UNIT 13 HRD IN HEALTH SECTOR

Objectives

After going through this unit, you should be able to:

- identify the importance of developing the competencies of Health Care Workers in department of family welfare;
- state the unique context in which human resources need to be developed for an effective implementation of the programmes;
- list various components of human resource management that need to be simultaneously attended to for facilitating family welfare programmes;
- list series of questions to be answered relating to each of the human resource functions; and
- identify gaps in HRD for Health Care Workers working in the Department of Family Welfare.

Structure

13.1 INTRODUCTION

According to the World Health Report 2000, provision of health care involves putting together a considerable number of resource inputs to deliver an extraordinary array of different service outputs. Few, if any, manufacturing processes match the variety and rate of change of production possibilities in health. The three principal health system inputs are: human resources, physical capital and consumables. The report further argues that human resources are the most important of the health system's inputs and consume major share of resources. Improving the performance of the health system depends ultimately on improving the performance of the workforce[1]. Human resources are a clear prerequisite for health care, with most medical interventions requiring the services of physicians, nurses or other types of health workers[2]. A variety of human

resources are in the government health services with different roles. The categories include Medical (medical officers, including specialists), paramedics (Male and Female Multipurpose Health Workers, Health Assistants etc.) and Para-professionals like AWWs (Anganwari Workers, Traditional Birth Attendants etc). In brief, the workforce (Health Care Workers) is large and diverse. It has unique characteristics and each category is qualified to do separate jobs with powerful working interests.

Three main processes influence performance of the health workforce[3]:

- Development of competencies, or the process by which the appropriate number of each category of providers is produced and equipped with the knowledge, skills and attitudes needed to produce the kind of performance needed to achieve the health services objectives.
- Deployment of the workforce refers to the process of allocating the workforce among types and levels of services, and among the various regions and sub-regions of the country.
- Management of the workforce is the process of creating an adequate organizational environment and of ensuring that the personnel perform adequately.

This unit focuses on the subject of development and management of human resources in the Department of Family Welfare. Since RCH programme has been a major intervention for the last seven years, the components of its programmes have been adequately analysed with regards to the success of their implementation and are being used extensively as illustration. The following will help to understand the total context in relation to the subject under discussion.

13.2 A CONTEXTUAL UNDERSTANDING OF NATIONAL POPULATION POLICY & HUMAN RESOURCES FOR HEALTH

Despite all earlier efforts, rapidly growing population in the country could not be controlled as desired. In 1994, during the International Conference on Population and Development (ICPD), held in Cairo, it was decided and recommended that family planning services should be provided as a component of the comprehensive reproductive health. Following ICPD recommendations, the government of India started the process of reorienting the family planning and MCH programme into a new programme called the Reproductive and Child Health Programme (RCH) and officially launched it in 1997[4]. The programme integrates all interventions of fertility regulation, maternal and child health with reproductive health of both men and women. The National Population Policy was also announced in the year 2000 with the immediate objective to address the unmet needs for contraception, health care infrastructure, health personnel and to provide integrated service delivery for basic reproductive and child health care. The NPP 2000 provides a policy framework for advancing goals and prioritising strategies during the next decade, to meet the reproductive and child health needs of the people of India and to achieve net replacement levels (Total Fertility Rate) by 2010.The long-term objective is to achieve a stable population by 2045. There is an explicit recognition in the document that the fullest coordination between a wide range of public and private players will be needed to succeed in the endeavour[5].

Production of Human Resources for Health

WHO advocates that countries must ensure that their health systems get the right number of service providers with the right skills to the right place at the right time.

India, having one of the largest networks of health care infrastructure and a pool of health personnel in the world, has been debating the issue of relevance and quality of medical education from time to time since the constitution of the Bhore Committee in 1946. Medical Colleges produce more than 19000 undergraduates and about 9000 postgraduates yearly. An increasing number of workforce producers are private and semi private institutions. With the regulatory role of Medical/Dental and Nursing Councils is ineffective, there are large variations in the quality of doctors, nurses and other categories that pass out from such institutes, including those that pass out of the government run medical colleges and nursing schools. According to the National Health Policy, 2002[6], the quality of education in the country's Medical and Dental Colleges is highly uneven and in several cases, even substandard. Also, the current curriculum is outdated and unrelated to contemporary community needs, making it difficult for the fresh graduates to effectively meet even the primary health care needs of the population. The National Population Policy recommends for modification of the under/post-graduate medical, nursing and paramedical professional course syllabi and curricula, in order to reflect the concepts and implementation strategies of the reproductive and child health programme and national population policy.

Despite provisions in the curriculum, pre-service training does not give doctors (especially if they are male) sufficient practical learning opportunities to become skilled attendants of reproductive and child health care. The fact is that there is no set standard being adopted by various medical colleges in the country resulting in a vast gap in the quality of medical graduates produced. Since Medical Council of India proved to be ineffective in improving and standardizing the medical education in the country, a Medical Grants Commission on the pattern of UGC was recommended in the NHP. The basic objective is to bring in uniformity and improve the basic medical and para-medical education in the country. Taking the norms for doctors as 1:2000 (as per Bhore committee), adequate number of doctors is available in the country and as per the statistics of MCI; the (registered) availability of allopathic doctors in India at present is in the ratio of 1:1800[7]. However, the ground reality is different and shortages in rural health services are very serious.

The difficulty of attracting workforce in the remote areas is widely recognized. The NPP acknowledges the shortage in manpower in the country. Vacancy position in India, according to the Bulletin on Rural Health Statistics in India, March 2002, shows a shortfall of 24382 Multipurpose Workers [Female] /ANM, 66902 for Health Workers [Male] / MPW [M], 3889,for Health Assistants [Female] /LHV, 5452 for Health Assistants [Male], 2310, for Doctors at PHCs, 1698 for Surgeons, 1699 for Obstetricians/ Gynaecologists, 1799 for Physicians, 2030 for Paediatricians, 12661 for Lab Technicians, 20842 for Nurse Midwife, and 1035 for Block Extension Educators. According to the Planning Commission, vacancy of doctors at Primary Health Centre is more in the states of UP, AP, MP, Bihar and J&K.

The overall shortfall in cadres of specialists, nurses, and Lab. Technicians in Primary Health Centres is more than 60%, which shows that a large section of rural population lives without primary and specialist health care. The shortages in staff means the shortages in numbers in relation to the posts sanctioned for the particular kind of institution, which may have no relation to the actual requirements on the basis of disease pattern and other relevant parameters. To make this point understandable, a hospital may have the sanctioned staff and no or little work as compared to another hospital, which has the appropriate sanctioned staff and is congested with over-work. This overloading may be either because of non-functional peripheral institutions in the catchments area, which creates increased workload or because of its location.

Migration of health work force is another issue that aggravates the shortage of doctors and other categories. Migration is particularly common from rural to urban areas and from government service to the private sector. Migration to other countries, which was

going on for more than three decades, worsened with opening up of the economy. The health care delivery system is not fully functional as conceived for the reasons explained above. The National Population Policy 2000 is quite clearly dependent on the existence of a fully functional decentralized primary health system, which regrettably, does not exist in a lot of rural areas in the country.

To sum up, we know that the pre-service training is inappropriate, shortages of staff are chronic throughout the rural health system in the country and it is an anomaly as to how can the services be functional without appropriate Health Workers? Health Care Workers not staying at their place of posting is another issue that has not been resolved till date. It is clear why a high proportion of the population in the country continues to suffer and die from preventable infections, childbirth related complications, and under nutrition in our country or is forced to get services from an unregulated private sector and our policies have not been achieved as conceived.

13.3 WHAT DOES DEVELOPMENT AND MANAGEMENT OF HUMAN RESOURCES IN HEALTH SECTOR MEAN?

In India, health care system comprises, the government health services including a large and rapidly growing private sector, which includes both profit as well as non profit health providers, practitioners of allopathic (or Western) and other systems of medicine, untrained (quacks) and informal providers. In government, there are two systems of medicine; Allopathic and the traditional, the later including Ayurvedic, Yoga, Naturopathy, Unani, Siddha, Homeopathy- previously known as ISM, Indian System of Medicine and now, renamed as AYUSH. It is customary to describe government health services at three levels, viz; primary, secondary and tertiary. These levels represent different types of care involving varying degrees of complexity. The network of government health facilities includes district hospitals, sub-district hospitals, Primary Health Centres, Dispensaries (Allopathic, Ayush) and Sub-Centres. Various characteristics of these structural rigidities divide health services into[8]:

- Operating islands (centre, states, district, sub-division, blocks, sectors, villages, very little coordination at different levels, highly unpredictable resources flows (cash and kind), high variability in performance and inconsistent practices, inadequate systems to handle complexities);
- Fragmented sector (structural divide, Health, Family Welfare and Ayush, which is further divided into schemes, projects, components, with very little coordination across different components); and
- Broken Hierarchy (little influence to steer the programme and its outcome, lack of clarity on linkages and resource flows, strategic policy and planning role inadequate, considerable gap in capacities, inadequate decentralization to address needs of population.

Human Resource Management weaknesses have been recognized and they include: low workforce morale and high absenteeism, low salaries, lack of a system for recognising and rewarding good performance, the mismatch between medical training and job specifications of primary care doctors, and the inadequacies of the non-salary recurrent funds in the system (such as petrol for supervision)[9]. In such systems salaries tend to be guaranteed, “high-flyers” are not recognised in any meaningful way because of weaknesses in the reward system, non-performers can easily “free ride”, and working conditions are generally not conducive to high performance[10]. Besides, the bureaucratic control over health delivery system is an unsorted issue. In addition, there are many other unresolved issues affecting the motivation of the workforce, therefore outside the scope of this chapter.

Primary Health Care (PHC) System includes, Community Health Centre, one in each community development block is a 30-bedded hospital/referral unit for 4 PHCs with specialized services. PHC, a referral unit for 6 sub-centres is 4-6 bedded manned with MO in-charge and 14 subordinate paramedical staff. The subcentre is the peripherial post of the existing health delivery system in rural areas, one SC for every 5000 population in general and for every 3000 population in hilly, tribal and backward areas. One male and one female multipurpose worker man each Subcentre. The main agencies of the government at the operating level are the PHCs catering to a population of 20000 in hilly, tribal and backward areas and populations of 30,000 in the plains. The staff operating at PHC level include Medical Officers (MO), Pharmacist, Nurse midwife, Female Health Worker/ANMs, Health Assistant (male), Health Assistant (female)/LHV, Block Extension Educator, among others. The functions of PHC cover all the 8 essential elements of primary health care and MO PHC and others as a team are expected to influence the target groups to adopt small family norms. The Tasks of the Medical Officer under RCH Programme are:

- Staffing
- Conducting monthly staff meeting
- Developing other health related functionaries and involvement of Panchayat members
- Motivating other staff members
- Providing supportive supervision
- Team work and leadership
- Providing on the job training
- Appraising the performance of the health personnel

In addition, MO has to ensure maintenance of cold chain and availability of drugs, vaccines and other important supplies in the institution under his control. Management of human resources in this context would mean getting right people for the right jobs, at right place, in right numbers, developing their capabilities to do their job effectively, monitoring their performance through appraisals, evaluation and incentives, developing their capabilities continuously so that they will be able to adapt themselves to the changing requirements of the field, ensuring their motivation continuously through appropriate reward systems and promotions and helping them at every step through guidance, counselling etc., and getting the best out of their capabilities. Human resource development (HRD) is concerned with the different functions involved in planning, managing and supporting the professional development of the health workforce within a health system, generally at strategic and policy levels. HRD aims at getting the right people with the right skills and motivation in the right place at the right time[11]. Since human resources (HR) is the key, the following functions may be involved in ensuring effective management.

Human Resource Planning: This function deals with prediction of manpower needs for the family planning organization considering the needs of the department and the community.

Selection, Recruitment: This function deals with identifying right persons for the different jobs to be handled and placing people in right places so that they can give their best.

Induction Training Programme: This function deals with the management of mechanisms so as to familiarize them to their job functions, rules and regulations and other relevant issues pertaining to the job, which generally, are not taught during their pre-service trainings and education.

Training: This function deals with ensuring the continuous development of capabilities in people so that they are able to perform their tasks well and meet challenges from the changing environment.

Performance Appraisal, Job Evaluation and Analysis: These functions ensure the accountability of people.

Rewards and Punishment: This function helps maintain the motivation of capable people and correct poor performers.

Transfers: This function ensures that the requisite health functionaries are rotated every few years so as to get a fair chance of working in different types of health institutions established by the government.

Employee Counselling and Feedback: This function ensures that guidance is available for employees from their supervisor and helps create a supportive working climate.

Employee-employer Relationships: This function ensures that people are not exploited, their grievances are heard and good relationships are maintained.

Career Planning and Development: This function ensures that people do not stagnate in their jobs and there is change in responsibilities periodically, which ensures their everlasting interest and zeal in their service along with enhanced income.

Organizational Design and Institutional Building Effort: This function ensures creation of proper environment so that people give their best and quality of work is continuously well maintained.

The following functions may be involved in ensuring effective management of human resources for achieving the goals of Population Policy.

13.4 HUMAN RESOURCE PLANNING

Human resource planning refers to the process of estimating the number of persons and the kinds of knowledge, skills, and attitudes they need to achieve predetermined health targets and ultimately health status objectives[12]. Planning can make the most important contribution in allocation of scarce resources so as to ensure health services to be made available equitably. There has been very little attempt to assess the human resource requirement and match it with health care infrastructure and the provision of services. The ability to forecast the future number required to achieve the objectives is not in place. Various approaches to forecasting and plan health personnel requirement such as need-based planning, personnel to population ratios and service targets are being advocated for forecasting.

The Medical Council of India/Dental Council of India has been registering doctors and dentists and the data is only available for the number registered. However, no data is available with regards to the doctors who have expired, migrated to other countries or ceased to practice. Similarly, the data for nurses is available with the Nursing Council of India; however, there is no reliable and accurate data available with regard to the availability and deployment of various paramedical professionals, since there is no council other than MCI/DCI/NCI. Lack of appropriate and acceptably accurate workforce data, especially relating to workforce supply, annual loss rates, private sector characteristics, service outputs and staff productivity hamper planning process[7]. Unlike health services planning, human resource planning in India has received inadequate attention. In addition, there are weak linkages between planners and decision-makers.

To sum up, integrated workforce planning, human resources planning and service planning, as recommended by in literature, is not in place. The Sector Investment Programme which is being implemented to strengthen the RCH Programme in the SIP states policy review on Workforce Management in the Health & Family Welfare Department has been advised. The objective of this policy review is to develop and articulate a new policy that can effectively attract, recruit, post, develop and retain competent and trained health care personnel at their designated places of work. The review would present the policy framework with particular focus, inter-alia, on the following[13]:

- Projected demand and supply of each staff category for the next five years and action to be taken to redress the imbalances;
- Relevance of the policy of deploying two multipurpose workers, one female and the other male, at the peripherial level, in view of the experiences with differences in staff supply rates and resultant workloads;
- An assessment of existing job descriptions, vis-à-vis, the technical capability required for delivery of RCH services at sub-centre, PHC and referral facilities and recommendations for more meaningful job descriptions for each functionary category;
- An assessment of the design and content of basic training for the ANM and LHV, vis-à-vis, the technical capability required of them for delivery of RCH services, with recommendations for strengthening the basic training;
- A review of in-service training set up in the State and its effectiveness with recommendations for an appropriate system;
- An assessment of the feasibility of introducing skills audit system as part of the in-service training systems proposed for districts to measure the impact of in-service training interventions with recommendations on its structure and necessary protocols;
- A review of the training capacity of the training institutions in the State with plans to strengthen it;
- A review of the remuneration packages of the trainers and stipends/allowances with recommendations for rationalisation, including performance based payment;
- A review of existing policy/measures for career development of trainers and recommendations on improvements needed.
- Suggest ways of imparting a client friendly face to the public sector services.

In addition, the workforce policy review will also examine the feasibility of introducing a new level of medical competence, including incentives, for encouraging public sector specialists and other functionaries to work in the rural areas.

13.5 SELECTION, RECRUITMENT

Recruitment is the process of searching for personnel to enter a particular job or position. Cohesive HR policies are dependent on effective recruitment and selection practices. A number of difficulties on the subject have been highlighted in the literature. Firstly the decisions about recruitment are handled at a much higher/ different level and are poorly linked to service requirements. Thus, in government, the posts and qualifications are identified and selections to the government department governed by the legal framework. No other criteria, apparently, is adopted and selection is made through written tests and interviews of the candidates with basic qualification as explained. Posts are also advertised as per the sanctioned strength approved by the State Planning and Finance Departments for posts under the State

budgets and similarly for posts sanctioned under Family Welfare, the GoI provides funds for salary. A doctor, holding an MBBS degree from any recognized medical college can only apply for the post of Medical Officer and similarly, a person with nursing diploma/degree can only apply for the post of a nurse midwife. A 10th class pass can join the ANM training programme of one and half years duration for ANM. Under RCH Programme, the GoI did advise the states to look for appropriate additional staff ANMs/Nurses on contractual basis, wherever needed.

Chatterji, Singh and Mehrotra of the Indian Statistical Institute, Calcutta studied the method of selecting field level family planning workers. They tried to evolve a battery of objective tests, which could be used for selection. The tests used by them include: socio-economic status scale, general information test, personality test, non-verbal intelligence test, verbal interest test, aptitude scale, attitude scale and value scale. These tests were administered to 55 female and 181 male family planning workers in two different sessions. For the female workers, the short attitude scale and the two personality sub-scales of emotional instability and hypo-manic temperament were the best predictors. Likewise, for the male workers, the general information test was the best predictor followed by the socio-economic status scale, intelligence test and the religious values test. There is a great need for more work in selection techniques. Related to this is the need to answer even basic questions like (a) What should be the minimum qualifications required for grassroots level functionaries? (b) Is it necessary to have post-graduates as extension workers or can one use less qualified people who are willing to work in rural areas and who can establish their credibility? Experiments on involving different agents in family welfare activities may throw some light on these aspects. However, we should look at how to get motivated people into the health sector in the first place.

13.6 INDUCTION TRAINING PROGRAMME

This function deals with the management of mechanisms to familiarize them to their new job functions, rules and regulation and other relevant issues pertaining to the job, which generally, are not taught during their pre-service trainings and education. Most of the organizations in the private sector use specialized induction training programmes. However, there is no uniformity in induction training programmes in the country, especially in the Department of Health & Family Welfare, which has not become a regular feature. According to the NIHFW document[14] all categories require to have induction training. For this a core capsule containing the important National Programs, priorities and problems has been incorporated in all the induction-training courses in the modified form, depending on the need of the category. Many problems relating to the effectiveness of the health system are being experienced primarily on account of lack of induction training imparted to most of the new recruits. In absence of a uniform need based, state and category specific strategy of induction training, poor performance of health activities and programme may always be expected. It is high time that the Induction Trainings are made mandatory for potential Health Care Workers as is being practiced in the private sector.

13.7 TRAINING

Training is the most important function that directly contributes to the development of human resources in any sector, including health. According to the NIHFW document[14] training alone is not a panacea for removing ills of health system in the country. Nevertheless it is assumed that repeated training will improve effectiveness of services. The document recommended development of a training strategy for which it is necessary to lay down a training policy and advised that the training contents should

be based on a problem solving approach, team building and vertical and horizontal integration. Before designing any new training program there should be training needs assessment (TNA) in view of the new program objectives, strategies and job responsibilities of key functionaries. Based on the results, a training strategy should be developed which should take into account the training capacities in the country. Training strategy comes before developing training design and curriculum. Training strategy needs to address three questions; Who needs training?; What are the skills deficits for which training is needed?; Who will be able to use the training provided?[15]

In addition, the training strategy has to address other issues like:

- **Pre-service Training** curriculum needs to be revised and updated to reflect Reproductive Child Health priorities and real life working situations. An innovative and highly interactive method of teaching needs to be used in basic training.
- **Appropriate Staff Appraisal System** so as to identify the areas of deficiency in the competence of individuals that enable training institutes to design effective courses for competency building and keep track of change of the improvement achieved.
- **Promotion** demands a higher level of competence and ability to perform new tasks for which the promotee may not be equipped. A well-designed promotion policy will link training to promotees' needs. Many experts recommend public health training as a pre-requisite for District level posts instead of seniority only.

13.8 OTHER HRM FUNCTIONS

- **Career development** should preferably be linked to training so as to stimulate trainees to upgrade their skill and competence voluntarily.
- **Post-training placement** should be pre-ascertained so that training does not go waste.
- **Career Development of Trainers** is imperative so that the training system be staffed by trained trainers in education/training technology, who are committed to and having an aptitude for training. States need to have a policy on appointment, transfer and career developments for trainers, since presently trainers have little career advancement prospects, so as to attract the best talent. A system of recognition for excellence in trainings needs to be developed making teaching, training attractive.
- **Training as a team** has also been successfully tried when all grades of staff from several PHCs in Janampet and Mahaboobnagar, in Andhra Pradesh received joint training in obstetric first aid under an Institute of Health and Family Welfare Project, needs to be encouraged.

Other Important Principles for Training that Require Attention are:

- Training linked to post-training performance;
- Training to be skill-based and focused on imparting critical communication, counselling and clinical competence;
- Training standards, including accreditation processes;
- Training to be conducted by high quality trainers who will be adequately rewarded (retired teachers and academics also to be involved);
- Training to be decentralized to state/regional/district level;
- To be provided in partnership with NGOs and the private sector;

- Training Modules to be regularly updated;
- Training infrastructures to be supported and strengthened at the state and district regularly;
- Developing a cadre of staff who is trained as trainers;
- Institutional excellence in training to be recognized; and
- Networking of all training institutions within the country and internationally.

Since, the majority of trainings in health are skill-based trainings the following seven steps of progression, suggested by Hargreaves[16] are recommended:

Step 1: trainee observes

Step 2: trainee assists the coach

Step 3: trainee does under coach's supervision

Step 4: trainee does with the coach in the vicinity

Step 5: trainee does on his or her own

Step 6: trainee perfects it through regular practice

Step 7: trainee now a teacher and teaches it

Why is Training Necessary?

Unlike material capital, knowledge does not deteriorate with use. But, like equipment, old skills become obsolete with the advent of new technologies, and human capital needs to be maintained too[1]. Human capital can be treated conceptually in the same way as physical capital with education and training as the key investment tools to adjust the human capital stock and determine the available knowledge and skills[17]**.** Continuing education and on-the-job training are required to keep existing skills in line and a great emphasis is being given to development of competencies of the workforce so as to achieve the goals of National Health and Population Policies. Introduction of new approaches (like RCH Program) and emergence of new diseases such as AIDS, Hepatitis B and other non-communicable diseases, further necessitate continuing the training of all members of the workforce. In addition, rapid introduction of new technologies, more demanding patients, deepening concern about escalating medical costs and increasing attention to the quality and outcomes of medical care require regular training of the service workforce. These also include an emphasis on the effectiveness, efficiency and changing roles of the Health Care Workers. A significant shift in the ethos and implementation strategy of the Family Welfare Programme was envisaged under the RCH program and the range of interventions became larger. Thus there was every need to design a new set of trainings. GoI, so as to achieve the objectives, devised comprehensive RCH in-service training programmes for all categories of health functionaries working in the department of family welfare. It is a great challenge to train such a large number of functionaries so as to equip them with the necessary competencies.

13.9 CONTINUING MEDICAL EDUCATION (CME)

The need for CME is well recognized and the challenge is to make it effective. The National Health & National Population Policy recommends continuing medical education. CRISIS, an acronym, stands for the criteria that must be met to produce effective CME programmes: convenience, relevance, individualization, self-assessment, interest, speculation and systematic. CRISIS is practical tool based on the experience in production and evaluation of CME programmes at the centre for Medical Education, University of Dundee in the United Kingdom[18]. The Medical

Council of India has been organizing CME Programmes. With an initial number of four programmes held during the year 1985-86, the number of programmes has now increased progressively to 100 to 150 programmes per year.

Professional Associations also regularly conduct CME Programmes for their members. Maharashtra State publishes a quarterly bulletin under Sector Investment Programme for updating and refreshing the minimum technical skills of the staff. The same is distributed to all the doctors at district hospitals, CHCs and PHCs in the state. The Working Group on Development of Human Resources For Health For The Tenth Five year Plan (2002-07)[7], in its recommendations had endorsed the emphasis of 9th Plan proposal of the government to make re-registration of doctors every five years compulsory, which will be linked with their undergoing CME for 30 credit hours every year, which needs to be given effect expeditiously.

In addition, the scheme of interlinking all medical libraries is encouraged with provision of adequate funds in the tenth plan period. This will lead to improvement in quality and coverage of cost effective CME programmes[7]. The Punjab Medical Council has decided to make credit hours in CME mandatory @ 10 hours/year. All doctors are required to communicate to the council the CME's attended (Credit hours) by them. A computerized CME Account for each doctor will be maintained by the PMC. In this chapter, as we are discussing the subject with special emphasis on the Department of Family Welfare so we prefer to discuss only the professional development course in management, public health for district medical officers and Trainings under RCH Programme because of paucity of space.

1) Professional Development Course in Management, Public Health and Health Sector Reforms for District Medical Officers

Excellent programme strategies implemented poorly have led to a failure to achieve programme objectives in the past primarily because District Officers are not trained in public health or management. District Officers (CMOs and DMOs etc.) and others attain their posts by seniority only from the ranks of government doctors (clinicians). Under this course, the District Officers are given a three-month course at the NIHFW, New Delhi. Since training senior doctors raises a number of problems, e.g., they normally do not easily recognize their need for more knowledge and skills or they require a change in their attitude. For this reason, the experts designing the programme dropped the terms 'training' or teaching' in the title. The phrase 'professional development' is used for following reasons[19]:

i) It is a term increasingly used internationally to denote a profession that is devoted to life-long learning.

ii) The phrase, leading naturally to 'continuing professional development' (CPD) makes it clear that this short programme is not seen as a final stage in the acquisition of knowledge and skills by the district officers.

Senior people do not take lightly to being given a long series of didactic lectures or talks, therefore innovative and highly interactive methods of teaching are used, including computer literacy, since it is considered that all the officers should have a minimum knowledge of word processing, graphics, simple use of spreadsheets, e-mail, accessing the internet etc. All background material and details of the course are provided on a CD-ROM for them to examine at their leisure.

2) Trainings Under RCH Programme

Since the RCH programme involved many major paradigm shifts, hence a massive training component was included as an integral part of RCH programme. Objective of trainings under RCH Programme was to upgrade the competence (knowledge, skills

and attitude) of health care service providers and managers so that the programme would be a success as conceived. NIHFW designed a national package, including guidelines for conducting the trainings. Well-designed documents for trainings, including facilitator guides, were prepared. At the ministry level, Deputy Commissioner Trainings is the overall in charge of all trainings and is assisted by AC, Trainings; amongst others. Master Trainers were trained by the NIHFW, New Delhi. The institute trained faculty members from the 14 'Collaborating Training Institutes (CTI)', spread all over the country. CTIs in turn trained District Key Trainers including faculty members in the State Institutes of Health & Family Welfare. These State level and District Key Trainers imparted trainings at state and district level respectively. All trainings under RCH are organized as per the guidelines issued by the nodal agency i.e, NIHFW, New Delhi and monitored regularly by them, the CTIs and others. Proficiency certificates were issued at the end of the training to the trainees after their having achieved the requisite proficiency.

The main objectives of trainings under RCH were:

- To train trainers (TOTs) 'District Key Trainers', at least one each for Management, Child Health, Maternal Health and Communication i.e. one team each for a particular District. In addition, faculty members of the Sate Institutes of Health and Family Welfare and ANMT schools were also trained.
- To ensure that the District trainers train the field staff to deliver effective and quality services and
- To ensure improvement in quality of services to the community's satisfaction (client satisfaction), so that more and more people take advantage through our services (increased demand generation), which is the goal of the RCH programme.

Review of Trainings under RCH: Two studies conducted on trainings under RCH are worth mentioning, so that the reader can really understand the issues completely and correctly. The first study sponsored by WHO-SEARO was conducted by Dr. B.V. Adkoli, Educationist, AIIMS, New Delhi in the year 2002. The report identified major deficiencies, some of which are:[20]

- Absence of training policies based on the assessment of training needs, a mis-match between training content and the job requirement, inadequate training infrastructure, absence of a comprehensive evaluation of the training program, especially the job performance after the training and lack of a holistic approach to the training and education of health workers/professionals.
- Evaluation and monitoring of training requires a major overhaul, especially in view of Quality Assurance models, which are emerging in the field.

Professor D.V. Mavalankar of IIM Ahmedabad conducted the second review of RCH Trainings. The following are some observations relevant for this chapter[15]:

a) Training under the RCH is a huge task as it covers hundreds of thousands of health staff in the country, which needs a very efficient and large training infrastructure in the country.

b) In the medical officer's module there is hardly anything on supervision or management, which is one of his/her main functions and supervision is one of the weakest links in the current program.

c) Issues like gender sensitivity, life-cycle approach, client focus, and emphasis on quality of services are some of the important issues missing in the curriculum.

d) Many international NGOs have developed good training material for various aspects of RCH. Such expertise and materials should be reviewed by NIHFW and adapted for use in the RCH program.

e) All training is meant to improve practice leading to better service delivery. No systems have been developed to evaluate changes in practice of the trainees in the skills taught during the course. Similarly there is no system set up to measure the improvement in performance of the staff when they go back to the field.

f) Training should be integrated with other HRM functions such as recruitment, task/job specification, performance appraisal and reward system for employees. The role of the training division should expand to Human Resource Development and Management. No state seems to have an HRD policy, strategy or Health Human Resource Information System. This is adversely affecting the training under RCH as it has affected other trainings in the past. \

Distance Education

In India health courses offered through distance education are few and offered by a limited number of institutions some of which are:

- Christian Medical College, Vellore (PG Diploma as well as M.Phil in Hospital Administration) in collaboration with BITS, Pilani, Rajasthan and Tulane University (USA)
- Christian Medical Association of India (a 1993 program for trainers of two year laboratory technician course).
- School of Health Sciences (SHS) IGNOU has developed competency-based programmes in various disciplines of Health Sciences.
- Yashwantrao Chavan Maharashtra Open University has also started a School of Health Sciences with community based health workers, nurses, hospital mangers as the target audience.
- SOHS-IGNOU is running courses for doctors on subjects like maternal and child health, etc.
- SOHS-IGNOU has developed a course on Certificate in Competency Enhancement for ANM/ Female Health Worker (FHW).
- NIHFW, with the financial assistance of WHO, developed and is conducting:
  - i) PG Certificate Course in Hospital Management,
  - ii) PG Certificate Course in Health and Family Welfare Management.

The distance education has tremendous potential for providing education and training programs in a country as large and diverse as India. The national agencies such as the Ministry of Human Resources Development, the Ministry of Health and Family Welfare and Indira Gandhi National Open University, International agencies such as WHO, UNICEF and USAID, DFID, EC and others need to play increasingly prominent roles in facilitating the achievement of the goals of National Population and Health Policies. The Internet offers a whole range of new learning experiences and opportunities that include:

- Computer-assisted learning packages (CAL) e.g., tutorials, simulations.
- Computerized assessment packages, e.g., Question Mark.
- Electronic textbooks, manuals and atlases, e.g., Textbook of Dermatology on CD-ROM; Pathology Text Stacks.
- Standard software tools, e.g., word processing, graphics, spreadsheets, databases, presentation packages, statistical packages.
- Bibliographic databases, e.g., Medline and CINAHL (Cumulative Index to Nursing and Allied Health Literature).
- Other databases, e.g., EBNF (Electronic British National Formulary); Toxline; Aidsline; the Cochrane Database.

- Image banks e.g., the National Slide Bank of Medicine.
- Decision support systems, e.g. Iliad, Dxplain, Quick Medical Reference (QMR).
- Electronic patient records.
- Computer conferencing, telemedicine.
- The Internet, e.g., e-mail, news groups, telnet file transfer protocols, the World Wide Web.

13.10 PERFORMANCE APPRAISAL

Performance appraisal systems in Health and Family Welfare departments are the same as those in other government departments and programme managers have not perceived separate format as recommended by experts. Researches by psychologists have established that behavioural change occurs more by positive reinforcement and the performance appraisal is an effective instrument for helping people to grow. It could be used as an effective mechanism of continuing education and learning from one another. Through a well-organized appraisal system every Health Care Worker can be recognized for his strengths and weaknesses, and through an organized system, the system can build on his strengths for betterment of both, the person and the organization. Researchers and experiences have shown that development oriented performance appraisal and review system when systematically conducted, contributes substantially to the organization's health.

Objectives of an Appraisal System are:

a) Strengthening the organization.

b) Appraising present performance matched with agreed objectives.

c) Developing people to meet future organizational needs.

d) Helping each person to develop potential.

e) Responding to two questions which everyone has:

''How well am I performing?''

''Where can I go from here?''

Thus a good appraisal system should primarily focus on development of the workforce and at the same time helping the organization in the management of people through rewards etc. In brief, a very potential tool like performance appraisal is not being used in government systems so as to develop individuals, teams and the organizations. Dr. J.P. Gupta et al 1986[21] in their report has opined that developing performance appraisal standards for such a large and diverse manpower is a gigantic task. Given the existing situation of lack of flexibility in rewards and salary administration, there are serious limitations for having an effective performance appraisal system. In many developed countries 360^0 appraisal, which originated in the commercial sector, and refers to "full circle' feedback from bosses, peers and juniors has been introduced in many hospitals and further results will have to be seen before this can be introduced. It generally does not include many items on technical or clinical skills, as there are other ways of measuring these. The District Manager and above, may be appraised differently from the doctors doing only clinical work and different weightage may be provided for different attributes for distant categories. Thus it may not be feasible to have a performance appraisal system that achieves the entire objective mentioned above, but it is possible to have a system that can take care of most of these. Realizing the importance of a good Appraisal System, some states are hiring experts to devise a proper system that is useful to all functionaries including the system.

Such an appraisal system could be based on:

a) Clarity of roles and responsibilities for each role.

b) Periodic goal setting for each role incumbent.

c) Annual or periodic assessment of performance in terms of achievement of such goals.

d) Analysis of the achievement of these goals and identifying the inhibiting factors and facilitating, in relation to the achievement of goals, formulating of action plans for overcoming inhibiting factors and strengthening facilitating factors.

e) Periodic review of behaviour, which contributes to employee's effectiveness and working out action plans for developing in such behaviour.

f) Identification of development needs and preparing plans for employee development through trainings and related activities.

g) Periodic review to be a regular feature.

In brief, appraisal system identifies the areas of deficiency in the competence of individuals that enable training institutes to design effective courses for competency building.

13.11 REWARDS AND PUNISHMENTS

Rewards and punishments as a mechanism of human resources management deals with issues like salary administration, advanced increments or stopping increments, incentives for workers, awards and other forms of recognition etc. While presently there is not much of activity happening in rewards and punishments, there were periods when the programme administrators had tried out different strategies. For example, the institution of 'warning letters' used in certain states was one such important activity. Similarly, instituting incentive schemes was another. Questions like the following need to be answered.

a) How does one motivate the health functionaries?

b) Since there are practically no promotional opportunities for family planning workers, can there be any other incentives introduced to keep the motivation of the staff high?

c) What should be the salary structure for the staff that provides scope for rewarding effective employees?

d) In what ways should effective workers be treated differently so that they remain motivated?

13.12 TRANSFERS

Transfer of the staff is a serious problem of human resource management in many states. Transfers take place because staff have their own interest and attractions for certain areas. At every possible opportunity employees try to get nearer to their preferred places, which invariably has to be a home posting or at a big hospital, which enhances his/her prestige, including other perks, that may include better private practice etc. Thus there are severe pressures put on the programme administrators for transfers to the so called prize postings! The transfers go on round the year and take a significant proportion of the time of programme managers at the district level and above. Besides taking away the time of the important functionaries, transfers also create serious disturbances in the field. Most states do not have a documented transfer policy. The ones, which do have one, because of political pressures, have not been

able to implement the same. Some reports do mention the corruption in the department, primarily because of transfers in accordance with the desire of the concerned staff. "Buying" postings and protection is common[9].

13.13 SUMMARY

Epidemiological, demographic, technological and economic changes impact on the delivery of services, in terms of requirements for new skills, new attitudes, new practice sites, and new work organization[3]. A formal organized training is only one tool for development of competencies of the service providers. Training in teams (small groups), a culture of 'Shared projects' and 'knowledge swap' including 'Team Learning Portfolios, are recommended at the workplace (Who learned what from whom, where, how and why)[22].

Other strategies for development also need patronage, amongst others: On-the-job learning through mentoring, cross functional assignments, memberships of 'Quality Improvement' working groups, additional job assignments, technical presentations and discussions at monthly meetings, seminars and workshops, interactive learning activities on internet and encouraging participation in scientific and professional organization meetings. The Continuous Professional Development of the workforce through all means needs to be promoted. This would mean use of on- the- job and off-the-job methods. Self Directed Learning should be promoted and good practices should be disseminated to all through traditional systems like newsletters, bulletins, journals and IT.

New approaches to skills development may be required; including management development approaches based on more through organizational development plans[23]. Research has highlighted a so-called "prime building block" of human resource management – the principle of "AMO". There must be sufficient employees with the necessary ability (skills, knowledge and experience) to do the job; there must be adequate motivation from them to apply their abilities; and there must be the opportunity for them to engage in "discretionary behaviour"- to make choices about how their job is done. The authors suggest that organizations wishing to maximize the contribution of their workforce need to have workable policies in these three broad areas[24].

HRD in health has been highly neglected by all, as explained earlier in the chapter. Recommendations of the researchers in the past were not taken seriously and hence not implemented. There is an urgent need to develop innovative processes and procedures for the management of human resources, a policy that can be implemented so that the health functionaries are attracted to rural areas, at least for few years in their total tenure of service. The design and content of a human resource policy must reflect the organisation and management structure of the health system in such a manner that the general human resource needs for the system to function effectively are known. That is, what competencies, systems of authority, accountability and career development are required for the system to function effectively?[25] The government needs to facilitate the formulation of an integrated human resource policy with full commitment with the active participation and in harmony with the interests of all stakeholders[28]. Without a foundation of skilled, available and motivated human workforce, healthcare systems cannot adequately respond to population health needs[26] The health sector needs to be working towards Strategic Management as a Professional and a Learning Organization[27]. All attempts of developing the competencies of the service providers will be worthless if they are not motivated or otherwise able to perform the tasks because of unsatisfactory incentives and working conditions or because they simply do not have the tools and supplies to do them. Improved management could bridge the gap between policy and implementation.

Health systems research might provide approaches to finding mechanisms to redress the problems that afflict the department.

13.14 SELF ASSESSMENT QUESTIONS

1) List various components of HRM in health sector with reference to Department of Family Welfare, India.

2) Discuss the importance of HRM in health sector citing examples.

3) Write short notes on following HR functions with reference to health and family welfare department:

   a) Training
   b) Performance Appraisal
   c) Human Resource Planning

4) Describe the need and functioning of Continuing Medical Education (CME).

13.15 FURTHER READINGS

1. WHO. (2000); "*What Resources are Needed*", in: The World Health Report 2000, Health Systems: Improving Performance. WHO, Geneva: Switzerland.
2. Dussault, G. Dubois, C. (2003); Human resources for health policies: a critical in health policies, Human Resources for Health 2003.
3. Dussault, G. (1999); *Human Resources Development*: The Challenge of Health Sector Reform, Human Development, Latin America and the Carriben Region, The World Bank.
4. Govt. of India (1997); *Reproductive and Child Health Programme, Schemes for implementation*, Department of Family Welfare, Ministry of Health & Family Welfare.
5. National Population Policy of India- 2000. Ministry of Health and Family Welfare, Government of India. Available: www.mohfw.nic.in .
6. National Health Policy of India- 2002. Ministry of Health and Family Welfare, Government of India. Available: www.mohfw.nic.in .
7. Report of the Working Group on Development of Human resources For Health, For The Tenth Five Year Plan, 2002-2007, (2001); Planning Commission, Government of India.
8. Bhat, R. & Maheshwari, SK (2004); *Human Resources issues and implications for health sector reforms*, Indian Institute of Health Management, Ahmedabad.
9. Mooij, J., Sheela P and George, A. (2003); *Health Decentralisation, Decision Making and Accountability in Andhra Pradesh.* Harvard School of Public Health.
10. Hongoro, C. et al. (2003); Draft Conceptual Paper, Human Resource Studies in Health for Poor and Transitional Countries, Health Systems Development Programme, Health Policy Unit, Dept of Public Health & Policy, London School of Hygiene & Tropical Medicine. http://www.dfidhealthrc.org/shared/events/events_reports/HR_workshop-final.pdf.
11. Martinez, J and Martineau, T (1996); Human Resources and Health Sector Reforms: Research and development priorities in developing countries. International Health Division, Liverpool School of Hygiene and Tropical Medicine.

12. WHO (1990); Study Group on Co-ordinated Health and Human Resources development. World Health Organisation, Technical Report Series 801.
13. Health and Family Welfare Sector Investment Programme in India (1999); SIP Document, Government of India, Department of Family Welfare, European Commission, New Delhi.
14. Gupta, JP. Bhatnagar, S. Banerjee, A.; Macrostrategy for Inservice Training of Health & Family Welfare Personnel, National Institute of Health and Family Welfare.
15. Mavalankar, D.V. (2002); Report of the mid term Review of The Training Component of the Reproductive and Child Health Programme of Government of India. Ahmedabad: IIM; March 2002. Report submitted to the Training Division, Ministry of Health and Family Welfare, Government of India.
16. Hargreaves, D H. (1996); A training culture in surgery, BMJ 313;1635-39.
17. Becker, GS. **(**1993); Human capital, A theoretical and empirical analysis with special reference to education, 3rd edition. Chicago, The University of Chicago Press.
18. Harden, RM. & Laidlaw, JM. (1992); Medical Education, Vol.26:408-422.
19. Health and Family Welfare Sector Investment Programme in India (2001); Institutionalising a professional development course for district medical officers in India ECTA Situational Analysis 2001/ 25, Government of India, Department of Family Welfare, European Commission, New Delhi.
20. Adkoli, BV. (2002); Report, Situation Analysis of Continuing Education of Health Professionals in India, KL Wig Centre for Medical Education & Technology, AIIMS, New Delhi.
21. Gupta, J.P. et al (1986); "*Reorganisation and Reorientation of the Health Services delivery system in India*", New Delhi.
22. Gupta, Y. (2000); "*Competency Building of Health Personnel: In-service Training for Health & Family Welfare Functionaries in Jammu & Kashmir*" Ph.D. diss., Birla Institute of Technology and Science, Pilani, Rajasthan, India.
23. Mapplebeck, T. (1995); Management development strategy for the health services of the new South Africa. Consultancy report to the Health Life Sciences Partnership, London.
24. Charted Institute of Personnel Development (CIPD), (2002); Sustaining Success in Difficult Times: Research Summary, London.
25. Kalon, SS. (2004); An Integrated Human Resources Strategy in Jammu and Kashmir for better health care, (Master's Thesis), Institute of Tropical Medicine, Belgium.
26. Narasimhan, V. et al. (2004); Responding to the global human resources crisis, Lancet. May 1; 363(9419): 1469-72.
27. Duncan, WJ. Ginter, PM and Swayne. LE, (1995); "*Strategic Management of Health Care Organization*" (2nd Edition) Blackwell Publishers, USA.
28. World Health Organisation. (1990); *Management Development for Primary Health Care* – Report of a Consultation. Geneva: WHO.