

**Management Capacity Assessment for  
National Health Programs:  
A study of RCH Program in Gujarat State**

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### Abstract

*The Ministry of Health and Family Welfare, Government of India administers a large number of national health programs such as Malaria control program, Blindness control program, National AIDS control program, Reproductive and Child Health (RCH) Program and so on. However, effective management of these programs has always come under scrutiny, as these programs consume a large amount of resources. As health is a state government subject in India, it is necessary to assess the management capacity of the department of Health and Family Welfare (H & FW) in each state.*

*In this paper, we focus on the management capacity assessment for RCH program. Based on extensive literature survey, and discussions with senior officers in charge of RCH program at the centre and several states, we have developed a conceptual framework for management capacity assessment. Central to our conceptual framework are the following determinants of management capacity at the state dept of H & FW: (1) Capacity to formulate a clear statement of the state's RCH Policy, Goals, and a Strategic Plan to achieve the Objectives, consistent with the resources available, (2) A well designed organizational structure for the H&FW department to provide the necessary support for achieving the policy goals, (3) Capacity of the H & FW department for effective management of RCH program, (4) Clear documentation of HR policies (qualifications, transfer, promotions, training etc) for RCH managers, (5) Role of External Stakeholders (6) Management Systems for Planning, Implementation and Monitoring RCH program, and (7) Institutional Processes and procedures*

*For each of the above determinants, we have identified a set of indicators to assess the management capacity and designed a management capacity assessment tool to estimate these indicators. A pilot survey of our management capacity assessment tool in a few states helped us to refine certain instruments in our tool and finalize the same. Our management tool has been accepted by the Ministry of H & FW, Government of India and it has asked all the states and union territories to carry out a self assessment of their management capacity for RCH program.*

*We have also recommended a suitable structure for effective management of RCH program for each state based on its population, the number of people in the reproductive age group, expected number of childbirths, and the current status of its H&FW department in delivering RCH services. This recommended structure can be used as a guideline by each state to identify its capacity gaps and take the necessary steps to augment its management capacity.*

## Management Capacity Assessment for National Health Programs: A study of RCH Program in Gujarat State

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# Management Capacity Assessment for National Health Programs: A study of RCH Program in Gujarat State

## 1. Rationale for the study:

Over the last 50 years, the Government of India has built a massive primary healthcare infrastructure, consisting of more than 450 district hospitals, 3000 community health centres/rural hospitals, 22000 primary health centres, and 130,000 sub-health centres.

In the 1950s and early 1960s, primary healthcare system focused on basic healthcare including maternal and child health. But since 1966, focus has shifted to the target oriented family planning program leading to neglect of maternal and child health. This trend was further aggravated with the launching of universal immunization program in the mid 1980s and polio eradication program in the mid 1990s. Following the ICPD conference in 1996, the government of India started the process of reorienting its Family Planning and MCH programs into a new program called reproductive and Child Health (RCH).

RCH has many components: Family Planning, Maternal Health, Child Health, Adolescent Health, RTI/STI, Urban Health and so on. However, institutional capacity was not augmented to manage the RCH program activities. This led to weak planning, poor implementation and unsatisfactory supervision and monitoring. As a result, the first phase of RCH (1997-2004) did not produce the intended results. A preliminary study by one of the authors highlighted the lack of top management capacity at the national level as well as at the state level in planning and implementing the RCH program. Other constraints arising out of poor management of human resources, lack of proper infrastructure and recurrent funding shortfalls are all related to inadequacy of management capacities as indicated by this study. The RCH-I program evaluation by the World Bank also emphasized the need to considerably strengthen the management capacity for RCH II (2004-2009).

Based on the findings of the RCH I evaluation, the Government of India requested the authors to carry out an in-depth study of assessment of management capacity for RCH II and develop tools which can be used by all the states.

## 2. Objectives of the Study:

The objectives of our study are to evolve indicators for assessment of management capacity for RCH and thereby develop appropriate instruments and tools for capacity assessment.

## 3. Our Methodology

**3.1 A Literature review:** The notion of capacity assessment and capacity development has historically been blurry and unclearly defined. It is difficult to

appropriately assess something when what is being measured is unknown. The literature presents a variety of different viewpoints regarding this lack of clarity and elucidates different ways to refine the theory behind capacity development and its assessment.

Samuel Paul (Paul (1995), in his seminal paper, established that past development efforts had been unsuccessful because of their lack of attention to the human and institutional capabilities of the countries involved. Donors were, and are, more interested in capital investments and structural capacity, but Paul noted that capital and structures will not be efficient unless matching human and institutional capabilities exist; trained personnel will only be utilized to their maximum potential in organizational settings that are well developed.

Christopher Potter and Richard Brough (Potter and Brough, 2004) further developed Paul's framework. The authors noted the widespread frustration with the now clichéd jargon of capacity development and assessment. Different stakeholders employ different conceptual definitions, thereby creating diverging expectations regarding action plans, goals, and timelines for achieving said goals. To avoid this, capacity assessment should focus on the capacity for program execution independent of changes of personalities, technologies, social structures and resources crises, thus implying the development of a sustainable and robust system," with assessment being the measurement of a system as such.

OECD (OECD 2006), in their document on capacity development, again recognized the continuing blurriness of the concept's definition. In response to the need for a concrete meaning, capacity was then defined as the "ability of people, organizations and society as a whole to manage their affairs successfully." Three analytical levels are employed in this definition: individual, organizational, and the enabling environment.

UNDP (UNDP, 2006) adopts a stand conceptually similar to the OECD framework. Their definition of capacity is "the ability of individuals, institutions, and societies to perform functions, solve problems and set and achieve objectives in a sustainable manner." UNDP used the same three analytical levels as OECD, but they further divided the levels into types of cross-cutting functional capacities to measure, which are the ability to: engage in multi-stakeholder dialogues; analyze a situation and create a vision; formulate policy and strategy; budget, manage and implement; and to monitor and evaluate.

There are two documents that are actual practice tools. The first is DFID's Source Book, (DFID, 2006) which describes the key tools used in institutional development and assessment. It covers analysis and diagnosis of the overall institutional framework, review and design of the assessment and subsequent intervention, and also describes implementation strategies for change. The second is the McKinsey Capacity Assessment Grid (McKinsey, 2003), which was designed specifically for NGOs and nonprofits to assess their organizational capacity, which includes many sample assessment questions.



General management issues such as national leadership, political commitment, and financial constraints have been identified as constraints in health development but capacity of top management has not been clearly recognized in developing countries (WHO 2006).

**3.2 Developing a framework:** Our framework for assessment of management capacity builds on an understanding of the issues in capacity development from the literature review outlined above and focuses on the management capacity of government health departments.

Our methodology starts with a situational analysis of existing management capacity in a few states for planning, implementing and monitoring the RCH program. Based on the understanding from the situational analysis, we develop a conceptual framework for management capacity assessment, identify critical indicators to assess the capacity, pilot test this tool in the selected states with active participation of the state department of H & FW.

We also recommend a suitable structure for effective management of RCH program for each state based on its population, the number of people in the reproductive age group, expected number of childbirths, and the current status of its H&FW department in delivering RCH services. This recommended structure can be used as a guideline by each state to identify its capacity gaps and take the necessary steps to augment its management capacity.

RCH Activities can be broadly classified as follows:

Main Activities:	Maternal Health Child Health Family Planning
Newer Activities	Prevention, Management of STI/RTI Safe abortion Adolescent and Sexual Health Gender, PNDT, etc Midwifery and Nursing Urban Health Nutrition
Support Activities <sup>1</sup>	Demography and Vital Statistics IEC HR Medical Devises, Drugs & logistics Transport and Communication Repairs and Maintenance (Civil, Elec, Mech, Biomed)

<sup>1</sup> These are for the dept of H & FW as a whole, not exclusively for RCH division only

## 4. A Conceptual Framework to assess Management Capacity

**Dimensions of Management Capacity:** Management is all about planning, monitoring and control. Assessing the management capacity of an organization is therefore about measuring the organization's structure and capacity to plan, monitor and control its activities. This calls for an assessment of the effectiveness and efficiency of the organizational systems, processes and procedures in meeting the organization's goals and objectives. Our framework for assessing the management capacity of an organization focuses on the effectiveness of management capacity across the following dimensions:

### A: RCH Policy, Goals, Objectives and Strategic Plans:

Does the Dept of H&FW have a clear statement of the RCH Policy, Goals, and a Strategic Plan to achieve the Objectives? This would assess the institutional understanding of the challenges in managing the RCH program. Some of the indicators to assess the state's preparedness to achieve policy objectives are:

- Does the dept of H & FW have a policy document on RCH Goals?  
If Yes,     How old are these policy documents?  
                  How were these policies developed?  
                  Were the stakeholders involved in policy process?  
                  How much external assistance sought in formulating RCH policies?
- Does the department have a strategic plan to achieve the policy goals and measurable objectives?

### B: Organizational Structure:

An examination of the Dept of H & FW's organizational structure would give an idea about the role and position of its RCH program officers/managers. It is necessary to clarify "who's doing what" for planning, implementation, and monitoring of the RCH II program. Some of the indicators to assess the effectiveness of organizational structure are:

- Does the dept of H & FW have an organizational Chart?  
If yes,     Is it the same as in the State Budget Document?  
                  Does it meet the department's needs?  
                  Is it as per the requirements of NRHM?  
                  Does it need any revision, strengthening?  
                  How many managers<sup>2</sup> are on full time regular appointments?  
                          Vs part time managers holding additional charges, consultants etc
- What are the arrangements for hiring consultants (EAG and Non-EAG states)?
- What is the technical and office support for RCH?

<sup>2</sup> For example, Managers in the Gujarat dept of H & FW include officers from the level of Assistant Directors and upwards. Since each state has different designations for its officers (Directors, Director Generals, commissioners etc) , we will use a general term "Managers".

**C: HR Policies:**

HR policies (qualifications, transfer, promotions, etc) are indicative of the management/leadership skills available to administer the RCH II program. Some of the indicators on the capacity of HR systems are:

- Is the structure, role and authority to the HR cell in the dept of H & FW appropriate?(visible from the organizational chart of the department)
- Are the qualifications/experience for managers well documented?
- Are the rules for recruitment, transfer, promotions etc well documented?
- What is the management staff turnover?
- Is there a training policy for management capacity development?

**D: Role of External Stakeholders:**

What is the type of managerial assistance (technical and financial) that external stakeholders provide to the RCH II program? This would provide an assessment of the institution's strengths and weaknesses and therefore its dependence on external stakeholders to fill the management capacity gaps. Some of the indicators are:

- Who are the external stakeholders (International and National)?  
Donor partners, NGOs, Professional bodies such as FOGSI, Medical Colleges,...
- What is the nature and support from external stakeholders? Management support, financial support, etc. Do they complement the state capacity?
- What Sectors these external stakeholders are involved?  
Health, Water, Nutrition etc (NRHM context)

**E: Management Systems:**

How well do the existing management systems for Planning, Implementation, and Monitoring facilitate delivery of RCH services? Some of the indicators are

- Does the dept have a well developed Planning Document?  
Planning for Human resources  
Financial resources  
Materials (Medicines and Drugs)  
Medical and Biomedical devices  
Repairs and Maintenance for equipment  
Repairs and Maintenance of health facilities
- Does the dept have a well developed Implementation schedule for its planned activities?

- Does the dept have a MIS (Live Monitoring) Vs Evaluation (Post Mortem)

### **F: Structure of Health Delivery Systems**

This is to assess the managerial work load for various services at each level and availability? Some of the indicators are

- Number of Government facilities (primary, secondary, tertiary services)
- Number of Private facilities (primary, secondary, tertiary services)
- Number of NGO, Trust managed facilities (primary, secondary, tertiary services)
- Number of Medical, para medical and administrative staff at each level
- What are the arrangements for Public-Private Partnerships?

### **G: Management Processes**

This is to assess the department's capacity to keep track of its commitments and obligations. Some of the indicators are:

- Does the dept produce an Annual statistical report with performance analysis and identification of critical areas?
- Does the dept produce an annual achievement report; Planned vs Achieved?
- Does the dept produce an annual audited statement of utilization of all resources? (Funds, HR, Medicines and Medical Equipment)

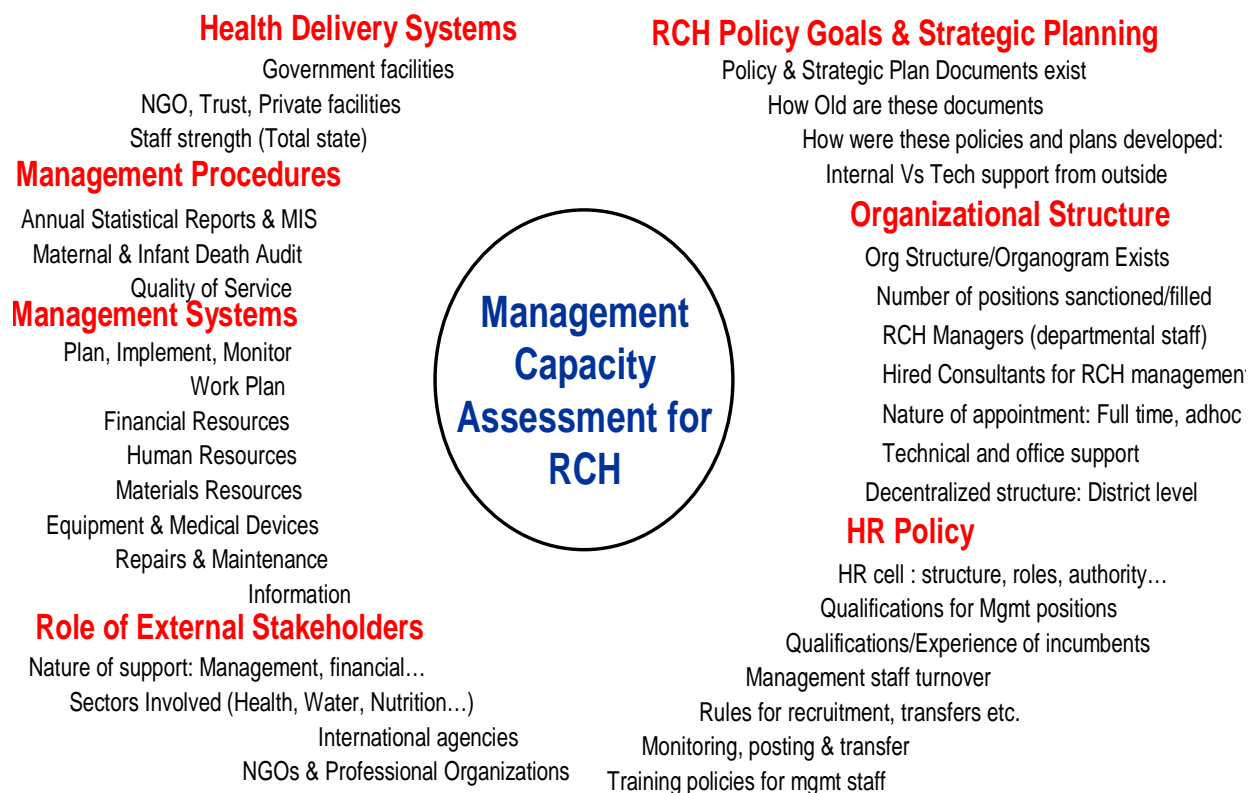
Our framework for capacity assessment, determinants and their indicators is summarized in Figure 1 below.

**Figure 1**  
**Management Capacity Assessment: A Conceptual Framework**

# Management Capacity Assessment for RCH

## A Conceptual Framework

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## 5. Preliminary Assessment of Institutional Capacity: Gujarat State<sup>3</sup>

Our preliminary observations on the management capacity assessment in the state of Gujarat are given below. These are based on discussions with several officers at the Secretariat, Commissionerate, and the District RCH units and review of documents and surveys<sup>4</sup>.

Currently the Health and Family Welfare department is divided into four major divisions, namely Health, Family Welfare, Medical Services, and Medical education. The Director of Medical Education looks after the six medical colleges and the attached hospitals. The Director of Medical Services looks after all the district hospitals, Civil hospitals and the CHCs. The rural health infrastructure is under the Director of Health, who looks after PHCs and sub-centres as well as the disease control programs. The director of RCH looks after FP and MCH related activities.

Below, we give our assessment of the capacity of FW department in managing the RCH II program. Our focus, as mentioned earlier, is only the effectiveness of institutional (management) capacity, and not the efficiency of the institutions<sup>5</sup>.

### 5A: RCH Policy, Goals, and Strategic Plan:

Does the Dept of FW have a clear statement of the RCH Policy, Goals, and a Strategic Plan to achieve the goals?

In the year 2000, The Government of Gujarat constituted a Social Infrastructure Development Board for achieving overall development in the state, which identified reduction in IMR, MMR, and TFR as priorities for the state. Subsequently, under the Directive of the Chief Minister of Gujarat, a high-level committee on Population Stabilization headed by the honourable minister of Health and Family Welfare was formed. The state population policy was released in 2002 with active support from UNFPA and involvement of substantial participative processes. Gujarat's health policy is part of its Population Policy. The state has not yet developed any specific policy document related to health, RCH, or NRHM.

The State has prepared a detailed State Program Implementation Plan (PIP) for RCH II as per guidelines provided by the central government and the World Bank, which

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<sup>3</sup> Even Gujarat, a well performing state, seems to be lacking in management capacity for RCH Program. The management capacity in many other states and especially in EAG states could be even worse.

<sup>4</sup> Please note that the final and a more realistic assessment of the management capacity of the RCH division in the Gujarat dept of H & FW will be done through a self assessment by the State appointed Nodal officer by administering our Assessment Tool.

<sup>5</sup> Efficiency assessments deal with the assessment of financial resources (input-output ratios). This assessment has been entrusted by MoHFW to a financial consultant. Hence IIMA is not involved in efficiency assessment analysis. ToR for IIMA is only for assessment of effectiveness of the institutional capacity.

describes in detail a strategic plan to meet the policy goals. The state also has issued several GRs related to merger of disease specific societies into a single health society and establishment of a State Rural Health Mission. Recently, the state has initiated formulating a Public Health Act for the state.

This State PIP document<sup>6</sup> gives strategy, objectives and activities for key substantive areas under RCH. For example, the annual plan for achieving 90 % complete ante natal care by 2010 is reproduced below.

### Plan for Ante Natal Care

% women receiving complete ANC	Current Status (RHS-2)	Cumulative Objectives				
		2005-06	2006-07	2007-08	2008-09	2009-10
Overall	27.21	32	42	57	75	90
Urban	32.03	37	47	62	80	95
Rural	22.96	27	37	52	70	85
SC/ST	23.62	28	38	53	71	86

Source: Government of Gujarat, SPIP 2005

RHS: Rapid Household Survey

This document was internally developed by the government officers including faculty from medical colleges and training institutes. This document also includes Gantt Chart of activity schedules.

Preliminary assessment on Policy and Strategic Planning: The state has taken several initiatives for developing a State PIP (and some District PIPs), a detailed strategic plan, innovative programs and schemes (eg: Chiranjeevi scheme) but lacks the institutional capacity to take the policies forward for operational planning and implementation. There does not seem to be any permanent policy advisory group at present within or outside the government which can provide continuous policy and strategic support.

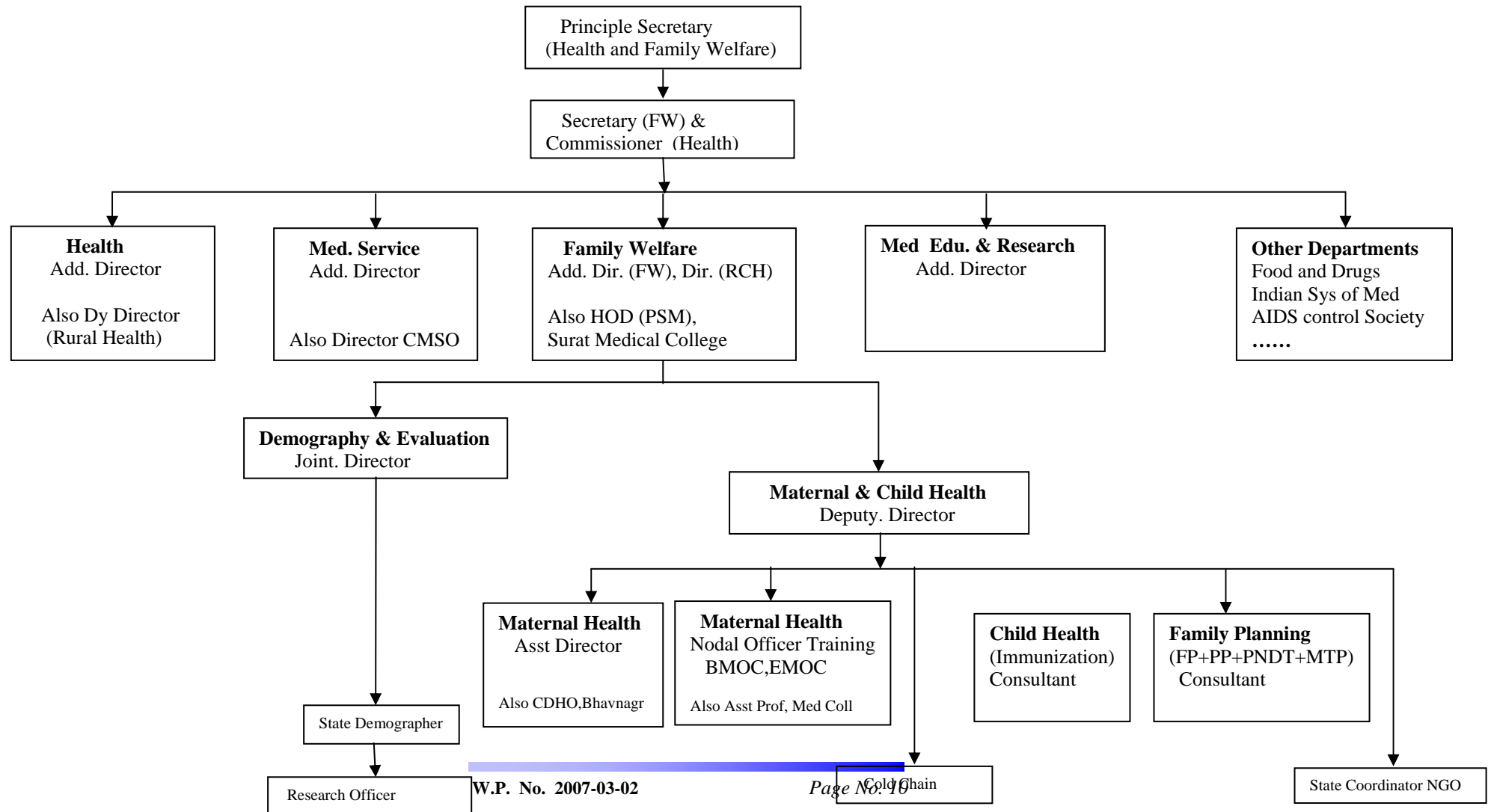
### 5B: Organizational Structure:

An examination of the Dept. of H & FW's organizational structure is necessary to clarify "who's doing what" for planning, implementation, and monitoring of the RCH II program. It also shows if the number of managers at each level of decision making is adequate or not.

It was difficult to obtain an organizational chart of the directorate. After several efforts we got different versions of the organizational chart (See Figure 2 below).

<sup>6</sup> This is an excellent document by the Gujarat state RCH division. We strongly recommend other states to follow the Gujarat initiative and prepare similar documents.

**Figure 2**  
**The Current Organizational Structure: RCH division in Gujarat H&FW dept**





Secretariat and Commissionerate: The secretariat consists of a Secretary (Health)<sup>7</sup>, Secretary (FW), and a Joint Secretary, all from the Indian Administrative Services (IAS). They are assisted by several deputy secretaries who belong to the Gujarat Administrative Services (GAS). The Secretaries do not have to undergo any technical or managerial training in health before or during their tenure (except mandated by DOP for IAS). Delegation of powers to the Commissionerate for effective management of RCH seems to be insufficient.

The Commissionerate is headed by the Health Commissioner (IAS), who is also Secretary (FW) in the Secretariat. Even though an IAS officer is the Commissioner of Health, many files and decisions are referred to the Secretariat. This leads to delay in decision making. Also, frequent transfer of officers between various government departments does not help in building management capacity to manage the health sector.

Number of Managers: Gujarat government has very few managers. The managers in Gujarat include Secretary (Health), Secretary (FW), Joint Secretary, RCH Director, Joint Director, Deputy Director, Assistant Director, and Consultant (see Figure 1)

Gujarat has a population of 5 crores and has only one or two managers for each of the key RCH programs. Each program under RCH is complex and requires substantial technical understanding, planning, directions, supervision and monitoring. Having only one manager looking after the whole programme of child health or family planning in the entire state is grossly inadequate<sup>8</sup>.

Supporting areas such as IEC and Nursing administration are not given due priority. Besides an IEC officer at the Commissionerate (recently appointed, holding additional charge), there are only a few district IEC officers. There are two nursing officers in the Commissionerate; they are not invited to many key meetings, and are therefore not party to decision making.

Full time directors Vs Ad-Hoc arrangements: Many managers are not full time RCH managers. Many hold additional charges (double or triple charges) or on ad hoc basis. For example:

- (i) Additional Director for RCH is also holding charge of Professor of Preventive and Social Medicine in the Government Medical College, Surat
- (ii) Consultant for Maternal Health is also an Associate Professor of Obstetrics and Gynecology at the Government Medical College, Ahmedabad
- (iii) Director, State Institute of Health and FW is holding additional charge as Professor of Preventive Medicine, Government Medical College, Ahmedabad

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<sup>7</sup> Secretaries are designated as Secretary, Principal secretary or Additional chief secretary based on their seniority.

<sup>8</sup> Sri Lanka has population of 1.8 Crore and about 40 managers while Gujarat has population of 5 crores and only about 20 managers.

Officers holding multiple charges or on ad-hoc postings are not able to provide sufficient time for their work at the commissionerate. Such adhoc and part time arrangements of filling of positions severely constraint the organizational capacity.

Support staff: Technical, ICT and office support services for the managers are unsatisfactory. There is no position of Junior Technical officer with medical/public health qualification who can do detailed work on planning, supervising implementation, quality checking or development of technical standards and guidelines. All of this requires substantial time which the managers do not have. In recent times, a number of consultants are being hired under RCH , who have some health management background in MIS, Finance etc. This will improve the management capacity. It would be useful to have a junior scientific officer with technical background attached to each senior officer. Many scientific departments of the government have junior scientific officers, but not the health department.

Preliminary assessment of organizational structure: Very few managers to handle too many tasks, frequent changes of the org structure, and insufficient technical and office support to the RCH managers are major constraints in building institutional capacity.

**5C: HR Policies:** HR policies (staffing, qualifications, transfer, promotions, etc) are indicative of the management/leadership skills available to administer the RCH II program.

Human resource policies and procedures substantially affect the institutional and management capacities of any organization. The HR policies include the recruitment rules with specific qualifications of officers who can occupy certain key positions. It also specifies criteria and rules for posting and transfer of officers, performance appraisal, reward, recognition and punishment. HR cell is headed by Chief Personnel Officer (GAS cadre, rank of Dy Collector). Our observations based on discussions with officers regarding recruitment, job responsibilities, length of tenure etc. are as follows:

HR policy documents: In spite of repeated efforts and requests in various meetings, we could not get any HR document specifically for the health department till very recently, even the RR document obtained is dated 1979, and is not comprehensive. General guidelines for all government departments are applicable to health department as well. As a result, the current recruitment rules do not ensure that the managers have specialized knowledge and training regarding the subject they are looking after. For example, managers in charge of family planning or child health may not have any special qualification in these areas.

Fortunately, minimum qualification (Diploma in Public Health) is required for many public health related positions in the directorate, as well as district levels posts.

Appointment of Top level managers/directors: Many key managerial positions are filled on ad hoc basis, as regular promotions have not taken place for a long time.<sup>9</sup>

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<sup>9</sup> There is no systematic process of promotions in the department. For each promotion different DPC is constituted. There is no fixed DPC. The system of promotion is highly person driven.

Even when senior officers retire, which is well known in advance, no prior preparation is made to fill up those positions; instead ad hoc arrangements and additional charges are given to fill up these positions. Regular promotions, posting and transfer are rare. Some key functions of RCH programme are in charge of consultants, who are hired on an annual contract.

Such arrangements, though producing results and help move the programme ahead faster, are not sustainable in the long run. For example, a change of the current health commissioner might result in losing some of the qualified officers who are currently appointed on such ad-hoc basis, and constrain the institutional capacity substantially.

Job Responsibilities: Even though managers holding key positions are responsible for the success of RCH program, their job descriptions are not clearly specified. It is assumed that the managers would know their responsibilities. If job responsibilities are clear, managers who are responsible for specific tasks could be held accountable for the responsibilities entrusted to them. Many times, they are busy in crisis management or doing routine work rather than involving in strategic and long term planning, quality control or specific monitoring. However, job descriptions for consultants, who are hired on temporary basis, are specified in their Terms of Reference (TOR).

Tenure of top level positions: There is no fixed minimum tenure for manager's position and hence sometimes their tenure is too short. The Portfolios of managers are also changed frequently which leads to disruption in the continuity of top management positions and hence loss of experience. Some managers are promoted to higher positions just before retirement, and such managers stay away from taking any important decisions before retirement. Similarly the tenures of health commissioners and secretaries are also not fixed. Fortunately in Gujarat, the current health commissioner has been in position for the last 2-3 years. But the health secretary has changed several times in last few years.

Training needs: Management training is needed for managers at all levels, but there seems to be no policy guidelines on this. HR policies on training should prepare lower level managers to take up higher level managerial positions. HR cell also should be aware of skill/capacity building available within the state department (eg. SIHFW), identify gaps and augment the training resources accordingly.

Our preliminary assessment of HR: There is a need for revision and transparency of HR policies and rules, all managerial positions should be filled by full time departmental staff with 2-3 years of tenure, role of consultants should be only on a need basis for specific tasks, and training policy to be formulated for capacity building. The position of HR cell needs to be strengthened and headed by a senior HR Manager.

**5D: Role of External Stakeholders:** What is the type of managerial assistance (technical and financial) that external stakeholders provide to the RCH II program?

International Agencies: In Gujarat several international/UN agencies (UNICEF, UNFPA, EC, CARE etc) are very active. All these agencies have set up their local offices to provide technical, material and financial support to the state government.

Each agency has specific mandate and area of work. For example, UNFPA supported the population policy development as well as supporting the campaign against female foeticide and gender imbalance. UNFPA is also supporting the development of EmOC Centres under the IPD project. UNICEF has been supporting child health interventions especially immunization and nutrition. CARE is supporting nutrition related interventions in close collaboration with the ICDS programme. These external agencies are closely working with the state government in the development of PIP for RCH-II. Other stakeholders such as Population Council have been supporting quality improvement in FP. WHO provided support for post earthquake health care, IDSP and Chiranjeevi Scheme. ORET of Netherlands Government provided support for MCH equipment.

Research and Training Institutions: Gujarat has many research and training institutions which have been providing support to RCH related activities. The PRC in Baroda has been involved in DLHS and other surveys related to RCH. IIM, Ahmedabad has carried out several studies and training programmes in management for the state and district level officers in the Health and Family Welfare Department. Food and Nutrition Department of the MS University has been active in the area of anemia control and other nutritional programmes.

NGOs: CHETNA, SEWA, SEVA Rural, and several other NGOs have been actively engaging and supporting the state government programmes with an overall view to improve the services. Several NGOs manage hospitals and dispensaries to provide curative care and MCH with partial support from the state government.

Medical Colleges and state training institutions: Government Medical Colleges and SIHFW have been involved in conducting research studies, preparing technical guidelines and documents and providing training to the health department staff. This has helped to some extent, and needs to be expanded and systematized.

Consulting and Commercial organizations: At times, the government has also sought assistance from consulting firms for HMIS, Drugs Logistics Management, Organizational Development etc. Arrangements with consulting firms have not been satisfactory. For example, RCH and hospital managers have not been able to clearly articulate their needs for management (performance indicators) to the hired software consultants.

Preliminary assessment of the Role of External Stakeholders: Continue building linkages with NGOs, Professional bodies and Research/Academic institutions, strengthen the department's capacity on analysis of data, and to articulate the departmental needs clearly to the consultants. The state should build its own capacity, so as to reduce its dependence on external stakeholders.

**5E: Management Systems:** How well do the existing management systems for Planning, Implementation, and Monitoring facilitate delivery of RCH services?

Planning: The current planning system is largely norm based and follows central guidelines. The RCH-II State Program Implementation Program (SPIP) provides a detailed activity plan based on a logical framework approach. The SPIP is a very

detailed and extensive document. However, there is no evidence of resource planning to achieve the stated goals. For example

MMR Reduction: The strategies for reducing the Maternal Mortality Rate (MMR) from the present level of 389 per 100,000 to below 100 per 100,000 live births are as follows:

- a) 90 % complete antenatal care
- b) 90 % deliveries assisted by Skilled Birth Attendants
- c) 80% institutional deliveries
- d) Increased access to Emergency Obstetric Care
- e) 90 % coverage of post partum care
- f) Early & safe abortion services (1/100,000 Population)
- g) Access to RTI/ STI services in all Primary health centres and community health centres

Detailed Plans of action for achieving each of the above mentioned targets for each year of the RCH II programme are also given in the State Programme Implementation Plan 2005-2010. For example, the annual plan for Emergency Obstetric Care services is given below, see Table below.

#### Plan for Basic and Emergency Obstetric Care Services

Type of EOC services	Current Status (RHS-2)	Cumulative Objectives				
		2005-06	2006-07	2007-08	2008-09	2009-10
BOC (100 % FRUs, 50 % CHCs, 10 % PHCs)	56	181	366	380	380	380
COC 90 % FRUs	39	64	102	102	102	102

Source: Government of Gujarat, SPIP 2005, and RHS: Rapid Household Survey

Resources planning to achieve the stated targets While detailed annual targets are given for BOC, COC, there is no evidence of planning for resource allocation to achieve the stated targets. For illustration,

What resources are required (HR- staff, Finance, Medicines & Drugs, Medical devices) and in what quantity to provide BOC services in 366 facilities in 2006-07 up from 181 facilities in 2005-06?

Similarly what resources are required and in what quantities to increase availability of BOC services from 366 facilities in 2006-07 to 380 facilities in 2007-08<sup>10</sup>.

<sup>10</sup> Gujarat Health Commissioner clarified that Gujarat has prepared a detailed resource planning document and is available in his office.

Obviously, the resource requirements are different for 2005-06, 2006-07, and 2007-08 to achieve the stated targets in each of these years, and the strategic planning also should reflect these.

It is also necessary to translate these state level targets into targets for each district, taking into account the status of RCH program in each district, and therefore the resources (HR, finances, materials, and equipment) required for each district.

Implementation: Implementation of many RCH-II components needs more attention. Since there seems to be no systematic planning of resource allocation, implementation of planned activities is likely to be weak. Shortage of field supervisors and ineffective supervision add further difficulty for implementation.

Monitoring: Gujarat state has a demography evaluation cell (D&E Cell) which compiles the MCH and FP data. The division of vital statistics compiles birth and death statistics. Individual officers also monitor their own programme statistics. The current monitoring pattern is largely based on CSSM/RCH formats, relying on Forms 1-9. Till very recently, there was very limited analysis of this data except comparing the achievements with targets. Of late, the D & E cell officers have started analysis of data to understand the trends and estimate measures of performance. Computer use is mostly limited to data compilation and preliminary analysis, besides generating forms 1-9 of CSSM/CNAA. GIS, Internet and WAN uses are on the increase.

One of the major problems with routine data reporting is that there is almost no field-level verification of the data reported by the field functionaries. All data is taken on its face value, assumed to be true, and compiled and sent upwards. This is in spite of the fact that some surveys and other independent data sources have indicated 30-40 % discrepancies. In the last couple of years, even the central government initiated verification of family planning acceptors has not taken place.

Some of the simple but vital data which are not monitored include the number of functionaries staying at the place of posting, which is very important for service delivery. There are several functionaries receiving training for various activities such as performing MTPs, sterilization, EOC etc. but hardly any monitoring is done on the performance of these functions by these trained employees.

The system of collecting maternal and infant death report is very weak. There have been some efforts to introduce maternal death audit following Tamil Nadu example. Unfortunately this initiative has not take off due to lack of time for the maternal health manager who is over burdened. It would be better to hire additional consultants or medical college staff to ensure that all the 4000 or so maternal deaths are registered, investigated and analysed and follow up actions taken. Investigation of infant deaths would be a more daunting task as the numbers would be several times more. One child health manager cannot manage all the child health interventions and organise investigation of child death in the whole state.

Infrastructure for supply of drugs, management of blood banks, equipment, vehicles etc. is also weak. Better management systems are required for managing these expensive resources if the state wants to ensure their proper utilization under RCH-II. It is very well known and documented in some evaluations of RCH-I that much of the



expensive equipment provided under RCH programme remains unutilized due to lack of monitoring systems and supportive investments by the state.

There is no proper integrated MIS. What is available is the Annual administrative report which reports data without much analysis and interpretation. The state government has initiated developing an HMIS through contracts to software consultants and foreign universities, without clearly articulating the MIS needs of managers at each level of decision making. The existing MIS was designed for CSSM and modified under CNAA which supports a centrally driven program. NRHM, on the other hand promotes decentralization. Hence the current MIS formats (Form 1-9) are less relevant under NRHM.

Preliminary assessment of Management Systems: Our assessment is that the state H & FW department should identify critical areas for managing the RCH II program under NRHM, and strengthen Operational Planning and implementation. It should also focus on Monitoring and Control (control calls for live interventions) instead of relying on evaluations which are like post mortem and audit functions. Evaluation is donor driven, while Monitoring and Control are management needs.

#### **5F: Structure of Health Delivery Systems:**

Gujarat has a large population but only moderate public health infrastructure. As Gujarat is a more affluent state, the expectations from its people especially in the developed districts are high and hence the management challenge for the public health managers is much higher as compared to other under developed states.

Primary healthcare services: Gujarat has provided only one medical officer per PHC whereas some of the developed states such as Maharashtra and Tamil Nadu have two medical officers per PHC. Many of the PHC medical officers (as well as ANMs and LHV) in Gujarat are not staying at the place of posting and hence their availability at the PHC especially in rural and remote areas is very limited. The recent initiative of the Commissioner to post AYUSH doctors at non-staffed PHCs is a welcome step.

Secondary healthcare services: Gujarat has a shortage of specialists in rural areas (gynaecologists, pediatricians and anesthetists), but many specialists in medical college hospitals. While the numbers of sanctioned posts are limited, many sanctioned posts are lying vacant. Lack of specialists has constrained the institutional capacity to deliver high level of skilled RCH services such as EOC and institutional neo-natal care in the government set up.

Fortunately Gujarat government has developed a very innovative scheme of contracting private Obstetrics and Gynaecologists, to provide maternity services in private hospitals to BPL families, under the Chiranjeevi<sup>11</sup> Scheme. This has expanded availability of institutional delivery by obstetricians in rural areas many folds. This innovative scheme seems to be quite successful and is being expanded to the whole state. The current cost of the scheme is fairly modest at about Rs. 1750 per delivery and transportation charge reimbursement of about Rs. 200. The scheme was first

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<sup>11</sup> Chiranjeevi Scheme has recently won an international award from the Asian Wall Street Journal.

introduced in 5 rural districts and the initial signs are very encouraging. A recent assessment of the Chiranjeevi scheme points out an acceptance rate of about 30 % by the BPL mothers. This scheme is now extended to the entire state.

Preliminary assessment of Health Delivery Structure: Our assessment is that even though the state has a large number of its own health facilities, the quality of its services are not very satisfactory. PPP is seen as a panacea for all problems, without paying attention to improving the working of government health facilities. Chiranjeevi scheme has expanded availability of institutional delivery by obstetricians in rural areas many folds. This innovative scheme seems to be quite successful and is being expanded to the whole state. Formal arrangements for Public Private Partnership have to be framed keeping the obligation of the government to provide health services to all sections of the society, particularly the poor.

### **5G: Management Processes:**

Gujarat state like other states does not produce any systematic health development plan on an annual basis. The state also does not produce annual health reports which show achievements under various programs and various health objectives. Only administrative report is produced which is required for submission in the state assembly. No report is available regarding the private sector services, even though private sector expenditure for health is as high as 80 %.

The capacity for analysis, writing and documentation is very limited. However, the state department of H & FW is proactive in putting a lot of information on its website. Website information should be routinely updated.

Many processes are centralized and archaic and leads to delays in decision making. Presence of a dynamic commissioner cuts short certain procedural delays, but this is not a permanent arrangement.

Preliminary assessment of Management Processes: Our assessment is that many of the management process and procedures are centralized, bureaucratic and archaic. There is enormous delay in decision making. The state should bring out an annual report on State Health Statistics covering both public and private sector achievements.



**Summary of our preliminary assessment:** Our observations on the Management Capacity for RCH program in Gujarat state is summarized in Table 1 below.

**Table 1**  
**Summary of our Preliminary assessment: Gujarat RCH program Management**

<b>Capacity Indicator</b>	<b>Strengths</b>	<b>Weaknesses</b>
Policy and Strategic Planning	State PIP gives RCH policy goals and strategic plans.  Chiranjeevi Scheme Proposal for a Strategic Cell	Does not seem to conduct regular policy and planning reviews
Organizational Structure	Already Set up three cells in RCH division:  Maternal care Child care Family Planning	Too few managers for a large workload (50 M population, 1.2 Million child births) Weak IEC Nursing, Midwifery neglected Frequent structure Changes No set up for IEC, Anemia, STI mgmt, Adolescent health, Urban health
HR	Excellent officers available within the H& FW department	Officers on Adl charge Many ad-hoc appointments Many full time consultants Short tenure, No career planning No document on postings, recruitments, transfer, promotion, Weak HR cell
Dependence on External stakeholders	Good linkages State NGO coordinator	Not enough capacity for data analysis, planning, and therefore limited capacity to articulate the state needs to consultants
Management Systems for Planning, Implementation, and Monitoring	State PIP has a Strategic Plan Annual targets also mentioned	No planning for Resource allocation to achieve the targets, Poor implementation Poorer monitoring Reliance on Evaluation (post mortem)
Health Delivery Systems	Large number of govt. facilities Presence of private providers	poor service delivery PPP not fully exploited
Management Processes	Commissioner is dynamic and so quick processing of files	Highly centralized, Delay in decision making No annual reports

Based on the above observations, we develop the following structure for Maternal Health division in Gujarat state.

### **Key Activities for Maternal Health as shown in state PIP<sup>12</sup>**

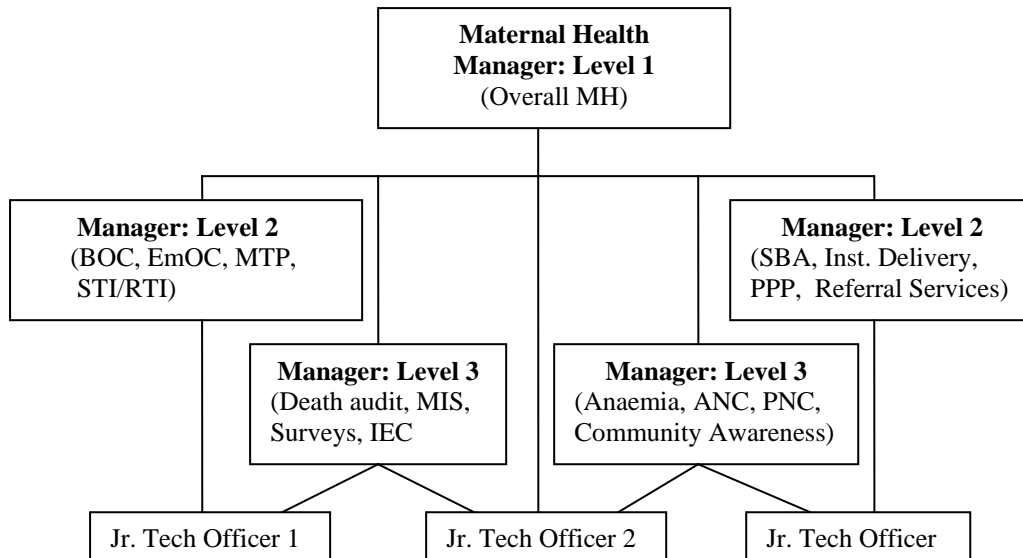
1. Improve coverage of antenatal care (90%) by 2010.
  - Organize weekly ANC Clinics to improve ANC registration and antenatal services.
  - Develop linkages with private practitioners for early ANC registration and services
  - Increase awareness in the community for enhancing the need of seeking care and services from health facilities during pregnancy, and community role in reaching adolescence mothers and SC/ST mothers will be promoted.
2. Increase the deliveries attended by SBA by 90%, Institutional. Deliveries by 80%.
  - Increase availability of SBA (ANMs, Nurses in 50% of PHCs for 24 hours delivery services)
  - Improve services environment of the PHCs and CHCs for institutional deliveries.
  - Streamline the health seeking behaviours of community especially pregnant mothers.
3. Increase access to Emergency Obstetric Care for complicated deliveries.
  - Operationalize BOC services in 100% FRUs, 50% of CHCs and 10% of PHCs
  - Operationalise CEmOC services in 90% of FRUs.
  - Developing partnership with private, trust and grant in aid hospitals for C/BEmOC.
  - Increasing awareness in the community regarding availability of EmOC services.
4. Increase coverage of post partum care (90%).
  - Ensure home visits (ANM, AWW, LHV) within 3 days of delivery in case of home delivery
  - Provide FP advice and services to all PNC mothers.
  - Undertake BCC/IEC related activities.
  - Sensitise MOs/ANM/LHV/AWWs on the need for providing care to women and newborns.
5. Increase access to early and safe abortion services (1/100,000 Pop).
  - Improve access to safe abortion services by ensuring one service centre in each block.
  - Increase awareness in the community regarding availability of MTP services, consequences of sex selective abortions and PNMT.
6. Improve access to RTI/STI services in all PHCs and all CHCs.
  - Strengthen all PHCs, CHCs and FRUs for diagnosis and treatment of RTI/STI
  - Increase awareness regarding RTI/STI and importance of seeking timely care- BCC/IEC.

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<sup>12</sup> Ref: Gujarat State PIP Objectives and Strategies to achieve an MMR of 100 by 2010

Based on the state PIP activities for improving maternal care mentioned above, we recommend the following structure for the Maternal Health division, RCH, Gujarat.

**Figure 3**  
**Recommended structure for Maternal Health, Gujarat State**



Similar structures for Child Health, FP etc can be developed by referring to the Gujarat state PIP, and hence not repeated here.

## 6. Recommendations: Management Capacity for Effective Management of RCH Program

Based on our assessment of institutional capacity for RCH program in Gujarat State, it is obvious that many states/UTs will have to substantially augment their existing institutional capacity, to ensure that all RCH projects and activities (under NRHM framework) are properly planned, implemented and monitored in the field, appropriate data collected and verified, data properly analyzed and the annual progress reports published highlighting the achievements against targets. The additional cost for augmenting the managerial staff can be easily compensated by the benefits from effective program management.

Many states have a large and rapidly growing private health sector which consists of individual private practitioners, NGO and trust managed hospitals, NGO managed community health programs, and large private corporate hospitals. The Chiranjeevi Scheme of Gujarat State is an excellent example of PPP for other states to follow.

NRHM addresses not only health issues but factors which are determinants of good health such as drinking water, sanitation, hygiene etc. This means that the H&FW directors have to closely work with related departments. There has to be therefore some institutional framework for such inter-departmental coordination and cooperation.

The H&FW department in each state also needs a separate division to focus on urban health and Tribal health. Urban health is a growing concern due to increasing urban population.

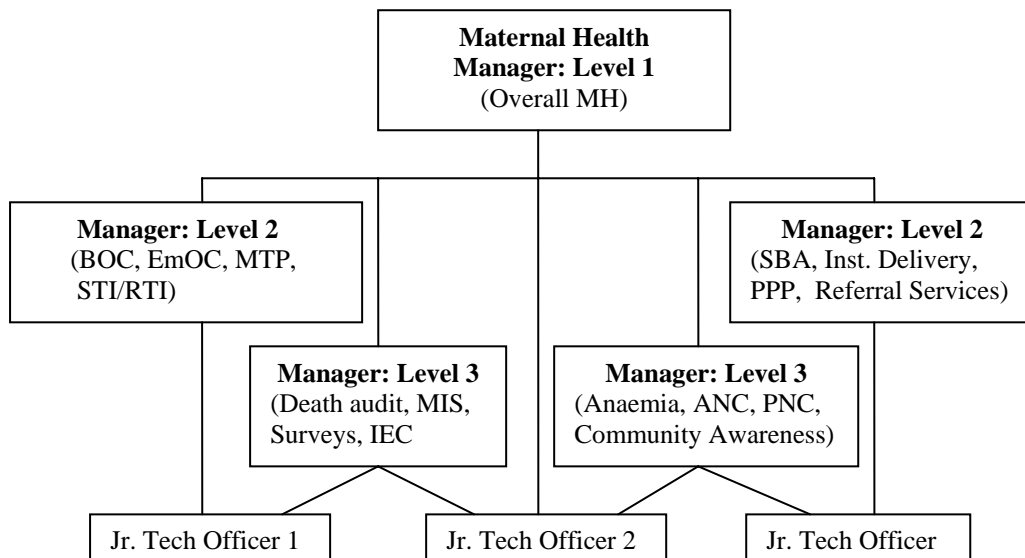
We recommended the following structure for the three key areas of RCH for a state with approximately 5 crore population.

- Maternal Health (Figure 4)
- Child Health (Figure 5)
- FP, Gender, Adolescent Health (Figure 6)

For other areas (Nutrition, Midwifery & Nursing, Urban Health, Tribal Health etc) the management structure needs suitable modification as per the state's needs.

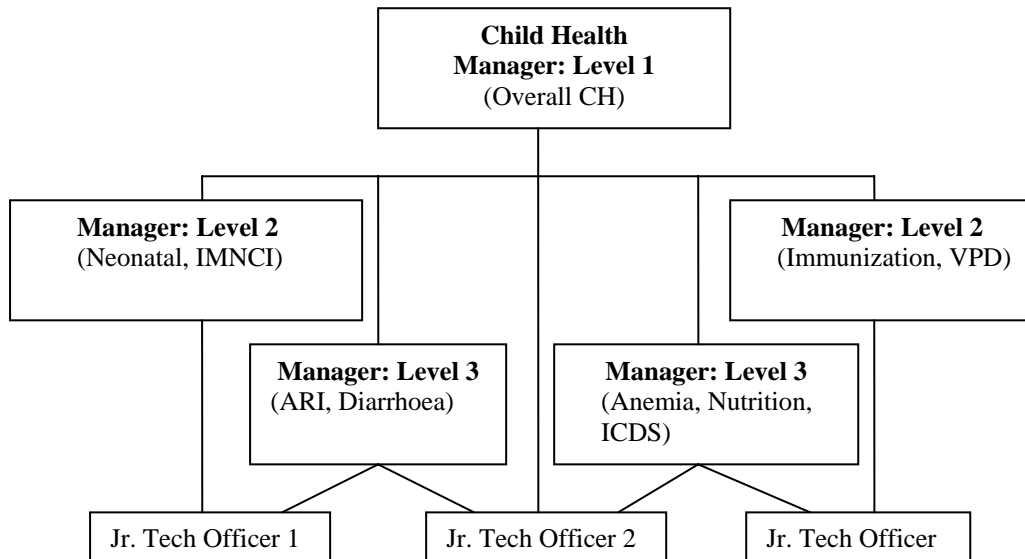
For supporting areas (Vital Statistics, M & E, HR etc), similar structure will be required; the details have to be worked out by the state as these supporting departments are not exclusively for RCH services.

**Figure 4**  
**Recommended Structure for Maternal Health<sup>13</sup>**



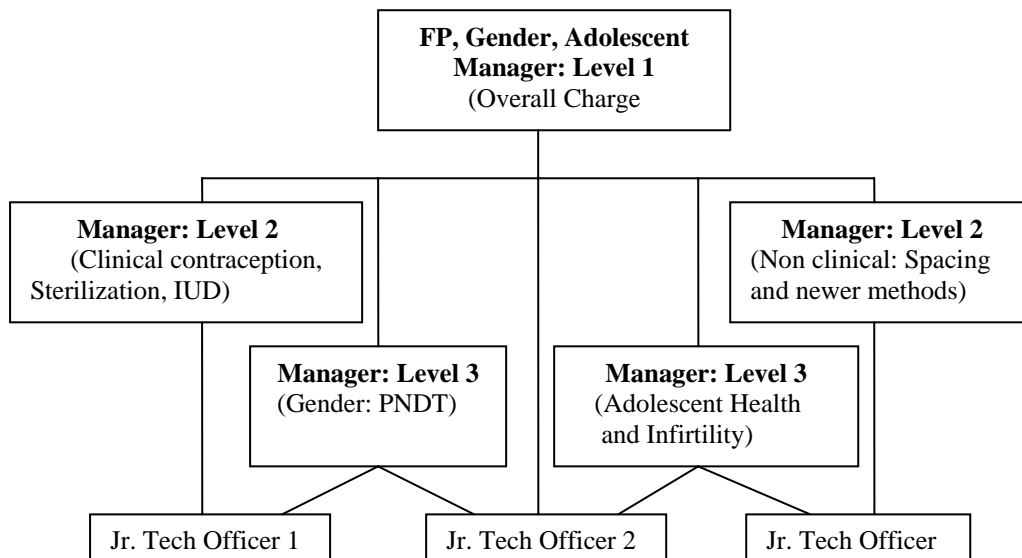
<sup>13</sup> This recommendation is for a NON EAG state with approximately 5 crore population. For EAG states, the number of managers should be 1.5 times that of non-EAG states.

**Figure 5**  
**Recommended Structure for Child Health<sup>14</sup>**



<sup>14</sup> This recommendation is for a NON EAG state with approximately 5 crore population. For EAG states, the number of managers should be 1.5 times that of non-EAG states.

**Figure 6**  
**Recommended Structure for FP, Gender and Adolescent Health<sup>15</sup>**



## 7. Conclusions

We feel that the framework developed by us for assessing the management capacity for RCH program can be extended, with minor modifications, to assess the management capacity of other national health programs as well. The assessment tool also needs minor modifications accordingly.

<sup>15</sup> This recommendation is for a NON EAG state with approximately 5 crore population. For EAG states, the number of managers should be 1.5 times that of non-EAG states.

## Exhibit 1

### A Tool for Assessment of Institutional Capacity for RCH Program

Based on the conceptual framework described in our study report<sup>16</sup>, we have developed a tool to assess the effective management capacity for RCH program at the state level.

The conceptual framework was presented in the meeting held on January 19, 2006 at Nirman Bhavan, presided over by Smt S Jalaja, Additional Secretary, MoHFW (capacity assessment framework attached herewith for ready reference)

The assessment tool, based on the conceptual framework was presented in the meeting held at Nirman Bhavan on November 6, 2006 presided over by Smt S Jalaja, Additional Secretary, MoHFW. This meeting was attended by RCH officers from Gujarat, Karnataka, and West Bengal besides many donor partners.

Based on the feedback obtained in the November 6 meeting, we modified certain parts of the tool and the revised tool was presented in the meeting held on December 18, 2006 at Nirman Bhavan presided over by Mr Partha Chattopadhyay, Chief Director, Statistics, MoHFW. This meeting was attended by RCH officers from Gujarat, Karnataka, Chhattisgarh, Rajasthan, and Assam.

Based on the feedback from the December 18 meeting, we have finalized the capacity assessment tool, which is described below.

### Please follow the Steps 1 to 5

**Step 1: Nodal Officer:** Each state to identify a nodal officer to administer the Assessment Tool and do a self assessment on the existing institutional capacity to manage RCH program. We recommend the nodal officer to be a senior officer who has been associated with the RCH program, and understands the working of her/his state department of H&FW. The nodal officer may choose a team of 2-3 officers to assist her/him in the administration of this tool and response analysis.

**Step 2: Self Assessment:** We strongly recommend self assessment by each state. Note that self assessment is always better than assessment by any external consultant, since consultants do not have a complete and accurate knowledge of the health system of any state.

#### Note:

- This tool is to be administered in parts to ALL those officers and consultants who are managers for the RCH program planning, implementation, and monitoring.

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<sup>16</sup> Report on “Independent Assessment of Effective Institutional Arrangements for RCH Program”, Centre for Management of Health Services, Indian Institute of Management, Ahmedabad, India 380015



(For example, RCH managers in Gujarat state department of H & FW are the officers holding the rank of Assistant Directors and above upto the level of Principal Secretary).

- Please note that this is only a tool or guideline and not a structured questionnaire. Hence please feel free to add items that are needed or omit items that are not relevant to your state.
- Eliciting responses from each manager will require different skills of the nodal officer, as it is likely to involve interviews, group meetings, references to various reports etc.
- This general tool for management capacity assessment may need some modifications to suit the needs of individual states. (EAG and Non-EAG states)

We strongly recommend that the nodal officer makes additional notes on all her/his observations, not otherwise available from the response to the assessment tool, and suitably modify the assessment tool to suit the state specific needs. The collected documents suggested in the tool should be analyzed for their quality and relevance to RCH management.

This tool consists of the following sections:

- A: RCH Policy, Goals and Strategic Plans:
- B: Organizational Structure
- C: Human Resources Management
- D: Role of stakeholders (outside the department)
- E: Management Systems
- F: Health Delivery Systems
- G: Management processes

**Step 3: Start and Completion Dates:** State the name and designation, address etc of the nodal officer administering this tool in the state, and the dates when it was started and completed.

**Step 4: Augmenting management capacity:** Follow our recommendations on management capacity for effective management of RCH program. Our recommendations are summarized at the end of this section.

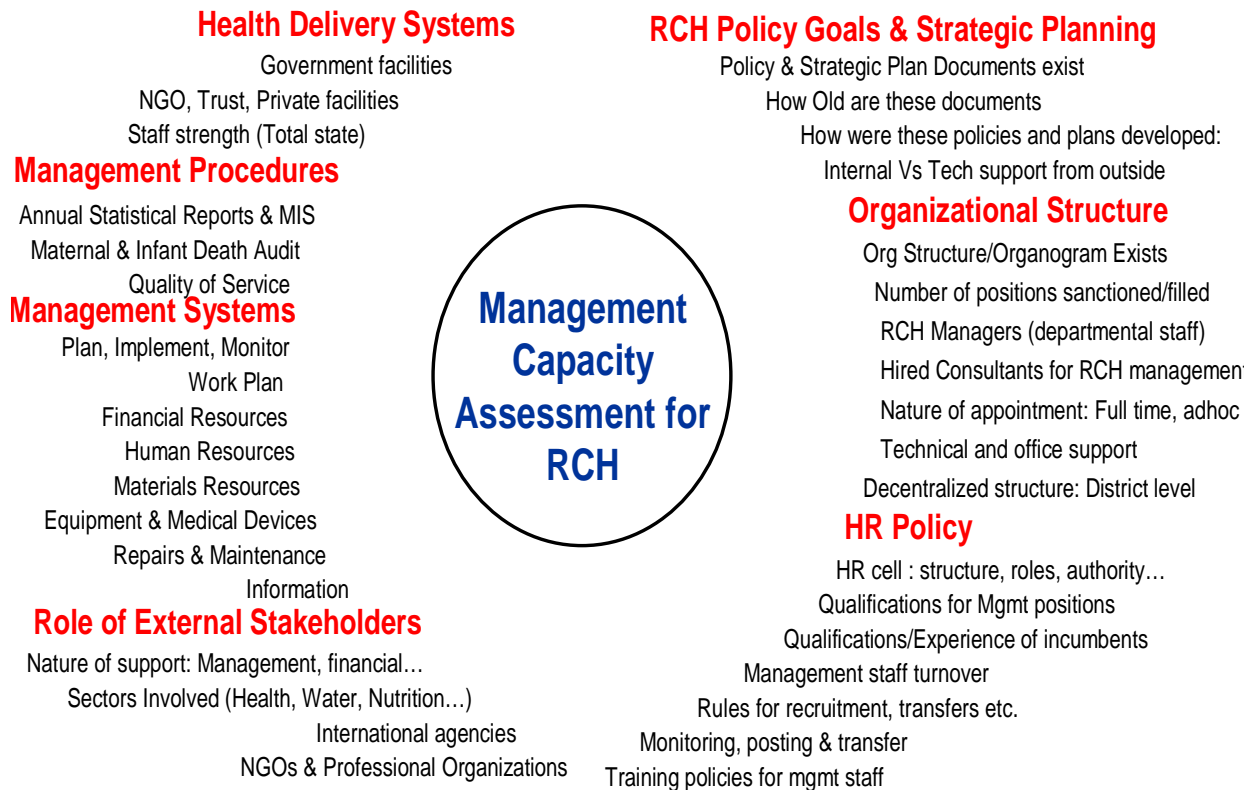
**Step 5: Frequency of administering the tool:** Based on the analysis of capacity assessment, the governments (both the Central and State Governments) need to develop action plans to enhance the capacity (fill gaps) to manage the program effectively in all states. This plan needs to be followed up with frequent monitoring of the progress made in augmenting the state management capacity. We recommend administering this tool every once in two years based on the progress made in managing the RCH program.

# Management Capacity Assessment for RCH

## A Conceptual Framework

K V Ramani & Dileep Mavalankar

Centre for Management of Health Services



**A: RCH Policy, Goals and Strategic Plans:**

**Purpose:** The purpose here is to understand the process of policy and strategy development and thereby infer the department's capacity to develop a state level policy on the guidelines of the national policy, and a strategic planning to achieve the stated objectives.

**Tool: A1 Documentation of RCH policy and Strategic Plans**

List in the following table all the documents (RCH, Population,...) on RCH policy and strategic Plans for your state dept of H & FW, and hand over a copy of each to the nodal officer. Also include other documents such as Vision document, RCH Program Implementation Plan (PIP), Nutrition, Gender, any special scheme for RCH developed by state government etc.

Title of the Document	Nature of the document Policy Document Strategic Plan Doc Program Doc	Date of Publication	Who developed these documents? List all the stakeholders involved

**A2** For each document mentioned in A1 above, describe the process adopted for policy formulation, dissemination and creating a shared vision/value in the department and community.

**A3** Also collect copies of the budget document, annual administrative report etc as they also show policy thrust.

**Assessment:** If the state produced an RCH policy document (eg.PIP), it is a confirmation of the state's capacity to develop a document reflecting the states' priorities. Availability of clear strategic plan is indicative of the department's level of preparation to meet the stated goals. A policy and strategic plan document developed in consultation with the stakeholders is an indicator of the institutional understanding of the challenges in managing the RCH program.

The quality of the documents on policy and strategic initiatives on the policy is an assessment of the top (secretariat) Management Capacity.

## B. Organizational Structure

**Purpose:** The purpose is to understand the structure, organizational size, and capacity to Plan, Implement and Monitor RCH program.

### Tool:

#### B1 Organogram/Organizational Structure

Is the current organogram at the state level different from the official publication as in the State Budget Document ? Yes/No

If Yes, Please provide a copy of both official (state budget document) and the current organograms. In the Organogram, please mention the positions filled by permanent officer (Full time or Additional Charge), or ad hoc appointment/consultant. Also show positions sanctioned but not filled.

If No, take the organogram from the budget document.

Also show in the organogram, the additional consultants on contract staff at the state level, such as SPMU.

### Assessment:

To assess if the number of managers is adequate for the tasks identified in the state Program Implementation Plan (PIP) to meet RCH needs of the state population.

To assess if the allocation of tasks is rational.

To assess if the managers are overloaded because of additional charges and ad-hoc positions.

To assess if the state is depending on Consultants for line management functions (program management: planning, implementation, and monitoring). Ideally consultants should be used in an advisory capacity for problem solving, and not in any permanent capacity for long term program management.

Note: While displaying the RCH Organogram, also please show all officers/managers in the state department of Health and Family Welfare (such as Medical Services, Medical Education, SIHFW etc) so as to understand the role of RCH program management in the overall context.

## B2 Technical and Office Support

**Purpose:** To understand the nature of support services from

- Technical Staff, and ICT for office support;
- SHRC, SIHFW etc for research, consulting , and training support
- State and District Health Societies for financial management and civil society involvement

**B2.1** Support from SHRC, SIHFW, Med Colleges, Research Institutes, NGOs etc and their role in RCH program.

**B2.2** Describe the Structure and functioning of State and District health societies, RKS etc along with copies of the documents, GRs etc.

### Tool

Designation of RCH Manager	Technical Support: No. of staff	Clerical support No. of Staff	Computer Staff No. of Staff	Computer Support (* )	Telecom Support (* )	Office (* )

(\* ) mention if each manager is given an independent or shared resource (computer, internet facility, Mobile, Landline phone, Fax, office space etc).

### Assessment

To assess if managers get the required infrastructure for technical support (data analysis) and communication (ICT and clerical support), which are vital for program management, as well as respond to frequently asked queries by the department staff and public.





## **B5 RCH Management at the District Level**

**Purpose:** To understand the decentralized management at district levels

### **Tool**

- B5.1 Provide Organizational charts/Organograms for District Level administration mentioning whether they are full time, part time, holding additional charge etc. Also, if they have consultants for DPMU etc.
- B5.2 For DPMU, give information on the number of consultants and the RR / ToR for each position, powers delegated to them, and coordination with the department staff.

### **Assessment**

To assess if the state is prepared to manage RCH program under the National Rural Health Mission (NRHM) framework. NRHM promotes decentralization, and coordination between health and related sectors (Water, Nutrition etc).

If the state department of H & FW has accepted NRHM framework, assess if the state has done capacity enhancement at decentralized levels, such as DPMU consultants for RCH management. Also assess, if the state has taken care of clarity of DPMU job responsibilities so as to promote coordination between DPMU consultants and the department staff.



## C: Human Resources Management

### C1: Management and technical skills

**Purpose:** To understand the management skills and technical qualifications of the managers for their assigned roles.

#### Tool                      Qualifications and Health Management Orientation

Name and Designation of RCH Manager	Min Qualifications (and years of experience) required for this position as per Recruitment or Promotion rules	Requirement on orientation and training for Health Management position	Qualifications and experience of the incumbent holding this position
Principal Secretary			

**Assessment:** To assess the HR policies for appointments to managerial positions and compliance with the stated policies. Certain states have felt that their H&FW departments need to be managed differently from other government departments so as to respond to the healthcare needs of its population better ; such states have appointed several managers on ad-hoc basis so as to manage the RCH program effectively. However such arrangements are temporary, and needs to be institutionalized.

Please assess if there is a need in your state to have a separate set of recruitment rules for its H&FW department (different from other government departments) so as to ensure effective management of the RCH program.

## C2 Staff Turnover

**Purpose:** To understand the length of tenure of managers at each level.

### Tool: Tenure of managers

Designation of RCH Manager	Name	Date of taking charge	Immediate past position held and number of months in that position	Scheduled date of Retirement	Number of officers in this position from Jan 2002
Principal Secretary					

### Assessment:

To assess if managers get frequently transferred within RCH departments (such as Maternal Health, Child Health, FP etc) as well as between H&FW departments (FW, Medical Services, SIHFW etc). Short tenure of top managers (less than 2 years on an average) will constrain the management capacity (If any managerial position has been held by a number of officers for short period of time, it will be very difficult to manage such positions effectively). Also prior exposure to RCH management will enhance the quality of officers and their capacity for effective management of RCH program.

**C3 : Rules for Recruitment, Transfer etc for managers**

**Purpose:** To understand the rules/policies for recruitment, transfer and promotion etc.

**Tool:**

Title of documents Rules and Policies (* )	Yes/No	Date of Publication of this document and date of last revision	Do you feel the need to change/revise  Yes/No, If Yes Specify
Recruitment Regular position Ad hoc position Additional charge  Promotion & Recognitions  Transfer  Retirement			

(\* ) for their area of work and not general Government HR guidelines

**Assessment:**

Assess the existence of HR policies (rules)  
And the transparency and appropriateness of HR policies and rules

Also assess if the HR processes and procedures are getting updated regularly, based on community needs, technological developments (eg. Computer knowledge, development of medical technology) and management skills in line with the healthcare status of the state.

## **C 4: HR cell's roles and responsibilities**

### **Purpose:**

To understand the organization of HR cell, its role and authority as well as its functioning.

### **Tools:**

- C4.1 What is the position of HR cell in the overall organization? Give details of its structure (No. of positions including consultants, qualifications etc of HR officers), roles and authority
- C4.2 Are HR projections made for the State level Management Staff for the next 5 years.
- C4.3 Describe the steps taken to fill up vacancies, reduce attrition rate etc.
- C4.4 Is personnel / HR information computerized? If yes give details.
- C 4.5 Is staff productivity, performance, staying at the place of posting, staff attrition rate, vacancy rate, promotion etc monitored regularly, give details
- C 4.6 How posting and transfer is monitored? Is any annual summary of Posting & Transfer prepared? Give details.
- C 4.7 Who is authorized for Posting & Transfer of staff : ANM, LHV, MO , Specialists, .... Directors/managers.

### **Assessment:**

Assess the significance and contribution of HR cell to support RCH management. Also assess transparency in HR decisions.

## C5: Training Policies and Programs in the last 5 years

**Purpose:** The purpose here is to understand the efforts taken by the HR department to equip the RCH managers (at each level) with the necessary management capacity skills.

### Tool:

#### C5.1 Training Programs for managers

Training program title, and details of the training institution	For whom	Type of training Management or Technical skills	Duration in days

C5.2 Is any training mandatory for promotion or inter-program transfer (eg: Malaria to RCH). Pl describe in detail

C5.3 Do SIHFW, RHFwTC etc provide management support, research, consultancy support ? Give details.

### Assessment:

To assess the HR policy on management training (for promotion, inter departmental transfers etc) and the efforts taken by the HR department to develop management skills in RCH managers. Also to assess if the HR department is relying on internal resources for training needs (eg SIHFW) and its dependence on external training institutes for building management capacity.

**D: Role of Stakeholders (outside the department)**

**Purpose:** The purpose is to understand the involvement of external stakeholders and their nature of involvement.

**Tool:****D1: Support from external stakeholders**

Stakeholder	Does a formal agreement exist	Sectors involved Health, Water, Nutrition etc)	No. of professional staff	Details of support (***)
International (*)				
National (**)				

(\*) Example, UNFPA, UNICEF, WHO, EC, USAID, .....

(\*\*) NGO, Professional Organizations (eg FOGSI, TNAI etc),  
University departments, Medical College departments,  
Management and Research Institutes, ...

(\*\*\*) Mention the nature of support: whether the support is of a technical nature, managerial nature, financial, supply of medicines, supply of equipments etc. Also mention the financial implications of each type of support

**D2. Is there any Technical or Management Advisory Committee for RCH?**

If Yes, explain their role and composition.

**D3.** If Health department has contracted out any RCH management or institutional task, please explain the need assessment, requirement planning and implementation planning by the department before contracting out.

**Assessment:** To assess whether the dependence is benefiting the state in its efforts to build management capacity OR is it making the state more dependant on external assistance for a variety of reasons. Long term dependence on external stakeholders may not lead to building institutional capacity.

Also to assess the nature and magnitude of work being done internally Vs externally. Is the dependence only for technical assistance or for advisory inputs?

To assess capacity for requirement planning for projects outsourced, Eg, HIS, Accreditation etc. Please explain.

## E: Management System for Planning, Implementation, Monitoring

**Purpose:** To understand the top management capacity to transform resources into annual targets

**Tool E1: Capacity to develop annual plans and a rational allocation of resources (Finance, HR,...)**

Are detailed annual plans available for the following (besides what is given as annual targets in RCH PIP)

Planning (state level)	Maternal Health Yes/No	Child Health Yes/No	Family Planning Yes/No	Other areas Specify (+)
1 Annual Work Plan				
2 Finance Planning				
3 HR Planning				
4 Material Planning (Medicines)				
5 Equipment Planning				
6 Repairs & Maintenance Building Equipment				

Attach copies of all documents plans, Wherever individual work plans do not exist for Maternal, Child, and FP, please give details of common work plan.

(+) Adolescent health, tribal health, urban health etc

### Assessment:

Assess the quality of the plan details to know whether the existing resources (financial, HR, Medicines and drugs etc) are enough to achieve the targets, and augmentation of resources if required. It is necessary to ensure adequate inputs of resources (Finance, HR, ...) to achieve a desired level of output (targets). For example, increasing the institutional deliveries by 10 % , say, from 60 % to 70% will require different levels of input resources of each type (Finance, HR,...) compared to a 10 % increase in institutional deliveries say from 70 % to 80 %.

Also please note that the state targets (state averages) have to be converted into targets for each district. For example, the state target of achieving 70 % institutional delivery may mean achieving a target of 60 % in a tribal district and 80 % in an urban district.





## F: Structure of Health Delivery Systems

**Purpose:** To understand the overall size of the health delivery structure (both government and private) and staff strength in relation to population so as to determine the workload of managers.

### Tools:

#### F1: Government facilities

Level of health facility	Number of facilities established	Number of facilities functional (*)	Average population per facility functional	How functionality is assessed
Medical Colleges				
District Hospitals				
Sub District hospitals /FRU/Civil hospitals				
CHC				
PHC				
Sub Centres				
Mobile MCH clinics				
Any Other centres for RCH (pl specify Eg: Municipal Maternity homes)				

(\*) as per standards/IPHS, Mention fully/partially functional and explain.

#### F2: NGO and Private Hospitals (mention data source)

Level	Number of facilities	Remarks (*)
Private/Trust Medical Colleges		
Private Maternity and Child Hospitals		
General hospitals (more than 50 beds)		
Nursing homes (less than 50 beds)		
Any Other (PSU, Rly, Defense...)		

(\*) Include a description of the efforts made by the state to promote Public Private Partnership for RCH program, including management structure for PPP.

**F3: Staff Strength (Total State level)**

Staff strength (Specialists)	No.in Med Colleges	No. in Medical Services: District Hosp, Civil Hosp CHC	No. in Rural Health: ( PHC, SC)	How are they involved in RCH program
OBGYN				
Pediatricians				
Anesthetists				
Pathologists				
Public Health specialists				
Medical officers				
District PHN				
Staff Nurse				
LHV				
Male Health Supervisor				
Male Health Worker				
ANM				
ASHA/other volunteers				

**Assessment:**

To assess the managerial work load at each level of services delivery and assess the potential for PPP to improve quality of service delivery. Note that effective management of any task is dependent on the magnitude (size), nature and complexity of the task. In the case of RCH services, it is therefore necessary to assess the effectiveness in relation to the magnitude (for example, number of people to be served), nature of service (ANC care, EmOC service, etc) and the complexity of services (for example, SBA services to rural Vs urban population).

**G : Management processes and procedures:**

**Purpose:** The purpose is to understand if the health department has capacity to organizer management tasks such as production of health status reports, development of information systems, preparation of manuals and protocols for quality assurance.

**Tools:**

**If answer to any question is YES, pl provide a copy of the document/report**

G1: Does health department produce annual statistical, technical or narrative report? (different from administrative report produced for state assembly).

- G2: Does the state produce an annual health report describing the overall health status, including the services by the private sector?
- G3: Does the department have a web site? What is the web site content? Is it up-dated, how frequently?
- G 4: Is there a state level information system for infrastructure (buildings, equipment, vehicles....) ? Give details.
- G 5: Is there a state level information system for Supplies (drugs, consumables...) ? Give details.
- G 6: Are there written, government approved clinical treatment protocols for common RCH conditions, FP methods ? When were they last updated? Give details.
- G 7: Is there a system of Maternal and infant death audit / review? Give details.
- G 8: Has the state commissioned any specific studies, research projects, reviews etc for Health system in general or RCH in particular?
- G 9: How is quality ensured and how it is monitored in various RCH activities ? Are there any Standard Operating Procedure (SOP) developed and used? Give details.
- G 10: Does the department maintain manuals, guidelines etc produced and used by state govt for RCH related functions such as manual for MOs, FHWs, supervisors, procurement, ?

**Assessment:**

To assess institutional capacity for generating statutory and management reports every year and actions taken for quality assurance and improvement.

**End of the Tool**

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(UNDP, 2006): “Capacity Development Practice Note”, 2006.

(WHO 2006): “Working Together, World Health Report, 2006”, WHO.

**Acronyms:**

ANC:	Antenatal Care
ANM:	Auxiliary Nurse Midwife
AWW:	Anganwadi Worker
AYUSH:	Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BCC:	Behavioural Change Communication
BOC:	Basic Obstetric Care
BPL:	Below Poverty Line
CARE:	Cooperative for Assistance and Relief Everywhere
CHC:	Community Health Centre
CNAA:	Community Needs Assessment Analysis
CSSM:	Child Survival and Safe Motherhood
D & E:	Demography and Evaluation
DLHS:	District Level Household Survey
DPMU:	District Program Management Unit
EAG:	Empowered Action Group
EC:	European Commission
EOC:	Emergency Obstetric Care
FOGSI:	Federation of Obstetric and Gynaecological Societies of India
FP:	Family Planning
FRU:	First Referral Unit
GR:	Government Resolution
H&FW:	Health and Family Welfare
HIS:	Health Information System
HMIS:	Health Management Information System
HR:	Human Resource
ICDS:	Integrated Child Development Scheme
IDSP:	Integrated Disease Surveillance Program
IEC:	Information Education Communication
IMR:	Infant Mortality Rate
IPD:	Inpatient Department
LHV:	Lady Health Visitor
MCH:	Maternal and Child Health
MIS:	Management Information System
MMR:	Maternal Mortality Rate
MO:	Medical Officer
MoHFW:	Ministry of Health and Family Welfare.
MTP:	Medical Termination of Pregnancy

NGO:	Non-Governmental Organisation
NRHM:	National Rural Health Mission
PHC:	Primary Health Centre
PIP:	Program Implementation Plan
PNDT:	Pre-Natal Diagnostic Test
PRC:	Population Resource Council
PSM:	Preventive and Social Medicine
RCH:	Reproductive and Child Health
RTI:	Reproductive Tract Infection
SBA:	Skilled Birth Attendant
SHRC:	State Health Resource Centre
SIHFW:	State Institute for Health and Family Welfare
SPIP:	State Program Implementation Plan
SPMU:	State Program Management Unit
STI:	Sexually Transmitted Infection
TFR:	Total Fertility Rate
TNAI:	Trained Nurses Association of India
UNFPA:	United Nations Population Fund
UNICEF:	United Nations International Children's Emergency Fund
USAID:	United States Agency for International Development
UT:	Union Territories
WHO:	World Health Organisation