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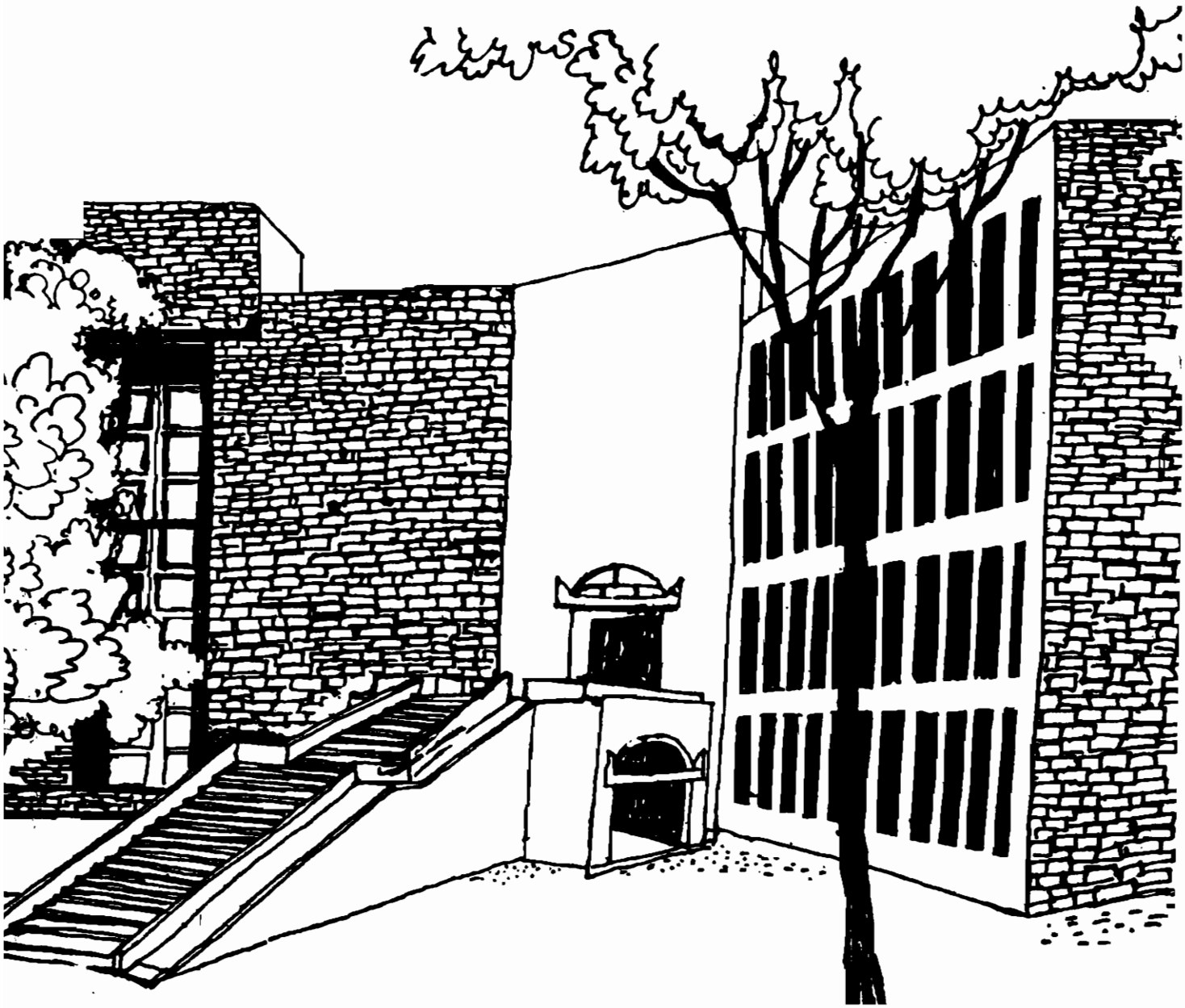

A REVIEW OF HUMAN RESOURCE MANAGEMENT (HRM) IN RELATION TO REPRODUCTIVE AND CHILD HEALTH PROGRAMME IN INDIA: ISSUES AND CHALLENGES

By

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A Review of Human Resource Management (HRM) in Relation to Reproductive and Child Health Programme in India: Issues and Challenges

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Abstract of the Paper:

The Internaltional Conference on Population and Development (ICPD) programme of action recommended reproductive health approach to reorient the family planning and other health programmes in the world. The reproductive health approach which focuses on client needs rather than demographic targets is a major paradigm shift in thinking and hence requires substantial and careful relook at the human resources management practices which are key to implementing such a large change in any health programme. The paper discusses the importance of human resource management (HRM) in relation with implementation of Reproductive Health concept as outlined in the programme of action of ICPD. The paper reviews the current situation related to various aspects of HRM in India such as training, supervision, accountability, performance appraisal and rewards for programmes related to reproductive health. The paper assesses the need for changes in HRM practices to effectively operationalize the paradigm shift which is intended under the reproductive and child health programme in India. A review is also made of the activities planned under the RCH project to improve HRM practices in future. The problems identified in the RCH programme's activities are discussed and recommendations are made to improve HRM practices to operationalise the reproductive health programme in the true spirit of ICPD programme of action.

A Review of Human Resource Management (HRM) in Relation to Reproductive and Child Health Programme in India: Issues and Challenges[1]

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I
Introduction:

International Conference on Population and Development (ICPD) held at Cairo in 1994, was a land mark in the development of the Reproductive Health (RH) approach in Indian and many other developing countries. While redefining health services delivery, the ICPD Programme of Action (POA) suggested that Family Planning (FP) and related health programmes should focus on needs of the individual couples across the range of RH services such as Maternal and Child Health (MCH), STD/HIV, reproductive tract infection management etc. rather than focusing only on demographic objectives. RH is seen in POA as part of Reproductive Rights which in turn are part of Basic Human Rights. The POA called upon all countries to strive to make reproductive health accessible through the Primary Health Care (PHC) system to all individuals (UN 1995). The implementation of POA implies substantial reorientation of the FP and related health programmes in developing countris.

India has been in the forefront of various international movements in health and population sectors. As signatory to various international conventions on human rights, and participant at the Primary Health Care conference in Alm-ata in 1978, India has accepted health as a basic right and Primary Health Care as an approach to Health for All. Over the years, India has built a large and complex infrastructure within the government sector to provide MCH, FP and other health care services[1]. Following ICPD, India has taken several steps to reorient the FP programme to address the emerging need of the community through the RH approach. Given that India's FP programme implemented through the PHC sytem has been highly top-down, selective, target oriented, quantity focussed and centralised, reorienting it to become client oriented, comprehensive, participative and sensitive to gender concerns and quality issues will be a very challenging task. In some sense, the spirit of ICPD demands that the whole culture of the FP and health programmes be changed to focus more on client need at micro-level leading to client satisfaction than macro-level demographic goals. Any service, especially health services are highly dependent on the people/staff, their understanding, orientation, motivation and commitment etc. The key to the success of such a major change, what has

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been called "Paradigm Shift" in India, is to change the mindset of the human resources (staff) involved and secure their commitment at all the levels in the programme for change.

This paper reviews the status of Human Resource (staff) systems in primary health care before ICPD - the problems it faced, the policy changes in the FP programme following ICPD and the efforts made to reorient the staff to introduce them to the policy and programmatic changes following ICPD. This task has just begun in India and there is a long way to go, hence the paper also discusses the key challenges for future in this monumental effort to reorient Indian family planning programme.

II

The Review of Human Resource Management (HRM) in Primary Health Care sector

India has a mixed health care system where preventive and promotive programmes are domintated by government run PHC system while the private sector (formal and informal) dominates the curative care areas. Both the public and private health care sectors in India are large and very diversified covering almost all of the country. The public health system has followed the three tire primary health care model with Primary Health Centers, district health offices and hospitals and state level health services.The enormity of the government health care sector lies in its large numbers and wide reach. The public health system has more than 100 teaching (tertiary care) hospitals, more than 450 district level hospitals, 21,000 PHCs staffed by one or two doctors and paramedics, and 130,000 Sub-health centers each staffed by a female Auxilliary Nurse Midwife (ANM)[2] and a male Multipurpose Health worker. This system has been in place for several years and is generally managed in a top-down manner focussing on family planning and a few major public health programmes such as immunization with little attention to the other health needs of individual clients. This has lead to the alienation of the people from the public health system. There are many other management problems with the health system which constrain its performance and effectiveness (Mavalankar 1998a). To reorient this huge system with thousands of specialists and doctors and hundreds of thousands of paramedical workers is obviously not an easy task. The health sector in India is further complicated by the fact that the key health polices are made by the national government and it also fundes national health programme which address key public health needs. But all these programmes are implemented by the state governments who, in effect, own and run most of the health infrastucture. Thus, the role and ability of the central government to affect change in the huge health infrastucture is limited . Another complicating factor is the large and uncontrolled private sector in health care on which neighter the state nor the central government has effective control. The private sector has several times more providers than the government and these providers are not organised into any system.

Key Human Resource issues limiting the ability of the health infrastucture

This large public health infrastructure follows a more or less similar pattern across the states. There are some differences which are state specific. This public health systems faces several managerial problems, which are well recognised and which limit the effectiveness of the system. Here we review some of the key problems related to the human resources:

1) *Deterioration of HR capabilities due to limited range of services offered:* Even though the health infrastucture has been developed under the Primary Health Care approach and the objective is to give all the basic health services covered under the definition of PHC, the government PHC system has *de-facto* focussed only on a few selective interventions such as sterilization in family planning and immunization in child health. All other health care activities have been neglected. This has eroded the staff's capacity to provide comprehensive health services even within the classically defined public health priorities such as MCH (especially maternal care during delivery), management of locally endemic diseases, health promotional activities such as health education and nutrition. Secondly, many needs of the community are not recognized as public health prioroties; for example, women's reproductive diseases, STDs, sexual problems, violence against women.

2) *Inadequate training at various levels:* Training is the basis for Human Resource development in any organization. There are several problems which have emerged in the area of training over the past few years. The basic medical education has been focused too much on urban curative care, and is provided in a tertiary care setting. This does not prepare the doctors for their role in the rural PHC system. There is hardly any system of induction training for the Medical Officers (MOs) of the PHCs when they join the government PHC system. Secondly, MOs do not have any public health or management training even though they are supposed to manage the PHC staff under them. The human aspects of care, what can be called 'caring' is missing in most training. There is no training for health education, interpersonal communication, doctor-patient, doctor-staff interaction and counselling. The technically oriented training does not help bridge the gap between the doctor who is regarded as supreme and patients who are usually poor and illiterate.

At the lower level, the Auxilliary Nurse-Midewife's (ANM) training is mostly technical with very little component of social aspects of health, community involvement, mobilization, health education etc. Over the past few years, even the technical components have deteriorated and become very theoretical with little practical skills of conducting deliveries or other important health care procedures. Our experience from an action research project in a state and consultancy work in other states showed that many ANMs do not know many basic skills such as taking blood pressure, testing urine for sugar and albumin, making sugar-salt solution for diarrhoea, managing a case of Acute Respiratory Infections (ARI) and the like, which have been integral parts of MCH programme for some years. The Independent Commisison on Health in India observed "... that the standard of teaching in ANM traning schools was very low", "the main reasons for substandard patient and community care are: substandard training, especially in the staff-nurse, midwife, and ANM training courses, the lack of proper system of training; and

absence of regular reorientation courses." (VHAI, 1997). The male Multi-purpose workers are even less well trained. Many of them originally joined as Small Pox vaccinators, malarial workers, FP workers etc. They received only 45 day reorientation training in late 1970s. Hence their ability to carry out basic health and family planning work is at best limited.

Supervisory levels Lady Health Visotor (LHV) or Female Health Supervisor (FHS) and Male Health Supervisor (MHS) are the weakest link in the PHC system. Many of them are less trained than the workers. The quality of training is poor and their role is also unclear. Their main job seems to be the compilation of reports of their workers. There has been no systematic effort to improve supervisory role in the past. Under various health programmes training modules are prepared for doctors and for workers but not generally for supervisors.

At the higher level - district and state, the key managerial positions are held by doctors and the top posts are staffed by generalist officers of Indian Administrative Service. There is no uniform system requiring these officers to have any public health qualification or management training. Management training in Primary Health Care system is weak (Mavalankar DV, 1998b). As a result most of the administration in PHC is run in a very bureaucratic and heirarchical fashion without the application of modern concepts of management or public health.

The poor quality training is a result of deterioration at the level of medical colleges and para-medical training institutions. Medical colleges increasingly focussed on high-technology, private medicine rather than community oriented primary care. Nursing and paramedical education deteriorated due to lack of resources, leadership and rapid expansion without attention to quality. The training infrastructure created by the Department of Family Welfare which is Regional Health and Family Welfare Training Centers, State Institutes of Health and National Institute of Health and Family Welfare are also plagued by lack of trainers, poor quality of trainers and lack of resources. Lastly, the link between the PHC system and training institutions became weaker over time thus reducing the relevance of the basic training to work needed in the PHC system.

There was hardly been any in-service training in the PHC system untill very recently. Fortunately, of late, under World Bank assisted India Population Projects (IPP) 6 & 7 , a systematic effort was made to develop in-service training in many states. This effort is also far from adequate as it provides only 2-3 day of training once every 2-3 years to each worker. The effectiveness of this effort is largely unknown.

Even in World Bank assisted projects, the training component was neglected in quantity and quality. A recent review of training programmes in the World Bank assisted population, health and nutrition projects in India from 1972 to 1997 indicated that out of a total of 22 projects costing 3.2 billion dollars done during this period only 7.6 % of the project budget was spent on training. Two projects covering several states (IPP 6 and 7) which were specifically for strengthening training also spent only 13% of the 233 million

dollars on training. This evaluation of training activities in Bank assited projects pointed out various shortcomings with training even in the IPP 6 & 7 VII which were training projects. The author of the report while reviewing these projects stated " knowledge and skills related to some specific areas of service delivery, such as temporary methods of contraception etc were poor among the health workers.", "there was a need to enhance training skills of most trainers at state and district level so that they could use participatory method of training and initiate an integral system of ongoing measurement of learning of the participants." (Ramaiah, 1998). Overall it is clear from the above that training has been a very neglected area in the health sector.

3) *Lack of availability and accountability of the staff:* Given the deterioration of work ethic in the public system over the past few decades, many of the lower level staff such as the ANMs and medical officers of PHCs do not stay at the place of posting. A recent study conducted by Indian Council of Medical Research (ICMR) in 23 districts in 14 states in India showed that only 52% of ANMs and 57% of medical officers of PHCs stay at the place of posting (ICMR 1997). Many of the staff prefer to and are allowed to stay in a nearby city or town from where they commute to their place of work. This means that the health services are not available all 24 hours in the PHCs and health centers as planned. In fact our observations and some other studies (Mavalankar et al 1998; Ghosh 1994) show that most staff spend only 3-4 hours at their place of work on a working day of 8 hours. Government services also have liberal holidays and leave provision for staff without provision for covering leave period effectively. For example, all kinds of leave due to the PHC staff including Sundays and half Saturdays add up to 42% of the days in an year. At lower levels such as Community Health Centres (CHCs), Primary Health Centres (PHCs) and sub-centres there is no one to provide care when the staff is on leave. To add to this, due to deterioration of work ethic many workers do not regularly go to their place of work. There are also many other interruptions in the regular work such as meetings, sterilization camps and special campaigns. The third level of problems is that, at many places, posts are vacant due to lack of trained staff or procedural delays in appointing staff. Thus the PHC system largely provides only out-patient services and that too quite unreliably. The major reasons for these problems are, general lack of accountability in the public services, lack of awareness in people and political influence which protect poor performers.

The following comments made by a senior health administrators highlight the situation. One District Health Officer who is very conscientious and meticulous pointed out in the meeting of medical officers of PHCs that when he visits the PHCs at nine in the morning, he finds himself too early - nobody has come to the PHC yet, and when he visits at 11 am, he is too late - all workers and the doctors are gone! A Secretary of the family welfare department of a state commented in an important meeting that all the PHCs and sub-centers are staffed by "ghosts" , meaning thereby that the staff is posted there on paper but they are never found at the place of posting. These comments indicate that most of the staff are not present at the place of work for a substantial part of their duty hours.

4) *Centralized planning and target oriented performance appraisal system:* Most key health and family planning programmes are planned at the central level and implemented in the states through the PHC system. The central level planning has killed any initiative at the state level to adapt or augment such programmes to local needs. States also lack leadership in health area and the public health expertise to develop new health programmes to meet people's needs. The states are not even allowed to take direct assistance from foreign donors or to collaborate with foreign partners in the health area without the clearance from the central government. The administration of the health programmes is highly centralized. Since 1966, the family planning programme became time bound and target oriented. Targets were given by the central government and all monitoring was limited to target achievement in FP. Since 1985 the immunization programme also became target oriented. Given the weak supervision and managerial capacity, the target oriented monitoring became a numbers game with substantial over reporting of performance especially in spacing methods of FP, immunization and other preventive programmes to avoid punitive actions by the supervisors. Under this type of management system, no attention was paid to micro-level planning, skill development, supportive supervision, quality of services and ensuring supplies to meet the needs of the programme. This lead to substantial over-reporting of figures and a culture of work where actual work did not matter as long as correct numbers were reported. This also gave a message to the staff that only those programmes such as FP and immunization are important whose performance is being closely monitored. Providing primary health care and even critical things like assistance during delivery became unimportant. For example, in spite of having 1,30,000 ANMs - who, as the name suggest, are midwives, they conduct only 13% of total deliveries in the country while still about 65% of felivaries are conducted by TBAs and relatives. (IIPS, 1995). Centralized planning and target oriented monitoring lead to deterioration of staff attitudes, values as well as skills in providing a wider range of health services.

(5) Lack of Team Work and Referral System: Several rhetorical statements in various policy and programme documents indicate that the PHC staff should work like a "team". Unfortunately, the reality is different. The PHC system has not done much to develop team spirit. It still remains a very hierarchical and bureaucratical organization. For example, our observation from action research project in a state indicate that in most meetings, the supervisor addresses the subordinate staff not by their name but by their designation and place of posting. For example Medical Officer Dr. X who is posted at PHC Y will be called in the meeting not as "Dr. X" but as "MO Y PHC." The same thing is repeated at the monthly meetings of the PHC staff. There are lot of interpersonal problems within the staff of the PHC and the district health office. At times, the supervisors and the subordinates do not talk to each other. All this gets reflected in the work performance of the PHC and their rapport with the community.

The referral system which is the key to provide comprehensive care and continuity of care is also weak or non-existent. There are structural and functional problems in this system. The PHCs, the CHCs and the district hospitals fall under different divisions of the health department leading to lack of functional coordination.

(6) Rewards not linked to performance: In the health system, there are no concrete rewards except promotions and increments in salary. All the promotions and increments are linked to seniority in the system, vacancy and at times to the caste and political connections. In many posts, promotions are few anyway. No consideration is given to performance in the evaluation for promotions. The current system of Annual Confidential Reports does not reflect performance as the reports are written as a routine procedure and all are shown as good except in very extreme cases. Postings and transfers to a good place like a big city or town are also not done based on performance but are based on "government's wish" where there is lot of scope for political and administrative contacts to be used. The staff who stay at the place of posting and provide 24 hour service gets the same salary as the staff which does not stay at the place of posting and is available at place of work only for 3-4 hours a day. This demotivates the conscientious staff who are staying at place of posting and providing services for 24 hours. In such a system staff settles for minimum acceptable level of performance. In this situation training does not help as staff does not see any benefit of the training to them.

(7) Weak supervision at all levels: One of the very weak links in the PHC system in India is the supervision. As per our studies and observation, for all practical purposes, there is no field level effective supervision. The supervisors only monitor the work of the subordinates through the reports they submit of the numerical achievements of the targets. Whatever little field supervision happens is policing in nature. The supervisor checks the presence of the staff and completeness of records. There is no effort to supervise the service delivery process, the quality of work or the client satisfaction. It is also reported and we have heard that when supervisors come to the field, the subordinate staff are more busy taking "care" of the supervisors by providing them tea, snacks, good food and at times looking after their other needs than attending to their duties. Supervision is also weak because there has been no training on supervision, there are no systems of supervision set in practice and there is no review of supervisory role at any level. Supportive supervision and problem solving is missing from supervision system. At times we have seen that because of various weaknesses of the supervisors they are not able to command respect or compliance from the subordinates.

Effect of Human Resource Related Problems on Performance of Health Sector:

The above HR problems and many other problems lead to the situation wherein in spite of the large health infrastructure developed in India, its impact on health indicators was only moderate. The birth rate and IMR declined gradually while there was no indication of change in maternal mortality. On the other hand HIV/AIDS spread rapidly in the country with estimates of 1-4 million people having been infected over the past 10 years. Health needs of many vulnerable groups such as adolescents, post-partum women, and post menopausal women are not addressed at all. Due to over emphasis on sterilization in family planning, the use of non-terminal methods has been very less. Due to gender bias in the FP programme almost all couple protection has been due to female methods with little contribution of male methods. Due to the neglect of Primary Health Care, many important

needs of women have not been addressed. For example, no attention is being paid to care during delivery, ante natal and post natal period and care for reproductive tract infections and other gynecological problems.

The HR problems discussed above lead to unhealthy work environment at the PHC, frequently resulting in conflict, frustration and stress among staff. The target oriented monitoring of the FP programme has lead to neglect of quality of service and neglect of other PHC functions. It has also lead to unhealthy tradition of over reporting of performance.

III

Human Resource Management Needs for Effectively Operationalizing Reproductive Health Approach

If RH was another technical programme such as ARI control, or immunization, one could have imagined that it may have been possible to implement it through the PHC system using the same methods of training, supervision and monitoring used in earlier programmes. But RH is qualitatively and conceptually different from other vertical health programmes. Besides addition of certain technical components such as treatment of RTI and STDs and adolescent reproductive health, RH approach needs a very different philosophy of work where the client becomes the focus of all the efforts, issues of participation, gender, quality of care and comprehensive care become the guiding principles rather than a vertical technical programme trying to eliminate a disease. Such a paradigm shift needs a major cultural and managerial change in the PHC system in India. And such major change has great implications on HRM in the organization. To radically change an organization's perspective towards clients and ways of providing services, it has to change its training, supervision, performance appraisal and reward system so that the individuals have incentive and support for changing their work behaviour, style of management and pattern of planning. Here we discuss the key implications of RH approach on training, supervision, monitoring and appraisal and reward systems in PHC.

Implications for training: Training serves several purposes such as developing understanding and perspective, imparting technical and managerial skills, and increasing motivation and commitment of staff. As the RH approach is very different from the previous efforts to improve health programmes in India, it will require a relook at training. Substantial time and effort will have to be put in to reorient the huge infrastructure to the new perspective and the philosophy of RH This new approach will need at least 1 week long orientation for the staff to understand the key features of the new approach. The methodology for the orientation programmes will have to be different as it is aimed to change the mind-set and not only provide information or knowledge. Hence a lot of interactive work would be needed where staff's understanding, values and perspective are explored and efforts made to change them. For example, the basic difference in approach will have be from doing a particular service because the health department needs it, to doing it because it benefits the clients. Thus client needs, demands, perceptions and

satisfaction have to be given more importance than mere government orders or instructions.

The skill training would have to mach the needs of the specific tasks and programme components. For example, MOs and ANMs may have to learn the syndromic approach to RTI treatment. This would have to be done using (as far as possible) real cases where they can learn the examination skills, interpretation of signs and symptoms and then treatment, counselling as well as partner referral and partner treatment. This may take up to 5-6 days time given the level of understanding of most peripheral workers. Similarly, there would be several other skills such as conducting delivery, management of ARI, IUD insertion that the worker will have to relearn if they are going to meaningfully implement the RH programme. Given the fact that some of the basic skills related to MCH and family planning have already deteriorated due to lack of use of such skills will also have to be developed if comprehensive care is to be provided under the RH programme. Table 1 gives the list of new skills that need to be developed and the skills that need to be refreshed or re-learnt. Hence it is imperative that adequate time be devoted to training each level of workers. The past trend of providing 3-5 days orientation type training as a substitute to skill based training will not be sufficient if RH programme is to be effectively implemented. At the same time basic training of the health workers would have to be reexamined and modified to include some of the concepts, approaches and skills related to RH. Proper system of induction training with emphasis on RH would be needed so that new recruits to the PHC system have the proper background before they start providing services.

Table 1: New skills that need to be learnt and the skills that need to be refreshed/re-learnt by the doctors and health workers to implement comprehensive RH programme:

New skills to be learnt	Skills that need to be refreshed
Management of RTI and STDs.	Management of normal delivery,
Management of Gynecological problems	Emergency Obstetric Care
Adolescent health , Sexuality and gender education.	Menstrual Regulation, Medical Termination of pregnancy.
Interpersonal communication & counselling	Sterilization, IUD insertions, Oral pill
Neonatal care and care of Low Birth Weight baby	ARI and Diarrhoea management
Use of Partograph in management of labour	Information, Education and Communication

Increasing motivation and commitment is more difficult to ensure through training alone. It need other organizational interventions such as building proper perspectives, values and provision of support in terms of supplies and supervision. Motivation and commitment also increases if there are rewards for good work and punishment for poor performance. Thus the whole organization's system of performance appraisal is linked to motivation and

commitment of the individual workers. Under the RH approach these will have to be relooked at and modified as needed.

Before the training programmes are designed, there has to be need assessment for training and task analysis which will clarify what is expected out of the health functionaries at various levels. Training has to be task oriented, and practice based otherwise it is not put into practice and becomes a waste of time and effort. What is taught in training should be feasible and should have been pretested, documented and studied before it is incorporated in training. Proper training materials including case studies, exercises, examples, audio-visual materials etc. should be prepared before the training is started. Skill oriented training should be based on practical experience including real cases to be managed by the trainees. Trainers training and preparation of curriculum and training modules should be completed before training is imparted. Various types of training such as orientation, skill development and programme management and IEC and the like should be clearly defined and adequate time should be allotted to each type of training.

Implications for performance appraisal and monitoring: For a major changes in any programme, direction, performance appraisal and monitoring become key tools. It is said and in fact is very true for the health and family welfare programmes in India that "what gets done is what is monitored", other things are neglected. Hence for the RH approach to be implemented on ground, it is very important to develop appropriate indicators for monitoring. WHO had already suggested global monitoring indicators for maternal health (WHO 1994) and recently also indicators for monitoring RH (WHO, 1997). Satia and Sokhi (Forth coming), have also suggested indicators for monitoring the Indian family welfare programme. This will help shift the focus from target oriented indicators to a broader set of indicators which will help access, process and quality of care besides the output.

The basic difference which will be required in performance appraisal and monitoring will be to develop indicators for assessing the quality of process of service delivery that will help understand gender aspects, indicators that will capture broader RH concerns through the life cycle approach and indicators which will measure information, choice and participation of the community in the service delivery. Indicators guide the performance of the system and hence it is important to choose the ones which are most appropriate that will lead to a meaningful performance in the direction suggested by RH approach and ICPD agenda. Secondly, deciding how indicators will be used for monitoring will be very crucial for the success of the paradigm shift that is being envisaged. In the past, FP targets were used to identify and fix personal responsibility for non-performance and to pressurize the worker to achieve them. The monitoring process has to change from using the data and indicators to identify for punishment staff who under-perform to identifying system that leads to low performance, look for systemic causes and initiate problem solving and supporting those who are staffing those systems. This kind of change will empower the workers, using the data that they collect, to ask for more resources and help to improve the performance, rather than falsify the data to avoid punitive actions as had happened in the earlier under the target oriented FP programme.

Implications for supervision and reward system: RH approach makes the clients the focus of service delivery and quality as series as one of the key strategies to satisfy the clients. In such situation the most peripheral worker is the "hero or heroine" of the organization as he or she serves the clients. All the supervisors are there to support the grassroots level workers. Such thinking is radically very different from what is usually seen in the health department. This means that for implementing the RH approach, the whole system of supervision has to change in style and content. It has to be more supportive, and coaching in nature rather than policing. Supervisors must solve problems of the workers, facilitate their work at the same time ensure accountability among the staff towards the clients. Supervisors have to treat the subordinates as internal clients and satisfy their justifiable and genuine needs so that they can perform better. Supervisor also has to play a role of trainer and reinforce the training provided by the training centers. Supervisor has to demonstrate client orientedness, concern for quality, gender issues and decentralise the decision making if the RH approach has to succeed.

The reward system also has to be reworked so that those employees who meet the needs of the individual and communities, and provide high quality care leading to client satisfaction will get rewards rather than those who fill up false reports to please the supervisors. This will require flexibility and encouraged initiative at the local level to adapt the services to meet the needs of the community.

Implications for accountability: ICPD has advocated RH in the context of Reproductive Rights. Rights approach to health means that getting health care is a basic right of the individuals. It is no more a welfare activity that the state may or may not perform. In India, health is also seen as one of the rights of the citizens. This approach imposes substantial accountability on the health care delivery system. Unfortunately in the past accountability of the system to deliver results has been eroded due to several reasons. To implement the RCH programme effectively accountability has to be brought back. Accountability has to be towards the community and towards the stated objectives. To bring accountability an approach similar to Citizen's Charter should be adopted where the health system specifies the services that citizens can expect and there are systems set up to monitor compliance with the promise made to the community.

IV

Review of Efforts Made by the Government Since ICPD

After ICPD, Governement of India has undertaken major policy changes and programmatic shifts in the family planning and related health sector. The government seems to be committed to the ICPD agenda and has tried to move towards the broader RH concept for which it needs complements. Here we review key policy and programmatic changes that have taken place and its relation to human resources management in the PHC programme after ICPD.

Target Free Approach (TFA) and Community Needs Assessment Approach (CNAA):

Following ICPD, beginning in April 1995, government of India started reorienting the family welfare programme. The major shift in policy was that targets for FP were de-emphasized and states were asked to experiment with one or two districts by removing target oriented monitoring of family planning programme. This approach was supposed to make the programme focus on client needs and quality services. The guide lines for the first year were very vague and states took their own approaches to monitor the programme in these experimental districts. In April 1996, without systematically assessing the effect of the experimental districts the central government decided to withdraw all the FP targets in the whole country. A manual was prepared to guide this major shift towards decentralised planning and monitoring without the use of contraceptive targets. (GOI, undated a).

This transition from target oriented monitoring approach to TFA was a major paradigm shift in policy and programme direction. It has a lot of implications for HRM aspects such as training, performance appraisal and monitoring. Unfortunately, this whole transition was managed by the central government and many state governments without much pre-planning, in a great hurry, with an ad hoc approach rather than a well studied and gradual approach. No alternate systems to monitor the programme were put in place, hence the staff felt relaxed and reduced effors for FP. The alternative system of planning and monitoring suggested in the TFA manual was untested and so complicated that none of the states adopted it. In the absence of alternate monitoring, the performance dropped in many states and in a few demographically sensitive states, it dropped dramatically. (Khan & Townsend, 1998). This lead to a wave of panic which resulted in the reintroduction of implicit targets in many states and explicit targets in some states.

Taking some feed back from the states the central government modified the TFA manual into a new manual called Community Needs Assessment Approach (CNAA) during the next year, that is 1997-98 (GOI 1998). Unfortunately the CNAA manual came very late, only in January 1998 and is also not very clear on many issues. It also seems to be put together very hurriedly without thinking through or pretesting the approaches suggested. This approach has not been put into use by most states so far.

The impetus generated due to ICPD and the advocacy from donors lead to major policy shift in Indian family welfare programme leading to TFA. But unfortunately the process of this policy change was poorly planned and managed leading to confusion, decline in performance, frustration in staff and finally reintroduction of the targets. Many of the HRM issues such as training, performance appraisal, rewards, supervision that were very closely connected to the problems of target oriented monitoring of the programme did not get adequate attention or were not addressed at all in this policy change. Thus, the experience of the implementation of TFA over the last two years showed that there has been hardly any difference in the target oriented family welfare programme following the great policy shift envisaged in TFA. The only difference this seemed to have made was

that instead of central government setting the targets, now the state governments and the district health officers are setting the targets in most states. There is no evidence that qualitatively the programme and process of services delivery or its monitoring has changed much in most places. (Mavalankar 1998C, Futures group 1998). Thus it seems that a great opportunity to reform the target oriented FP programme in India is lost.

RCH Programme.

Following ICPD conference in 1994 there has been a move, largely guided by donors, for directing the family planning and MCH programmes to broaden the services to cover reproductive health concerns. The government of India embarked on the great journey to recast the family welfare programme into a new programme called Reproductive and Child Health (RCH) programme. This RCH programme along with TFA approach is seen as a paradigm shift in the family welfare programme of India. Looking at the reproductive health package suggested for India, (World Bank, 1995 and Pachauri, 1994) it is clear that a substantial part of it was covered, at least in theory, under Child Survival and Safe Motherhood (CSSM), family planning programme, AIDS control programme, Primary Health Care and Integrated Child Development Scheme (ICDS). Thus giving India a good foundation for moving towards RH. The RCH programme envisaged by Government of India includes family planning, CSSM, Women's health (management of RTI/STD and HIV/AIDS) and adolescent education as the main components (GOI undated B). It also has a different perspective. It talks about life-cycle approach, participatory bottom-up planning, quality of care, and IEC as the main focus areas. This programme is expected to cost about 1.25 billion dollars and is being funded by World Bank's soft loan and grant from European Union and other donors besides Government of India's funds. In theory and intent this programme is planning to implement some changes suggested by ICPD POA and also by the World Bank in its sector review of India's family planning programme (World Bank 1995). This new programme plans to bring massive change in the way the Indian FW programme has been working, and thus has wide implications for various HRM areas such as training, supervision, performance appraisal and rewards and the like.

Notwithstandin the rhetoric and the grand intent, unfortunately, the way RCH programme is being planned, developed and implemented, it seems that it will be not much different on ground than its predecessors such as CSSM, Universal Immunization Programme (UIP), India Population Programme (IPP) and other donor assisted projects. Perhaps the RCH programme may perform even worse than the CSSM or UIP as the objectives of RCH are many, diverse and unclear, the strategy (participatory, bottom-up approach) is untested and needs major change in culture and management style of the government. The difficulties of implementing this programme are compounded by the fact that there are many more players such as non-governmental organizations (NGOs), *Panchayats* (local self-governments), private sector to be involved in this programme. Finally, there is a lot of confusion at state and district levels and also perhaps at the central level between TFA, CNAA and RCH. To manage such a programme so that the original intent and objectives are achieved, is a great challenge.

The managerial capacities at the central and state level are quite limited as compared to the needs of such a complex programme which entails major policy and programmatic shifts. To cope with this situation the government has adopted the approach of operationalizing the programme through specific "schemes for implementation". Unfortunately, the rationale and reasoning for developing these specific schemes is not very clear from the document that lists these schemes (GOI 1997a). Many schemes are for augmenting facilities, number of personnel, supplies and some training, but there is not much detail on how the existing infrastructure will be better used, how its quality will improve and how will it become client oriented. The RCH programme does not outline how the change in mind-set will be created so that the programme really becomes a people's programme rather than another government "scheme".

HRM Efforts Related to TFA and RCH

The various training efforts made so far since 1990 and even after ICPD, have been scanty, ad hoc and without adequate preparation. Some of the training plans have been delayed and some did not happen at all - for example skills training under CSSM project. In 1996, Government of India produced a guidelines for developing in-service training plan for district level with the intention of coordinating all the training efforts under various initiatives at the district level (GOI, 1996 a). Unfortunately, these guidelines have not yet been put into practice, hence ad hoc, un-coordinated trainings are still continuing. Following TFA approach with the intention of changing orientation of the family welfare programme staff from target oriented top down to client oriented participatory planning approach, Government of India funded some 2 day orientation-training efforts in all states. Table 2 gives a brief summary of the important training efforts made since 1990. In our opinion, these training efforts have not yielded results in the past as they have been inadequate, of poor quality, and not linked to enabling factors such as supplies, reorganization of work routines or supervision and monitoring. Even in the new RCH project training is not seen as part of broader HRM effort or organizational development effort but rather as a stand alone activity. The resources devoted to training still remain small. In the World Bank assisted RCH project only 11% of money is allocated to training. (World Bank, 1997) while in the overall RCH project budget only 6% of funds are far training. (GOI, 1997)

Table 2: Summary of key training efforts in the 1990s in Indian family welfare programme.

No	Title of the training or subject area, year implemented	Duration, participants	Comments
1	CSSM module training 1993-6	6 days, for MO & PHC staff	Only orientation type training, skills training weak. Equipment and supplies came 1-2 years after training.
2	CSSM integrated skills training	3 months, for MO & specialists	Training did not take place in most places. even modules were not developed for maternal care.
3	On the Job training under IPP 6 & 7 1993-7	2 days for health workers & supervisors	Only done in states with IPP project. Useful but too short and infrequent - 1-2 rounds in 5 years.
4	Skill training for ANMs under IPP 6 & 7 and SIFPSA in UP	21 days for ANM	Useful but implementation variable. Follow up unkown, not linked to monitoring
5	Management training under IPP 6 & 7 1993-7	15 day, for Medical officers of PHCs	Useful but too short, quality not very good at least in some states.
6	Skill training for IUD insertion, 1995-6	6 days, for ANMs	Supported by GOI, practical training but no module was prepared, no emphasis on quality of care.
	Training related to RCH / TFA		
7	Orientation on RCH, TFA, Maternal and neonatal care, ANM as trainers of Traditional Birth Attendants (TBAs). (GOI, 1996 b)	6 days for ANM & supervisors	Done in a hurry, module developed but some technical problems, too many things in one programme, practical part weak.
8	Orientation training for TFA, 1996-98	2 days for MOs and Staff.	Objective & methodology unclear. Too short
9	Training of ANMs for building effective partnership for implementing RCH programme, 1997-8 (GOI, 1997 b)	6 days, for ANMs	Only done in some states, training liked by the ANMs but contents not implemented in practice

10	RCH awareness generation for all concerned sectors	1 day for staff of health and other concerned departments' administrators and staff	Being planned with help from UNICEF.
11	RCH management training for MOs (NIHFW, undated)	about one week	Being planned by National Institute of Health and Family Welfare (NIHFW). Coverage of important topics are very brief. Many key topics not covered.

Unfortunately, there is hardly any systematic external review of the training efforts of the government and hence the quality of the training or the impact are not very clearly measured. Our observations of some of the programmes indicate that the practical and skill component is very weak in many training programmes. Training is many times very theoretical and do not relate to day-to-day realities. Most training is not followed up by supervisors to see if performance has improved or not. Training quality is also very poor in most places as the trainers posts in the health department are not very coveted ones and hence do not attract good people. All this has limited the usefulness of the training programmes. Unfortunately, there does not seem to be any qualitative change in training in the RCH project and hence it may happen that some of the previous problems seen in other training may be repeated in the RCH project.

Under TFA government on India suggested major changes in planning and monitoring, but they were so complicated that in effect hardly any change happened except the pressure exerted for target achievement got reduced somewhat and some efforts made to set targets in decentralised way. There was no focus on quality or client needs in most states. This approach did not link rewards to performance, nor it had any problem solving process or better accontability mechanisms.

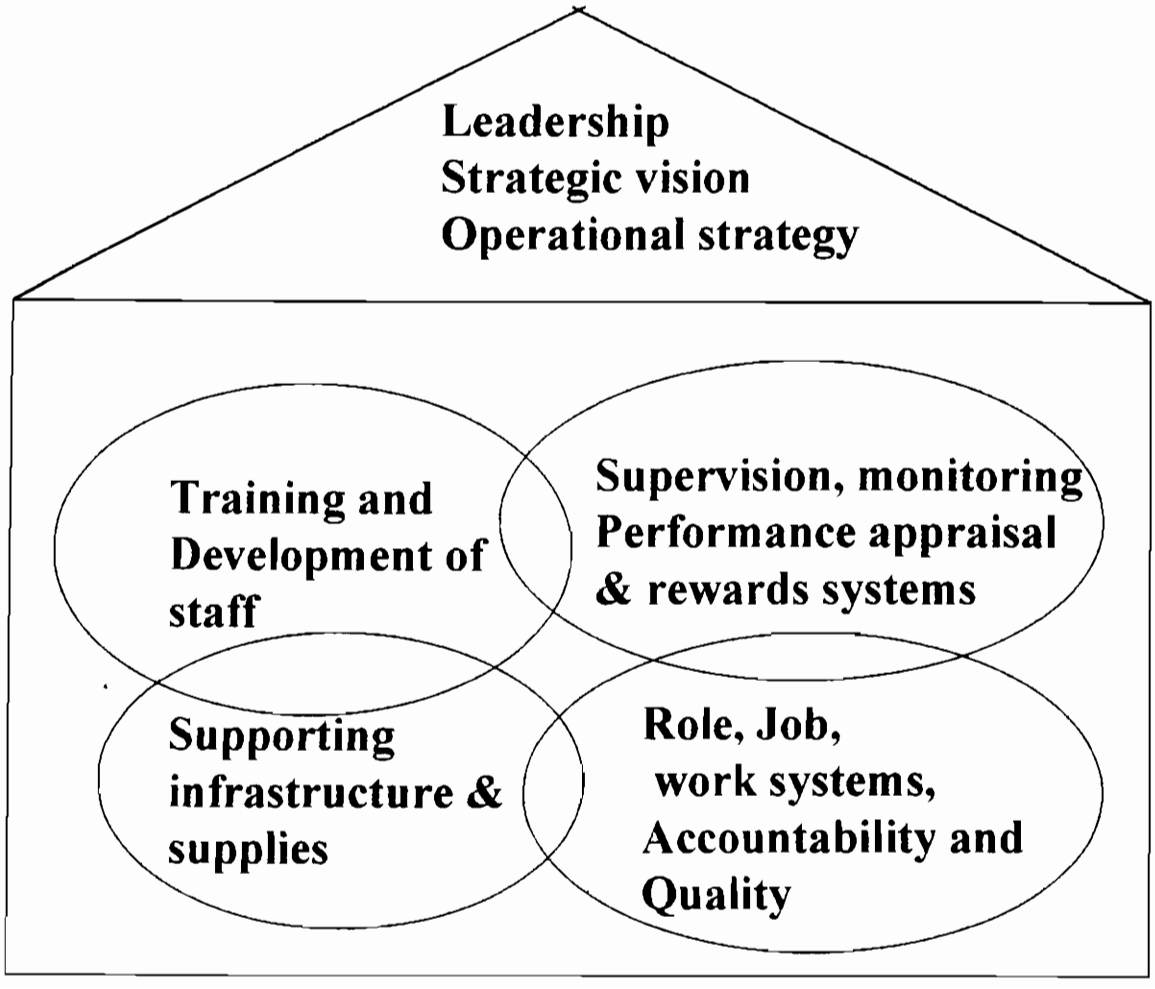
This indicates that even after TFA and RCH, in the health department training is generally seen as an indpendent activity in itself and not as a part of HRM process or organizational development effort. Hence training is not linked to other aspects of HRM such as job specifications, monitoring and rewards, thus reducing effectiveness of training intervention.

V

Challenges Ahead

Given the fact that four and a half years have passed since ICPD, it is time to look back and see what has happened and what has not and then plan for the future. The review done above indicates that in the area of family welfare there have been substantial policy changes in India. The new programme on RCH has also started in the whole country. The top programme managers envisaged a major paradigm shift from the old target oriented FP programme to TFA and new RCH programme. This has implications for HRM in the health sector. Unfortunately the efforts so far to reorient the programme have been ad hoc, very limited and focusing only on brief orientation type training. The results of such unclear changes have been mixed. But there is a ray of hope if the process of this change could be managed well in future. For this HRM will have to be managed strategically and in an integrated manner. Here we present a model of HRM which is adopted from Pareek and Rao (1992) and takes an integrated look at training and other key HRM functions so that the implementation of the RCH programme becomes a reality which is qualitatively different than previous vertical programmes such as family planning or immunization.

Figure 1: Integrated Model of HRM for Effectively Implementing the RCH Programme



To be effective the RCH programme should address all the four major aspects of the above presented HRM framework. Training has to be seen as an integral and interlinked part of the whole package of interventions which must include development of support services such as referral, follow up, supply of essential drugs and commodities, and proper infrastructure for delivery of services. Next is the supervision, monitoring, performance appraisal and rewards. Training must be linked to performance norms and measurement and be reinforced by supportive supervision and problem solving. The performance indicators must monitor a broad range of services which the worker is supposed to provide. The indicators must include quantitative and qualitative parameters and professional as well as community assessment. The workers who perform better on these indicators must be recognized and rewarded to reinforce their good work pattern. Finally, the whole system should specify clear role and tasks for all staff who should be accountable to the community and to the programme managers. Proper systems to enforce such accountability should be established so that the staff feel responsible and deliver the services they are supposed to provide. Quality assessment should be a part of the accountability and performance measurement system. Only such comprehensive approach to HRM in the context of RCH will ensure that the programme will succeed. Piece-meal and ad hoc training, monitoring and supply interventions will not produce better performance. It will only lead to wastage of resources as has happened in the past projects. The RCH programme is too important for such a poor fate. Finally such an integrated approach to HRM issues related to RCH is possible only if there is dynamic leadership at the central and state levels who can provide strategic vision and encourage a detailed operatational strategy needed to manage this paradigm shift which is being planned under the RCH project.

Hopefully, Government of India and international agencies will take concrete steps to operationalise the objective that ICPD has set before the country. This will need major changes in which human resources are managed in the family welfare programme in India. It is imperative that all the stakeholders in the civil society, such as NGOs, academic institutions and professional organizations actively advocate and participate in this change taking place in the family welfare programme as it moves towards a real reproductive health approach in the true spirit of ICPD. Without such external pressue there is all the chances that the RCH programme will follow the old style of contralised planning, will face well known implementation problems and will fail to achieve its objectives.

Endnote:

[1] In India Family Planning, MCH and immunization are under one programm called Family Welfare (FW) and are fully funded by the central government and are managed by a department of family welfare within the ministry of health and family welfare. Other health programmes such as specific disease control programmes for Malaria, TB, leprosy are managed by department of health.

[2] ANM and Male Multi-Purpose Health Workers are the most peripheral health workers in India. One of each are appointed at a sub-health centre covering population of 5,000-7,000.

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