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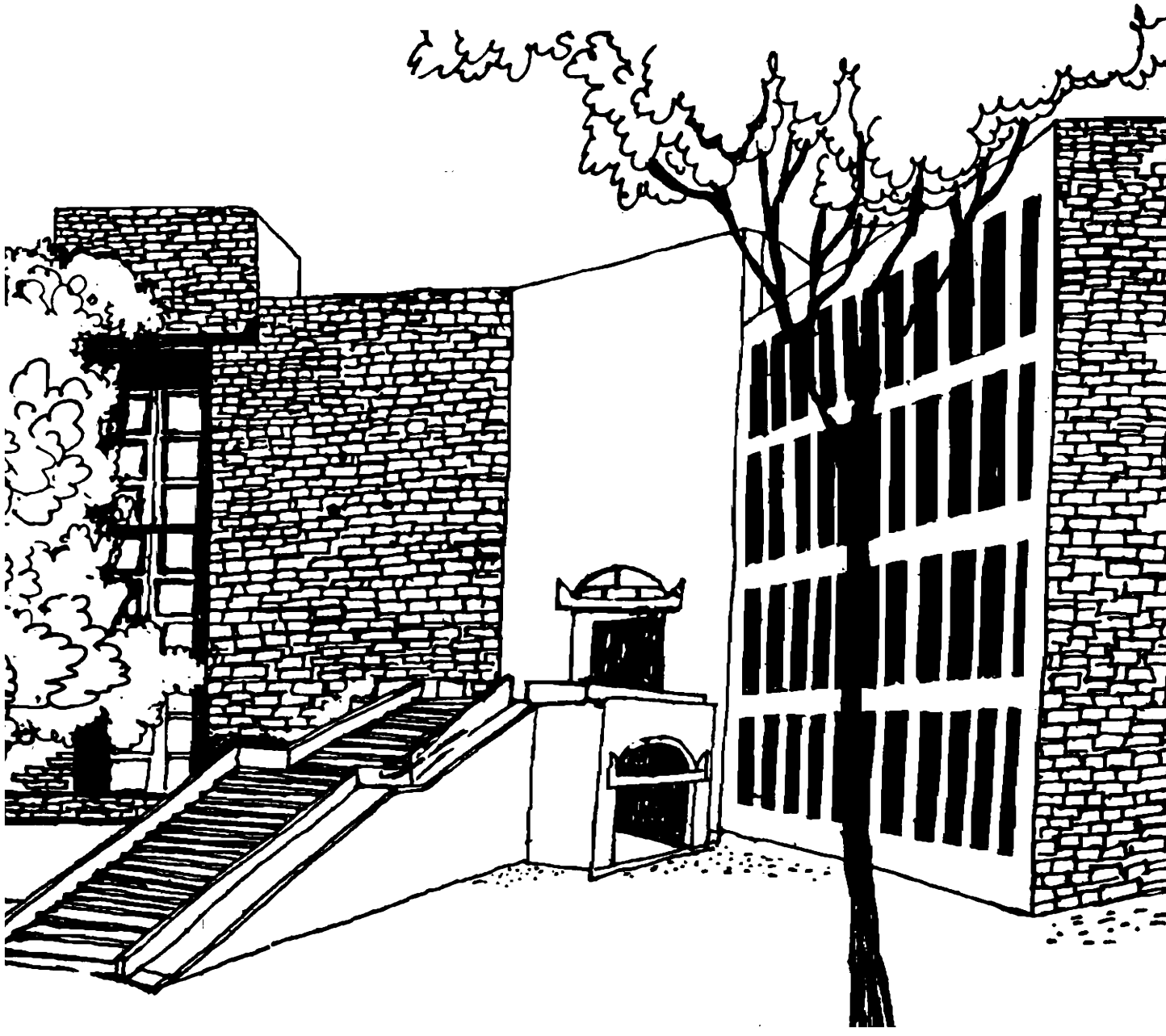

Current Problems of Family Welfare Programme Administration and Principles and Techniques of Management Applicable to Family Welfare and Reproductive Health Programme

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CURRENT PROBLEMS OF FAMILY WELFARE PROGRAM ADMINISTRATION AND PRINCIPLES AND TECHNIQUES OF MANAGEMENT APPLICABLE TO FAMILY WELFARE AND REPRODUCTIVE HEALTH PROGRAMS

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Introduction

India's population is second only to China and is likely to be the largest in the world in the next century. This is in spite of the fact that India has the oldest Family Planning (FP) programme in the world. The achievements of the Indian Family Planning Programme cannot belittled as crude birth rate has declined from 42 per 1000 in 1951 to 29 in 1992 and the TFR has declined from 6 to 3.6 in the same period. The Couple Protection Rate (CPR) has increased from mere 10% to 45% and number of births averted increased from 40,000 to 169 million during the same period[1]. Despite these achievements India is quite a distance away from the National Health Policy goals of Crude Birth Rate of 21 and CPR of 60. In spite of increasing resources diverted to the Family Welfare (FW) programme, which is a name given to FP and MCH programme in India, are now about Rs.50/- per eligible couple per year, the results do not seem to be commensurate. This indicates that weakness in the management of the programme could be the main reason. Recently Several authors have commented on weakness of management of the Indian Family Welfare Programme[2,3,4]. This paper analyzes some of the administrative and managerial issues confronting the national family welfare programme and suggests possible management principles and techniques which may be applied to improve the programme's efficiency and effectiveness. After the International Conference on Population and Development at Cairo, the Indian government is now reforming the FW programme to mould it in to Reproductive Health (RH) programme. As both the programmes have large overlaps the suggestions offered here will equally apply to FW and RH programme.

The paper is based on our understanding of the programme obtained from various studies we have done, which are mainly in Gujarat, and reading of studies done all over the country. We have also incorporated insights obtained from our discussions with other researchers, programme managers and review of secondary sources of information on the Indian family welfare programme. The paper is more interpretive and based on several sources of information and personal observations. The suggestions emerged from our experience in the field of health management and experimental projects and programmes done in India and in

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neighbouring countries.

Key Management Problems in the Administration of Family Welfare Programme

We have identified several key problems in the family welfare programme. Here we discuss them in detail.

1. Lack of Accountability and Supervision

The overall impression of the PHC system in India is one where accountability, supervision are weak and inappropriate. It is not uncommon to find that doctors and key staff are not available at PHCs. Many PHCs do not remain open during the regular hours of the day. Many of the sub-centres have similar problems. The scheduled visits of the workers to the villages and houses of individual couples are irregular and infrequent. The supervisors also do not seem to be knowledgeable, effective and supportive. Most supervision is "policing" type where worker's presence and registers are checked or it is very friendly type where nothing is checked, rather than supervising actual performance field work. Systematic feedback by supervisor is hardly given except routine scolding the workers for non-achievement of targets.

Accountability and supervision have become synonymous with method specific acceptor target monitoring for family planning especially sterilization. There is a tacit understanding that workers' main function and purpose is to achieve sterilization targets; as long as they meet them no other work is asked from them. If they are unable to meet the target they are assumed to be not doing their work and are reprimanded/punished in various ways. This target orientation has skewed the accountability and supervision system to the extreme. In this case all other activities of the family welfare and health get neglected. This is especially true during the family planning season of December to March. Supervision is further hampered by lack of commitment of the supervisor to his/her work and lack of transportation to go to the field. Many supervisors themselves are irregular, do not stay at their head quarters and lack commitment to the work. This undermines their credibility and authority. On the other hand strict and committed supervisors do not get support of their superiors if they take action against erring subordinate staff, this also weaken's their authority. Many PHCs do not have vehicles for the doctors and none of the PHCs have any vehicle for the supervisors hence their mobility is very limited and so is their ability to supervise the field activities.

2. Poor Infrastructure and Maintenance

At most primary health centres, the physical infrastructure is large but in poor condition. The construction of the centre is defective to begin with at many places and hence problems such as leaking of roofs, non closing windows, termite infestation, broken floors are not uncommon. The maintenance of cleanliness and hygiene in the PHCs is extremely neglected. Even regular dusting and mopping is not done in many places leaving coats of dust on furniture and the floor. Broken and unused furniture and equipment are stacked up in many PHCs. In some PHCs we recently visited look like storage house for junk equipments, room after room are filled with them. Even operation theatre where sterilizations are carried out are not clean and hygienic. Running water and electricity are not available regularly in many PHCs. Toilets are almost universally unclean, ill-maintained and many a times in-operational,

not only at PHC levels but even at district health office and state health secretariats! Equipments in PHCs are old, dilapidated, unrepaired and inadequate in many places and in excess at other places. This is because there is no proper maintenance system for the PHC equipment. Secondly, equipments are equally distributed to all PHCs without looking at their need, requirement and potential use. a PHC which does not have full staff and gets only a few patients every day will have the same equipment as one which as a very busy PHC because the equipments are distributed equally by a single norm. We have seen piles of unused equipments in many PHCs and shortage of other necessary equipments in other PHCs.

Sub-centres are in worse conditions. Most do not have their buildings and those who have also face many of the same problems as PHCs. The higher level centres like CHCs rural hospitals, districts hospitals and medical colleges also suffer from infrastructural deficiency and are poorly maintained. Given such deficiencies in infrastructure one cannot expect that good quality of care will be provided at such centres. Infrastructural problems are not only problems of civil engineering and physical maintenance system but are also problems of attitude, habits, behaviour, supervision and overall management of PHC. Nobody seems to take serious notice and try to improve at least the maintenance of PHC infrastructure and equipments. This will not require much additional resources. There are instances of excellent maintenance when particular in-charge doctor has taken keen interest in doing so. Hence systemic management problems as well as lack of individual initiatives both contribute to poor infrastructural facilities in the Primary health system. One exception to this general observations of poor maintainence is the Cold Chain system which is working well and is regularly maintained. This is due to continuous collaboration of UNICEF at the central and state levels with the respective governments.

3. Inadequate Logistics and Supplies and Poor Store Management

Generally the contraceptive supplies are in excess of demand and are literally pushed down the system based on targets. But supplies of supportive medicines, linen, gloves and other materials and equipments are irregular and inadequate. It is not uncommon to find torn linen, old instruments and inadequate supplies being used during surgery and other contraceptive delivery procedures. The PHCs does not have systematic supply and logistic system which periodically leads to shortages of essential supplies. The indenting procedures and procuring mechanisms are age old and centralized which adds to the problems in the system. Studies by survey agency have shown that in many states peripheral health institutions like PHC and sub-centres do not have stocks of contraceptives. The social marketing of condoms also seems to suffer from these deficiencies. There are many small villages where condoms are not available regularly. Poor management of stores adds to this problems. Near expiry or expired drugs are not uncommon in PHCs. Excessive stock of drugs and materials supplied are also common. In appropriate purchase of drugs and equipments are common and at times motivated by kickbacks rather than needs. Condemnation and disposal processes are also not well set and hence PHCs are filled with old, dilapidated equipments and furniture. New equipments are supplied without bothering about repair or disposal of old equipments.

4. Serving the Boss not the Clients

The general attitude and implicit belief of the workers and doctors is that they are employed as servants of the government and are responsible for serving their superiors rather than

serving the community needs. The rigid blue print of the National Family Planning Programme and other national health programmes along with the target system enforced from the highest level reinforces this belief. Workers were more responsible to the targets,rather than health and welfare of the community. This attitude percolates through out the departmental hierarchy. Each level tries to keep his supervisor happy rather than supporting his subordinates in their function to serve the community. This keeps the bosses happy but eliminates the community from the family welfare programme. Practically this translates into neglect of the clients, compromise on safety standards in performing procedures and at times work done only on paper.

5. Poor Technical Direction

Family planning is thought to be a non-technical area generally managed by generalist administrators - IAS officers. These administrators are very good in administration and sometimes bring a fresh perspective and momentum to the programme. But they lack the technical understanding of the nitty-gritties of contraceptive technologies or demographic behaviour of the community. This makes the technical direction quite weak part of programme administration. It also reflects in the health education and IEC efforts related to family welfare. The technical quality of care has also suffered because of weak technical direction of the programme. Most programme administrators, even the technical personnel like the Directors of Health Services in charge of family welfare and additional DHO at district level, who are all doctors by training, hardly keep abreast with latest knowledge about family welfare. This is partly because of lack of time, lack of training opportunities and partly because of lack of initiative on their behalf. There is hardly any regular contact between health and FW department and teaching institutions and research organizations. Of late there are many workshops and meetings organized with international assistance for such interaction but generally participation in them from the health department is weak.

6. Over-Centralization of Decision Making and Financial Powers

Family Welfare being a centrally sponsored scheme most decisions are taken at central level. Most states do not feel ownership of the programme. The general feeling is that the states are obliging the central government by carrying out family welfare activities. The states neither take any initiative nor use their own resources in this centrally assisted programme. Even at state level most decisions are taken in state capital and uniformly implemented in the district and PHCs. The authority available to district level officers, and PHC level officers is quite limited and for small sundry things files have to have up to the state government level. This delays decision making and over burdens the policy making level with routine day to day operational issues. The lower level officers who are capable and want to take initiative get frustrated in the system and may tend to leave such a system. Postings and transfers are highly centralized and generally above the control of the direct supervisor of that level. Most of the times the direct supervisor is even not consulted before a posting or transfer is made. This erodes the authority of direct supervisor over his subordinates.

Financial authority of various levels and programmes remain fixed except for salaries which are generally adjusted for inflation. This means that many financial limits become impractical over a period of 5-6 years. For example, We are told that the contingency money allotted to Urban Family Welfare Centres has remained at Rs.1,000/- per year for more than 20 years.

Even higher levels of the government may require permission of Finance Department for spending the money allotted to them. This may cause delay and under utilization of budgeted moneys. The release of money is quite late from the centre and state head quarters causing severe problems at the peripheral levels. One hears of many stories of how money arrives only in the last part of the year and at times only in the month of March when it can not be used. Streamlining financial flows and maintaining continuity of funds would be crucial to proper functioning of the family welfare programmes.

7. Political Interference and Corruption

Political interference and corruption occurs in several forms at various levels in the system. The more common forms are in purchase of medicines and equipments, postings and transfers, nonattendance of duties at PHCs etc. It is difficult to gauge exact extent of these problems and its impact on the system. But it is clear that it has very deleterious effect on the health services.

The political interferences and corruption in postings and transfers are routine and well known. They harm the overall system of authority and management beyond imagination. There are several examples where strict and honest officers are harassed by various ways by the subordinate staff with political support and in such a situation the higher authorities do not support the honest and strict officer. This has lead to erosion of authority and accountability of the officers and supervisors. The usual story is that a worker or medical officer is transferred to undesirable place because he is not working. But he gets back to his original attractive post because of political pressure or corruption.

8. Lack of Awareness of Cost of Service Delivery and Wastage

The current accounting system does not calculate the cost per client served and other similar costs measures. Given the gross under utilization of capacity of family welfare system it would be very important to measure such costs. For example, a PHC clinic having one full time doctor and 3-4 supporting staff on an average see about 24 cases in a day as per a study in selected PHCs in Gujarat[5]. Hardly any patients are admitted to the PHC which suppose to have indoor facility. A recent study done in 2 PHCs of Karnataka on time use in PHCs has shown that on an average 30% of time of professional manpower is wasted in unproductive activities. Cost of this wasted time in a PHC is estimated at about 2,40,000 to 4,40,000 Rs per year[6]. Taking data from National Family Health Survey and from annual report of ministry of health and FW. I have calculated that cost of condoms wasted in the system is roughly 15 crores every year. All of this would be revealed in terms of cost if the accounting system calculate the cost per clients served and cost of idle time and resources. Wastage of building space in the PHC system is also large and unaccounted for. To this on has to add the cost of unused equipments and furniture. All this can add up to substantial amounts. But the department is unaware of such wastage in the system.

9. Lack of required Skills and Training

It is assumed that each staff member joining the health and family welfare department has the required skills for family planning because he possesses the specified educational qualification. Given the deterioration in medical education and poor quality of para-medical

training such assumption may not be valid now. The PHC system does not invest adequate time and effort in training the new recruits in skills required to provide good level of care. Many private organizations spend initially six months to one year in training key management functionaries of the organizations. Health department generally has three to six weeks administrative training for the PHC medical Officers. Due to many reasons the PHC officers get this Induction Training after a period of several months to years of joining. There is hardly any refresher training which is skill based. This has led to the situation where many doctors and nurses are not confident in providing basic family planning services and procedures. Mis-concepts and mis-information are not uncommon among the health functionaries and PHC doctors themselves. While discussing this with a senior teacher in a medical college, she felt that it was because of poor quality of trainers which staff the state training institutions. We agree with her observations. Overall, training is not seen as an important tool for programme improvement. Many senior administrators see training as a past time and hence will not release staff for it when required. Training methodology used are mostly classroom lecture type where several guest faculty are called to deliver lectures. But problem solving, skill based training, practical demonstration exercises etc. are missing. This makes the training less relevant to the field conditions.

10. Lack of overall Consistent Leadership

Success of Indonesia's family planning programme has been attributed to strong and consistent leadership at the national level. In India, family planning does not receive political importance or administrative priority given the scheme of things. After the backlash of "Emergency" most political parties and national leaders have kept away from family planning programme. Even health and welfare of women and children has not received its due political priority except in Tamilnadu. This has reflected into frequent changes of secretaries at the central and state levels, who head the family welfare department. Frequent changes in leadership led to disruption of programmes and inconsistent policy direction. Even though the government is highly bureaucratic but the policies and programme directions are quite susceptible to personal views and beliefs of individuals in the secretary's position. This is specially because politicians have not taken any interest at policy level and are generally limiting their attention to individual cases of posting, of cases transfers, contracts and such matters, while technical officers have little real power.. Without strong leadership, the programme just drifts in various directions loosing its momentum. The state and district level leadership also have similar problems. Corruption and political interferences further damage the leadership as referred earlier.

11. Lack of Involvement of the Staff

In the hierarchical organization and bureaucratic management of family welfare programme, the PHC and the district level professional staff do not seem to feel involved in this important health programme of the country. They seem to have developed detached attitude where things are done only for meeting the targets and getting salary. The staff indifference gets reflected in the quality of work they do as well as their interactions with the clients. Lack of involvement leads to lack of empathy for the poor and the neglected sections of the society which increases the social distance between these classes and the service providers. The lack of involvement also leads to lack of initiative in improving services for the community. Uninvolved staff try to get satisfaction by doing other activities and businesses outside the

purview of their job some of which are undesirable. For example many doctors are involved in private practice even in states where it is not allowed. The lack of involvement also seems to percolates upwards in the managerial cadres and many of them develop a sense of helplessness and negative attitudes towards change. All these makes improvement much more difficult. Personal interest many a times dominates over public or organizational interest.

12. Under-funding of the Programme and Financial In-flexibility

The recent study done by the World Bank shows that India's family welfare programme is substantially under-funded. It is estimated the indian FP & MCH programme spends about 0.60$ per capita while recommended norm just for family planning is 0.90$ per capita. More resources are hence called for. It may be true that overall the programme would run better with more resources. But looking at the under-utilization, misuse and wastage in the programme itself, I feel that the priority should be given to increasing efficiency of the programme by internally moving resources to more productive areas and redeploying the staff in an appropriate manner. Lot of resources are deployed in constructing buildings that remain unused or only minimally used because of their poor location or non-availability of staff posted there. Staff salaries are also wasted when staff do not perform full days work due to non-staying at their head quarters, non-availability of supplies and lax supervision. There are may doctors and other staff which spend less than 4 hours of a working day in performing work related activities. Hence, first goal should be getting adequate return on the investments already made in the PHC system. Additional resources available should also be employed to increase efficiency of the system rather than just using them for doing more of the same. Poor planning, financial inflexibility and restrictive auditing requirements add to the wastage. All this has to be addressed first before new investments are made in this sector. Financial flexibility and more meaningful auditing would be key to stopping wastage and encouraging prudent use of resources.

Principles of Management Applicable to Reproductive Health

The World Bank review of the family welfare programme suggests that the programme needs to be more client oriented and quality centred. To this we add that the programme also has to be efficient, effective and affordable. To move in this direction several principles of modern management can be applied at various levels in the family welfare and reproductive health programmes. We briefly discuss the various management concepts which can be applied to family welfare programmes to solve some of the problems listed above.

1. Application of Principles of Human Resource Development

As discussed above the family welfare programme lacks appropriate skills for service delivery. In the past training was seen as a solution to this problem and of late some refresher training has been going on. Training is important but its effectiveness would be limited unless it is woven into the framework of human resource development and organizational development. The organization must select the right kind of staff who would be willing to stay in rural India and serve the community continuously. For this selection procedures may have to changed and staying in the head quarters may have to be made a precondition for the employment. The other aspect of this would be that the basic needs of the staff should be

taken care of when they are posted in difficult and remote areas. For example, proper housing and educational facilities for children are prerequisites for such a move.

After proper selection each level of staff must be properly trained and oriented to his/her duties. Job descriptions of each level should be clear and well communicated to the employee and supervisor. The training should be skill based and be specifically geared to the work which is required to be performed. General and theoretical education of the worker will not help his work performance. Most staff of any service organization require very good interpersonal skills. Ensuring that they possess such skills and such skills are fully developed is one of the functions of management. Training should specifically emphasize interpersonal and community skills which are currently neglected. Developing such skills would require different training methodology and a lot of hands on practice in the community.

Training alone will not ensure performance. The required equipment and supplies have to be in place so that the training becomes effective and the workers can practice what they have learned. The experience of CSSM programme has highlighted the need for coordination between training, equipment and supplies to be effective. After ensuring supplies the organization must build incentives for practising the training given. This can be done to modifying the record keeping system and monitoring system so that the workers are evaluated on the performance of certain activities in the community. Appropriate measures will have to be developed for such performance measurement. Performance measurement should be linked to reward, punishment and retraining so that workers can further improve their skills. Besides explicit rewards which are many a times difficult to give in public system one must also think of and develop non-monetary rewards and recognition systems for workers who are performing as per expectation. Such system can become a great motivater for the staff.

The supervision system in the current programme also need to be changed to become more developmental and supportive as well as much stricter in ensuring quality and work performance. Currently the supervision function is quite weak which reflects on the programme performance. Systematic training and development of the supervisors in how to supervise specific activities, development of checklists for supervision and a monitoring system to ensure adequacy of supervision needs to be developed. Supervisor themselves have to be technically and managerially sound to implement such a system of supervision. Currently there are hardly any efforts made to strengthen supervision in the programme.

Currently the promotions and postings are more a matter of seniority, political influence and at times corruption rather than capability or performance. A system by which the person's capability and work performance are given more importance in promotions and postings would help improve the management of the programme by moving good managers into key positions. Currently there is no system of rewarding excellent managers and management practices. Rewards are only based on numerical target achievement rather than quality of work and overall impact. The supervisors should also develop a system of random and surprise visits to peripheral health institutions to develop understanding of actual function of the system under normal circumstances. Most commonly done preannounced supervisory visits lead to lot of window dressing so as to hide the reality from the supervisor. Periodic unannounced visits would also ensure that staff are regularly available, working and ensuring quality at all times rather than only at time of supervisor's visits.

2. Quality of Services

Improving quality of services is essential to better programme performance. Poor quality may appear cheaper in the short run but always proves expensive in the long run. There has been substantial research and experience on how to improve quality in industrial setting and service organizations. Of late, substantial material has also been produced in the area of quality improvement in the family planning. Many of the principles of quality improvement from the industrial and service sector can be applied to family planning. **The important principles of quality improvement are**

* **top management commitment,**
* **continuous and incremental improvement,**
* **setting up guidelines and standards,**
* **measurement of the current status and the improvement,**
* **developing a system of incentives and rewards for improvement,**
* **worker participation in improvement and**
* **understanding clients' needs.**

Quality improvement is highly dependent on local mid level managers and the field workers. Empowerment of workers is an important attribute of service quality improvement. Empowerment can occur through proper selection, training, equipping and supporting of the most peripheral functionaries by the organization. The recent concept in service management puts the most peripheral worker who interacts with the community at the top of the organizational 'pyramid' and each of the supervisory level at a lower level symbolizing the fact that the supervisors are there to support the peripheral workers who interact with the clients. Such reorganization, in fact inverting the pyramidal structure, and new client oriented perspective will help, improve quality of service.

Another and complimentary avenue for improving quality would be to bring legal pressures and consumer awareness within the clients so that they pressurise the health delivery system to provide optimal levels of care. The recent Supreme Court verdict of including the medical profession under Consumer Protection Act may help in this direction. Finally it must be understood that improvement of quality is a medium to long-term goal and can be achieved only by sustained efforts over a period of three to five years. Quality improvement also forces one to look at costs involved in the current ways of working and costs of improvement. This will also help in making the programme efficient and effective by removing unproductive activities and concentrating resources on productive activities.

3. Marketing of Services

Family Welfare programme has IEC as one of its components which tries to inform and motivate people to accept family planning methods. The social marketing of condoms and oral pills tries to reduce the social and economic costs of acceptance of these two methods. Beyond these the family welfare programme has never systematically thought of how application of marketing principles can help its services. Marketing is commonly mis-understood as promotion or advertising of a product or a service. But Promotion is only one of the four key elements of marketing. The other three elements being **Product, Price, and Place** or distribution. Market research should help identify what the customers' need. The

organization should produce such services that the customers want. This function is completely neglected in the family welfare programme. Lot more studies have to be done to understand what the community wants from family planning and then the programme should be modified accordingly. Making the programme client oriented is the basis of Reproductive Health approach. Understanding client needs will also help develop appropriate constellation of services which is an essential element of quality of services. All this will make the family welfare programme much easier to sell to the clients.

The second important element is Place or Distribution of the services. Looking at the current picture, the distribution of service points seems okay on paper. But there are many service points which are non-functional due to various reasons. Several places services become inaccessible and unacceptable because of the social distance between the provider and the client. Efforts have to be made to reduce this by proper location of centres, activating non-operational centres and training the staff to become more empathetic to the poor community thus reducing the social distance.

The third element of Price has never been thought of in the family welfare programme as services are offered free and at a negative price due to monitory incentive. As an initial strat..y this may be alright for a few years but now the programme has to consciously think of stopping incentives and recovering some of the costs from the clients who can afford. Such internal resource generation will make programme more sustainable and increase the value of the service in the minds of the people. Pricing structure have to be in tune with social and economic realities in each area so as to ensure that the price does not become a barrier to service use.

Promotion of the family welfare programme through IEC is useful but proper analysis and segmentation of the target audience needs to be done to ensure development of appropriate messages for maximum effectiveness for each segment. Lesson can be learnt from the Immunization programme, especially the recent Pulse-Polio Immunization programme which apparently was quite successful. The proper mix of mass-media and interpersonal communication has to be achieved to get optimal impact. The communication methods used should use the modern methods like TV, VCR, Cable TV, and radio as well the traditional ones like folk songs and dances, street plays, traditional story telling and puppetry. The messages in the mass media as well as in interpersonal communication should be correct, epidemiologically important, relevant, meaningful and understandable to the community. This means that centralized production and distribution of material have to be discontinued in favour of developing communication strategies at centre which get appropriately adapted to the local conditions and implemented at the state and district levels. Mass media should be complemented with interpersonal communication during home visits and small group meetings. Further such efforts need to be supported by proper counselling of the clients at the time of acceptance and follow up. It must be well understood and internalized that IEC or promotion is business of everyone in the organization and not merely the mass media section or the Block Extension Educator. Finally, quality of the services is very important dimension of marketing of any service and hence it has to be maintained at a high level.

4. Work Organization and Operational Planning

Initial success of the malaria control programme and continued success of the immunization

programme can be largely attributed to proper work organization. In each of these programmes detailed micro-level operational planning was done specifying who will do what and when through work routines. Systems of supervision were also set up to ensure that the work gets done according to plans. Unfortunately, in the Family Welfare programme most activities have not been well thought out and planned, with the details necessary, at the operational levels. This means that workers can do whatever they feel like, whenever they feel like, and wherever they feel like under the name of doing family planning work. Proper work study methods should be used to analyze the current work pattern of the field workers and suggest changes so that the field work becomes more systematic, purposeful and hence effective. We strongly feel that if field work is well organized most activities of the family welfare programme can be done without the need of much pressure of targets. There are several examples of workers having performed very well on the family planning indicators just because their community contact through MCH field work is regular and systematic. On the contrary most workers do not perform adequate MCH field work and hence their family planning performance becomes very difficult. Thus micro-level operational planning and work organization are very critical for the success of the family planning programmes.

5. Monitoring and Management Information System

Currently substantial portion of worker's time is lost on filling up of records, registers and reports. Large amount of data is collected and transmitted upwards in the system without much use being made of it. This system has to be changed to a well designed management information system where only required data are collected and transmitted to the managerial level for analysis and action. Some states and certain health programmes have already experimented with computerised data system and reduction and rationalization of registers and records. Such effort should be studied and replicated in the family welfare programme to reduce the drudgery of record keeping and compiling and forwarding. This will also allow fast access to data for decision making. An important part of development of a useful MIS system is managers' training in use of the data for decision making and action. There are several institutions in India which can provide such support to the government health programme. Proper use of in-country resources may help to restructure the MIS system. The watchword should be keeping it simple and practically useful. Such efforts are usually done in the externally aided projects but generally not in the regular programme. Monitoring efforts should be based on not only reported service statistics but also on periodic surveys like NFHS. Tamilnadu has already planned similar survey after three years and other states can easily do the same to ensure that independent data is available for assessment of impact of the programme. If such surveys are regularly done then they should also include some operational parameters such as frequency of worker's visits, participation in health education meetings and use of health care services. Proper and well designed but simple MIS will help redirect the programme effort towards more effective and efficient activities.

6. Application of Operations Research and Operational Research Techniques to Family Welfare and Reproductive Health

There are several well known Operations Research (OR) techniques which have been applied to the health sector in the west. Operations research provide a systematic way of analyzing problems and arriving at optimal solution using quantitative techniques. This helps in reducing bias of the manager or other external forces in selecting particular solution because

of extraneous considerations. Secondly, it also helps to base decision making on the available data. We will not describe in detail various techniques here but the following table can help give an overview of techniques and their application.

Technique	Application
Network Analysis and Facility Location Models	Location of PHCs, FRUs and sub-centres and any service delivery point in relation to the population and demand
Queuing Techniques	Queues in over-crowded facilities, allocation of scarce resources for multiple users
Scheduling Techniques	Staff scheduling at any service delivery point especially where staff rotation and multiple constraints are present, patent appointment scheduling for operations
Routing Techniques and Emergency Medical Service Models	Vehicle routing for distribution of supplies, supervision etc., workers' home visit in the field area; location and distribution of ambulances for Emergency Obstetric Care.
Capacity Planning	Planning indoor-bed capacity for large service organization
Problem Structuring Methods (Soft OR)	Developing a shared understanding of a problem and encouraging participation in its solution
Linear Programming	Allocating scarce resources like operating facility between various users under several constraints
Decision Analysis	For decision making in clinical settings and programmatic setting with incomplete information
Inventory Control techniques	Management of drugs and contraceptive supplies and other supplies.
Systems Analysis	Systematic analysis of problem and finding solutions to problems

Several of these methods could be profitably applied to family welfare programme management to increase its effectiveness and efficiency. There are excellent resources at the national and regional institutes and at universities, who can help in application of OR and systems analysis to help programme managers. Unfortunately the managers in the government programmes have not really tapped into such resources.

Besides quantitatively oriented Operations Research substantial work can be done in the area of what is known as Operational Research where a particular problem is identified, various options are generated to solve it and the most suitable option is implemented on pilot basis with proper control to assess the effectiveness of the intervention. Such field testing is quite useful not only in family planning but in all service activities. In service management literature proper pretesting of any new service is highly recommended to iron-out unforseen

problems and make the service efficient. Overall systematic application of OR could solve many of the management problems of the health system in India.

7. Public Private mix of Services

Currently there is not much interaction between the Health Department which provide free service to the community and the private practitioners as well as NGOs operating in a given area. Most government programmes and plans do not take into account the availability of private health care. This leads to duplication of resources and wastage. Various surveys have shown that the majority of the people use private health services for curative care while they use public health services for preventive and promotive care. Given this reality we must carefully analyze all our public health programmes and identify elements of service for which could be done by the private sector and for which people may be willing to pay and other elements of service which the government health sector is able to provide and for which people are not willing to pay. Such analysis will help in identifying areas where government needs to collaborate with private providers by training and motivating them to provide appropriate care to the community. Government can also think of contracting some of its centres or delegating some of its functions to private providers or NGOs and reimburse them for the cost of serving the poor clients. For example, some PHC and CHC could be managed by private non-profit organizations and government can reimburse the costs to them. Such arrangements may prove to be more efficient and more amenable to control when running a centre which is highly under-utilized. Some voluntary organizations and profit motivated companies or private practitioners may be willing to run certain health centres at a prescribed cost and still make money by running it more efficiently than government. Such opportunities should be explored and pilot projects to test them out could be started in selecting locations.

Women's Organizations are in the forefront of criticizing family planning programme and emphasising reproductive health approach. May be government should encourage such organizations to run women's reproductive health programme in selected locations so that they can get a chance to develop and demonstrate ideal reproductive health care package. Similarly in the areas which are rapidly industrialising government should work with Industries Associations and individual industrialists to set up suitable reproductive health/PHC programmes which can be delegated to the concerned local industries. Such mix of public and private health care provision can provide optimal reproductive health in the country. Government should not restrict its planning to its own health centres but should include all the resources available in the society.

Franchising has been a very rapid way to expand high quality services in the for-profit sector. Religious organizations have also used similar method to expand their activity. Government should think of such arrangement to provide reproductive health care in some areas where individual entrepreneurs or non-governmental organizations are ready to take up family planning and Reproductive Health franchise and operate clinics and extension activity as per government guidelines and norms. Such delegation of activities to other sector may increase government ability to manage the programme in a more efficient way.

8. Application of Concepts of Strategic Management

Strategic management is a new concept which envisages taking a long term view by the

organization and adapting itself to the changing environment. Government programmes generally and family welfare programmes in specific have not adapted themselves to environmental changes. FW programme has been run on annual target basis with little long term planning and management. Strategic management of the programme would involve periodic assessment of the organizational Strengths and Weaknesses as well as analysis of environmental Opportunities and Threats - acronym for which is SWOT analysis. Given such analysis the organization must build on its strengths and guard against weaknesses, and capitalise on the opportunities in the environment and protect against possible threats in the environment. For example, in the context of reproductive health taking support of the women's movement in India would be an effort to capitalize on the environmental opportunity while taking help of private practitioners would be seen as move to protect against the weakness of the government system which is unable to deliver curative care. The infrastructure of the government in terms of facilities and staff should be seen as strength on which reproductive health activity could be built. One must keep in mind the weaknesses of the infrastructure and make appropriate change in strategy while developing a strategic management plan. It would be worth noting that the success of small-pox eradication programme could be attributed mainly to use of strategic management approach. Similar success could also be possible if the approach is followed in other programmes including Reproductive Health.

Conclusions

We have reviewed in the paper several constraints and management problems faced by the Indian Family Planning Programme. Many of these problems are not peculiar to the health programme but are problems of general administration of the government. Hence along with specific interventions suggested above to improve management, the government must also reform its administrative processes and procedures within the whole Public System. Application of specific principles of management and certain techniques would only be possible and effective if there is strong commitment to improving the performance of public health programme in general and reproductive health component in particular. Such commitment must flow from the top to the bottom of the organization including the political system. Such a change of moving from ad hoc and crisis management type of administration to more systematic and well planned administration with application of modern scientific techniques would be a long term effort. But small beginnings must be made immediately and should be consistently followed to improve the overall system. Once small improvements are noticeable in the management of the programme the process of improvement may get its own momentum to push it forward and snow-ball into a larger movement in the public system.

Osborne and Gaebler [7] in their book "Reinventing Government" have propounded 10 principles of how government in USA needs to change. We list these principles as they are equally applicable to family planning and reproductive health programme in India. The principles are:

1. **Catalytic Government**: Steering Rather Than Rowing. Government must steer the programme through policy level measures rather than bogging down with the service delivery. It must ensure proper FP and RH policies.

2. **Community-Owned Government**: Empowering Rather than Serving. Government

must empower the people to look after their own health and develop their own services mechanisms rather than just serving them passively.

3. **Competitive Government**: Injecting Competition into Service Delivery. Government must compete with the private and NGO sector for the clients. In this process the most competitive sector should provide the care, thus eliminating the inefficient sectors.

4. **Mission-Driven Government**: Transforming Rule-Driven Organizations. Governments must be driven by its mission rather than rules and regulations. Rules should be flexible and should be bent to move in the direction of the mission.

5. **Results-Oriented Government**: Funding Outcomes, Not inputs. Government must pay for results rather than inputs or efforts. Funding should be linked to performance not to the staff of buildings.

6. **Customer-Driven Government: Meeting the Needs of the Customer, Not the Bureaucracy**. Government services must exist for serving the people not its own interests or just for employing some lucky and well connected people.

7. **Enterprising Government: Earning Rather than Spending**. Government must look for ways to earn or at least recover the costs of the services from those who can pay and should pay rather than just spending money subsidising the well-to-do. It must find ways to redeploy the resources in the most profitable ways.

8. **Anticipatory Government: Prevention Rather than Cure**. Prevention must be the main effort rather than curing or repairing after the damage has occurred. Government must forecast and act to preempt problems and improve performance.

9. **Decentralized Government: From Hierarchy to Participation and Teamwork**. Government programmes must change from top down to bottom up approach with active participation of the people and the lower employees. Team work should be promoted.

10. **Market-Oriented Government: Leveraging Change Through the Market.** Government must develop markets and use them effectively to provide health services to the segments that can participate in the market mechanisms. This will reduce government's burden so that it can serve those who are left out of the markets.

Changing from the current FW programme to an efficient Reproductive Health programme will be a great managerial challenge for the Indian health administrators for the next decade.

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