up to determine long-term sustainability of leadership effect.
- Compassionate Leadership Not Specifically Utilized as clearly Measured-No studies employed the term "compassionate leadership" or emotional intelligence/empathy measures clearly.
- Underreported Actual World Clinical Outcomes-Paucity of models of mentoring reported improved adherence without measuring downstream clinical outcomes (e.g., maternal mortality).
- Limited Sampling Diversity-Some employed purposive or convenience sampling, which restricts generalizability.
- Short Implementation Durations-Most were pilot-tested on brief durations (<12 months) without global cultural transformation.
- Lack of Hierarchical Culture Attention-None addressed systemic resistance or power disparity, although kind leadership is meant to mitigate those issues.
- Gender Relations Not Explored- Bihar's health workforce has a gender imbalance; however, gender-influenced leadership or mentoring effects were not explored.

Overall conclusion and recommendations-

Compassionate leadership is not merely about being nice it's about actually understanding what patients and healthcare professionals are experiencing and doing something about it in ways that make a difference. Globally, particularly in nations such as the UK and Canada, compassionate leadership has enhanced collaboration, minimized staff burnout, and improved patient experiences.

In India, and especially in such states as Bihar and UP there remains a huge gap. While efforts such as the Ananya program have served to enhance services, leadership has tended to be top-down or lacking the human touch. Most healthcare workers feel neither supported nor adequately worked nor heard. Empathetic leadership where leaders listen, engage their teams, and are concerned about emotional health is still not installed in the system. Without it, quality care and patient safety are impacted.

In India more work on compassionate leadership is needed to be done to support HCPs and to enhance patient safety and quality so that patient's confidence is strengthen on healthcare providers and foster a virtuous relationship.

RECOMMENDATIONS

- Regular training for leaders to be empathetic, active listeners, and understand team and patient experiences.
- Open forums for healthcare professionals to express concerns and provide feedback.
- Inclusion of compassion in performance reviews to measure leadership.
- Fostering teamwork, not just dictates, to enhance care.
- Long-term, not just temporary initiatives to create a culture of compassion.
- Appreciating and rewarding kindness to motivate employees.
- Making compassion part of the system, from policy to training to daily operations.

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ANNEXTURE:
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Kokil Agrawal ST report

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