

Human Resources and Management of Health Systems

Proceedings of Workshop

October 16-18, 2008

Puducheery

National Rural Health Mission, MOHFW, GOI

In collaboration with

WHO Country Office for India

DFID

National Health System Resource Centre

Record of Discussion of the Puducherry Workshop on 16th -18th October, 2008

Human Resources and Management of Health Systems

The National Rural Health Mission hosted a national workshop on Human resources and Management of Health Systems in Hotel Sunway, Puducherry from the 16th to 18th of October, 2008. This workshop was sponsored by WHO and DFID with NHSRC providing organizational support.

Shri. Naresh Dayal, secretary, Ministry of Health and Family Welfare inaugurated the workshop. Shri Amarjeet Sinha welcomed the participants and detailed the objectives of workshop the foremost being to share state experiences in addressing the crisis in human resources for health and to discuss the various possibilities by which states could utilize the NRHM for addressing these issues and scaling up HR availability. Shri Amarjeet Sinha briefly explained the specific strategies being rolled out such as expanding nursing education, multi-skilling, ASHA's training etc. He stressed the immediate need to consider the opportunities, innovations and implementation modalities. The other major objective of the workshop was to discuss the report of the "Task Force on Public Health" - analysis of management structures for public health, and recommendations for focus on public health.

Session 1 – Learning from the States

Dr. P. Padmanaban, Advisor (Public Health Administration), NHSRC gave a presentation on Tamilnadu's health system model with a focus on HR issues and public health management. This was supplemented by comments from Secretary (Health) and Mission Director, Tamilnadu. The TNMHC contribution for efficient procurement and distribution of drugs and supplies and of equipment were highlighted. In, HR the main steps were the recruitment of doctors and paramedics, contractual doctors on time scale of pay, compulsory rural service of 3 years for doctors and nurses on completing of education from government colleges, reservation of seats in post graduate courses for in-service government doctors, full salary for in-service candidates undergoing PG courses, weightage of service in difficult areas for admission selecting for in-service PG seats through a system of bonus marks, a transparent and fair transfer policy where vacancies are posted and choices made on a seniority cum counseling approach. As a result of these measures the vacancy situation was not a major concern, even in relatively remote areas.

The structure and functioning of the public health cadre in Tamilnadu was also elaborated by him. All administrative posts of the public health and family welfare directorates are held by this cadre. After three years of service, those who opt for this cadre are posted as health officers. They are required to get themselves qualified in public health and after 5 years of service would be promoted to the position of deputy director of health services and then rise through various levels of administration till the post of director. The tremendous benefits in terms of programme outcomes and health systems performance, that such sound management practices brings was evident in the picture of a glowing well performing public provisioning of health care in tamil nadu that he detailed.

Ms. Mona, Mission Director, Gujarat presented management of health systems in Gujarat. In HR management, the state has taken a number of steps for rationalization such as integration of the health activities by putting them under one commissioner, revising recruitment rules, the merger and integration of many closely related field cadres, rationalizing actual job allocation, and introduction of new cadres like accountant, and systems manager in exchange for outdated cadres etc. The state has also developed mechanisms to appoint officers with right attitude and sincerity as civil surgeons. For capacity building, training and sensitization activities are being taken up along with exposure visits within the country and abroad, for even junior functionaries. 13 new ANM schools and 3 new nursing schools in tribal districts have been operationalised. 6 nursing schools have been upgraded to nursing colleges (2 schools in PPP mode) and 4 colleges for nurse midwifery practitioner have been operationalised. The state has approved PG in psychiatric nursing. 5 new medical colleges have been proposed and institute for Hospital Administration is being set up. The state has dedicated project implementation unit for infrastructure projects in health sector (a workshop to brief other states on the same organized in Gujarat in 2007).The state has outsourced some of the diagnostic and laboratory services and has evolved partnerships for service delivery in the form of the

Chiranjeevi Yojana. Some of the other activities for health system strengthening are upgrading the health facilities to NABH and Laboratories to NABL.

Dr. John Ekka, Mission Director, Assam, presented Assam's efforts in meeting human resources. The state under NRHM has been able to recruit 4088 contractual ANMs, 2230 GNMs (in their home districts), 91 specialists, 147 medical officers, 493 Laboratory technicians and 183 pharmacists. Mobile medical units are functioning in all the districts along with boat clinics under PPP. The state, through recruitment Mela, has distributed appointment letters to 4000 paramedical workers. It has also instituted ASHA awards for the best performing ASHA in the district. The state has proposed a Hospital Administrator for every district hospital and has increased recruitment of MOs and Specialists from Medical Colleges through enforcement of the compulsory government service bond.

Shri. S.K. Lohani, presented Orissa's efforts in improving human resources and health management. The state of Orissa has increased seats in the four medical colleges in undergraduate course from 107 to 150 each. Posting at difficult areas have been made more rewarding by giving additional incentives to regular doctors. Enhancement of pay and allowances for doctors has been done by up gradation of entry level post for doctors to Junior class 1, increasing specialists extra allowance/pay from Rs. 150 to Rs. 3000 per month, post-mortem allowance of Rs. 500 per case. A proposal for restructuring the cadre of doctors for creating better promotional avenues is being considered. The re-structuring principle adopted has been more specialist posts at CHCs, strengthening of CHCs with senior persons, strengthening of SDH to function as FRU etc. For managerial training for doctors 3 months professional development course on health management is being imparted to doctors. Three-phase training on district health planning and management for doctors is in process with support of NHSRC. Doctors have also been nominated for the 1 year diploma course in Public Health Management in IIPH, Kolkata. Initiatives taken on nursing front include opening of M.Sc. Nursing course, restructuring of nursing directorate, PPPs for expanding nursing education, proposals to set up 8 GNM schools, a centre of excellence for nursing education, cadre re-structuring for staff nurses, enhancement of remuneration for contractual staff nurse, walk-in interviews to accelerate filling up of vacancies and creating new nursing posts. The state has doubled the numbers of seats in diploma of medical laboratory technology and medical radiography courses and is persuading private medical colleges to start these courses.

Discussion on the presentations followed thereafter. Shri. R. Srinivas, MD Rajasthan said that performance outcomes for health workers needed to be defined and provision of termination of contract for long absenteeism and non-performance be activated. There is also a need to professionally assess various strategies being rolled out rapidly like insurance, EMRI, PPPs, etc.

Shri. A. K. Anthony, Tamilnadu raised the need for inter-sectoral coordination, issue of quality of care and HR gaps especially with reference to the increased demand generated by JSY programme. Responding to this, Ms. Aradhana Johri, Joint Secretary stated that a UNFPA –GTZ conducted survey in 6 states showed that many of these problems were now being addressed and the period of stay of the mother in the rural health institution increased to 18–24 hours and more if there were complications. She suggested that IPHS should be implemented phase wise.

Announcing the HMIS Web-Portal.

In a small session specifically meant for the purpose, Sh. Praveen Srivastava, Director (Stats), MOH&FW presented on the new web portal being launched by the MOHFW for facilitating HMIS. The portal was scheduled for a formal launch on the 21st October, the launch programme being linked to a training camp on HMIS for state personnel. The presentation described the process of rationalisation of data being collected, and the development of indicators and then the finalisation of formats, together with development of a software, a web-portal where states could upload their data and the linkage with NIC. Shri Praveen Srivastava demonstrated the key features of this portal and described how it would soon be able to support a considerable variety of analytic functions. He also stated the hardware configurations needed for the system to be functional. One HMIS nodal officer was required to be designated by the states at state, district and block levels. This could be a member of the SPMU/DPMU/BPMU.

Ms. Girija Vaidyanathan, MD Tamilnadu raised the issue of compatibility with their existing systems and the need for integration of several simultaneous data flows, e.g of the IDSP, the health systems development project, the disease control programmes. They wanted three months time to be able to link to this software. Shri Lohani, MD, Orissa desired to know about the HMIS formats and software developed by NHSRC that their state had already adopted and their staff had already been trained in. It was explained that use of all old HMIS formats was to be stopped completely. The disease control monitoring systems were being integrated but that would take time and till then it could continue to be a parallel stream. Also clarified that states could use systems and even indicators of their choice and needs as long as the core data elements required by the center was provided to it, and in the format prescribed, and preferably from the end of the current month, but certainly by the year end.

Session-II: Focus on Nursing:

Dr. Thamma Rao, Advisor(HR), NHSRC made a presentation on the 'Key Human Resource Challenges in States'. Highlighting the gaps between the prevailing health status indicators and the goals for the NRHM and the MDGs, he highlighted the slow pace of improvement in them, and argued for the urgency of measures to deal with them. Focussing on the HR gaps in quantitative terms, he used the IPHS facility based norms to compute the shortages. The shortages were clearly more for nursing cadres than for any other category.

Dr. Prakasamma, Director, Academy of Nursing Studies, Hyderabad gave a very thought-provoking presentation on 'Growth, Decline and Revival of Nursing and Midwifery in India – Role of Private Nursing Institutions'. Tracing the history of nursing education since Independence when there were only two nursing colleges, she identified the periods of growth as well as the changes in task descriptions of various nursing cadre in the public health services. For ANMs, she thought that the initial 2 year clinically trained provider of services to women and children, had been deskilled in the process of shifting to a multi-purpose worker scheme. In her view, the NRHM needs to clearly define the role, work expectations and skill needs of the ANM, specially when a second ANM is being put in place. Only then will the content and outcomes of training be commensurate with the work requirements. The social and gender related pressures on the ANM had to be factored in, and career progression pathways worked out.

She ascribed the decline in Public Health Nursing in the country to discontinuation of the LHV course, and the reduction in institutions offering the DPHN course in which there was integration of public health nursing into the nursing syllabus, and discontinuation of the post of DPHN Officer in many states. She called for re-starting bridge courses for LHVs\ANMs to become GNMs. She described the uneven distribution of nursing institutions across the country, the southern states having over two-thirds of colleges and PG degrees. Private nursing colleges have numerically multiplied and this was closely related to the rise of private corporate sector in health care and the rising international demand for nurses. The quality of many of these new colleges is questionable, with severe shortages of faculty. She made a number of suggestions regarding fast track building up of ANM training capacity and nursing faculty development, through optimal utilization of

existing capacities and institutions, including through partnerships between state governments as well as through agencies which operationalise the 'establish, maintain and transfer' strategy.

Ms. Madhavi Das, DDHS (Nursing), West Bengal, presented their experience of training of second ANMs under the NRHM. West Bengal had an existing capacity of training 500 ANMs per year, even this poorly functional at the start of NRM and they needed to generate almost 10,000 more ANMs- or an estimated need of 3500 per year. To meet this demand the capacity of ANM training schools in the existing government sector was expanded through up-gradation of Infrastructure, additional equipments and deploying teachers and in addition new schools were set up in the govt. sector for ANM and GNM training bringing their total upto 18. In addition 23 training schools have also been also set up via the Public-Private Partnership route, wherein a private sector hospital with sufficient beds and patient load was supported to hire a faculty to conduct the course. The candidates for the course, were married women resident in the area whowere selected by each panchayat and sent for training on the condition that on completion they are hired by the panchayat to serve in the sub-center located there. A special feature of West Bengal has been the 'Nursing Service' as a distinct cadre. The highest position is State level ADHS (Nursing) with 3 Deputy ADHS. This seems to have paid dividends in terms of the initiative the state has been able to take in upscaling ANM and GNM training on large scale without compromising on quality.

Participating in the ensuing discussion many participants endorsed the nature of problems pointed out in the presentations. Shri Madanagopal, Secretary(Health),Karnataka voiced concern about the abysmal condition of private nursing colleges several of whom were attached to one hospital. Shri T.V. Anthony, Member, Population Stabilisation Fund raised the issue of a growing need for geriatric nursing at home, for which specific training programmes are required. Shri Sunil Nandraj, WHO country office, pointed out the need to think beyond the doctors and nurses to other personnel required for public health such as public health environmentalists, hospital administrators and public health managers.

In his key note address, the Secretary (H &FW) summed up the discussions of the two sessions and responded to some of the key issues that were raised in the morning session. With regard to human resource development, he welcomed the fact that states and centre had all come to recognize that this is the key constraint in health sector development. He stated that given the global shortage emigration is inevitable and need not be seen only as a problem. He pointed out that planning for producing health human resources should include those expected to go abroad after specialization. In some areas where the global shortage is high,e.g. among audiographers and psychiatrists, almost everyone leaves. In his view atleast 30% of those trained in many categories would emigrate and our generation of skills should take this into account. In the interim approaches like multi-skilling and nurse-practitioners, should be encouraged There should be a continuous production of ANMs, who would be able to perform various functions even when their cadre need is fulfilled. Developing bridge courses for upgrading ANMs to nurses through GNM education after some years of experience in the field would be useful. He shared the information that the INC regulations were being amended and made more flexible and relevant especially as regards land area and post-graduate faculty requirements for nursing colleges. Amendments to the MCI regulations had been framed on similar lines by the MOH&FW and were under consideration by the MCI. These flexibilities must be used by many states with major human resource deficits to expand nursing and medical education rapidly.

To overcome the skewed regional distribution of colleges, state should invest in setting up new medical and nursing colleges. Under the XIth plan, the GOI would support opening of specialist courses in strengthening the National Mental Health Programme commended setting up Centres of excellence and departments in government medical college departments.

Finally, he reiterated the importance of strengthening the public sector services. Presently, 80% of health care in India was being availed in the private sector. In contrast in countries like Brazil and Norway and in most countries doing well, it was mainly public sector provisioning and financing. Only in the USA, was universal access to health care largely reliant on the private sector and this was not seen to be working. The NRHM is committed to engage in the task of strengthening public health systems and, he hoped, that in the 3 days of the workshop, learnings from states would be shared to strengthen the work.

Session 3: Medical and Specialist Skills in the Public Health Workforce

Shri Debashish Panda, JS(DP) made a Presentation on “Medical Education – Proposed Amendments in MCI Regulations” which focused on acute shortage of medical professionals in the country and on regional imbalances in the growth of medical colleges among the States. Over 51% of the medical colleges are concentrated in 4 States, namely, Maharashtra, Karnataka, Andhra Pradesh and Tamil Nadu where as there is acute shortage of medical colleges in States like Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Chhattisgarh and the North Eastern States.

Whilst provisions of IMC Act, 1956 providing permission to establish a new medical college were quite stringent, Govt of India is engaged in multipronged strategy for increase/expansion of medical colleges. MCI Regulations are being amended to rationalize the existing norms like requirement of land and make it easier to start up medical colleges without losing quality. The ratio of teacher to the number of students to be admitted in any department is proposed to be relaxed from 1:1 to 1:2 in super-specialty and 1:3 in pre clinical and para clinical courses. Teaching experience gained by foreign post graduation degree holding Indian citizens in recognized foreign medical institutions shall be counted towards teaching experience for appointment as teachers as medical colleges. It has also been decided to allow recruitment up to 50 % non medical teachers in pre and para clinical departments to meet the shortage of medical teachers. Other significant steps include equivalence of DNB with MD/MS by deleting requirement of one year additional teaching/research experience for DNB qualification holder for appointment as medical teacher and increase in maximum age limit for appointment of teachers from 65 years to 70 years. All these measures would help fill up the faculty gap. On the issue of post-graduate medical education regulations decision has been taken to have 50% of PG Diploma seats reserved for in-service doctors who have served in rural areas for 3 years. One year rural posting shall be mandatory for admission to PG courses. (Except for pre-clinical and para-clinical). The government is also encouraging Public Private Partnership (PPP) in EAG states, and in North-east and hilly area states, and the corporate sector is being allowed to set up medical colleges. Other steps include central assistance of Rs. 1350 crores during XIth plan for starting /increasing PG courses.

Ms Aradhna Johri in her presentation elucidated upon multi-skilling as an intermediate human resource strategy. Analysing the causes of maternal mortality and infant mortality she outlined the need of improved access to comprehensive essential and emergency obstetric care services, for increasing the number of 24 hour institutional delivery facilities, and providing IMNCI and SBA skills to peripheral service providers. Dwelling on the required services vs. HR availability she said that there was shortage of about 3000 obstetricians and anesthetics & 2500 pediatricians and there is need to train about 63,000 more ANMs/SNs for SBA & CH, She further elaborated upon types of multiskilling and training for various strata of service providers. The success story of multiskilling for anesthesia and emergency obstetric care puts at rest all the misgivings and apprehensions about it. She expressed the need to tap all available capacity e.g. engagement of tertiary sector in a big way & accrediting private sector facilities in use as training sites

Dr. Vinod Shah, Dept of Distance Education ,CMC, Vellore gave a presentation on “Up scaling Post Graduate Diploma in Family Medicine”. He spoke about the concept of family medicine and the skills it provided for a doctor to be able to provide a comprehensive care at the PHC and CHC, thus reducing unnecessary upward referrals and being able to manage referrals from peripheral workers. He made his suggestion to train 150 graduate doctors per state per year (cumulatively 2400 in 5 years) with an intake every 6 months, and starting the program with UP followed by Assam, Jharkhand, Bihar, Chhattisgarh & Rajasthan.

Ms Vandana Prasad, PHRN in her presentation on “Building Of Capacities Towards NRHM Goals” outlined the present and future role of PHRN in improving the quality of district health planning, in providing access on essential information and opportunities to dedicated individuals and organizations leading to the emergence of pro-active state and district level resource groups involving both government and non government practitioners of public health. Support of NRHM, NHSRC,SHRC Chattisgarh, NE-RRC, ICCHN,CINI – Jharkhand &Others (NIHFW, SIHFWs, RRCs, PFI) in this endeavour was acknowledged. The programme had two modes. One mode, ongoing in Jharkhand, Orissa, Chhattisgarh and in the north east

in collaboration with NHSRC and the state government was a fast track capacity building programme where five to ten medical officers per district were trained as a group. Another was an open enrolment mode where anyone interested could participate for a payment of a course fee. There were over 100 districts currently being covered by the fast track mode and about 300 participants in the open enrolment mode. In both modes the programme provided for 18 days of contact classes and mentorship support over 18 months and was based on a structured course material. Soon the course would be linked to a diploma in district health management awarded by IGNOU, open to those who opt for it.

Visit details of the Tamil Nadu Institutions on 17th October, 2008

The second day of the programme was given to visits to health facilities and institutions in Puducherry and Tamilnadu. The participants were divided into three groups and they visited the following centers:

1. **Mother Teresa Post Graduate and Research Institute of Health Sciences, a govt. of Puducherry institution** – It is an autonomous institution functioning under the Chairpersonship of Chief Secretary of Puducherry and Secretary Health as a Vice-chairperson of the Governing Board of the institute. The Dean is the Executive Officer and the Member Secretary of the Governing Board. Dr. Baliga, present Dean and Principal gave presentation on structure and functioning of the institute. Institute has branches at Karaikal, Mahe and Yanam. There are 4 colleges under the institute for Physiotherapy, MLT, Pharmacy and Nursing. It is the only government institution to have post graduation course in physiotherapy. The diploma courses run by the Institute are DMLT, DCRA, DMPHW (M), DMPHW (F), M.Pharm, MPT, M.Sc. (N), B.Sc. (N), B.P.T. and Diploma in pharmacy. The institute had a clean and well maintained infrastructure and surroundings with well provisioned class rooms, computer rooms and laboratory facilities. It was informed by the Dean that the students passing out from the institute get on- the- campus placement immediately after the course is finished. He offered to train resource persons from other states in the institute so as to replicate the model in their state (with provision of fees by the states concerned).
2. **Indira Gandhi Government General Hospital and Post Graduate Institute, Puducherry** – It is a 750 bedded hospital with super specialty facilities available. The institute was briefly visited through a round to the private and general ward. It is clean and well maintained and this too by the regular staff and not outsourced, which was remarkable considering the number and level of patients. The OPD per day as told is 7000. The hospital however is required to put in place the process system as long queues for medicine disbursement was seen at the counters. There are no user fees.
3. **Villupuram district Mailam PHC**- It is a 30 bedded hospital with remarkably clean surrounding and well maintained infrastructure. It has a telemedicine facility having linkage with Narayana Hridayalaya, Bangalore.
The number of deliveries at this PHC have increased by 300% from 2006-07 to 2008-09. The PHC has been given facelift in its appearance from the Patient Welfare Society funds with arrangement of waiting hall for patients, installation of inverter and computer, TV and DVD etc. The staff's attitude was very friendly and motivating. For improving the quality of service delivery of PHCs doppler apparatus for monitoring foetal heart rate, calling bell at the ward bed side, scenery and well baby pictures at labour room and wards have been put up. Other amenities include allowing birth companion during delivery, provision of safe drinking water, free meals for the mother and the attendant, free chappals to the mother, free transportation while coming for the delivery, issuing free birth certificates at the PHC and JSY cheques at the time of discharge.
One interesting feature of the visit was the conduct of a bangle ceremony that brought attention to all pregnant women and improved quality of antenatal care.
4. **Drug Warehouse:** Another important visit was to the drug warehouse. This helped us understand the drug logistics and procurement system of Tamilnadu. The warehouse is spacious and all drugs neatly organized along expiry dates, the earliest stocks being kept in front. Each facility maintains a pass book on which it has a fixed value of drugs allotted and against which it could draw at will from the warehouse. This ensures that distribution is responsive to demand. When the stocks of any particular drug fall below what was consumed in a three month period of the preceeding year- the state gets the information and immediately the selected firm is asked to deliver the one years supply of drugs to the

district warehouse directly. The firm is selected on an annual rate contract. Every batch of drugs received is quality tested by two independent labs, which are also selected by tendering process.

5. In addition to the above four other groups visited other PHCs as well.

Session – 4: Discussion on Field Visits and Reflections on State experience:

On 18th morning, the sessions started early – at 8.30 am. States were requested to share their experiences on the visits undertaken to various institutions of Puducherry and Tamilnadu by the participants on the previous day and consideration of replication mechanism in their respective states of the initiatives found suitable.

Open discussions on experience sharing and learning from field visits by other states were held. The states which shared their experience and learning are Jharkhand, Bihar, Rajasthan, J&K, Nagaland, Manipur, Chhattisgarh, Andhra Pradesh. Shri. T.V. Antony, National Advisor on Commission on Population Stabilization also shared his experience. The states appreciated the measures taken and efforts put in by the Govt. of Tamilnadu in improving Public Health Care Delivery system under NRHM. The visits to various institutions in Puducherry and Tamilnadu were found to be good learning experiences. Specific issues complemented were the cleanliness, especially of toilets, the skilful use of local traditions in the form of the bangle ceremony, the lack of any user fees and the way that functionaries did not go along with the concept that user charges are needed for people to value services and finally the high degree of motivation, ownership and professional pride shown by the service providers including doctors working in these facilities and the many small but important patient amenities which made the government facility into a pleasant and positive experience for the patient and their families.

Session- V

Presentation on Task Force Report on Public Health: This was presented and discussed by a panel consisting of Shri Amarjeet Sinha, Dr T.Sundararaman, Dr K. Padmanaban and Dr Amarjeet Singh, commissioner health Gujarat.

Shri Amarjeet Sinha explained the context of the task force which had been set up under the Chairmanship of DGHS to bring a public health focus into the health system and to formulate standards and norms for state and district level public health management. A sub-task force to work on just the public health act had also been set up under this task force. The reports being presented were the draft outputs of these task forces. The diversities across the country had prompted states to have their own models for managing human resource. He explained that these workshops were the platforms for sharing those unique models, analyzing them, learning from them and adopting them suitably for other states. The human resource issues widely include making available well skilled resident human resource where needed most, expand the network of pre-service and in service training institutions, continuous skill development of the workers and planning as per state specificities / shortages / institutions. The synergizing actions for the same include getting the directorates of health involved in delivering quality services, integrating non-medical professionals within health systems, securing professional space for technical interventions and pushing governance reforms. The health act is necessary to develop IPHS, hold institutions accountable to communities, to pursue health as a patient rights, to secure better regulation in seeking partnership with NGOs and to promote ethical and efficient health care with rationale drug use.

Some of the broad principles emerging from the Task Force report for consideration of the states are the basic need of health systems to have specific skills for specific tasks, which in turn requires defined selection criteria with defined career profile. It needs non-medical professional skills along with public health professional skills. Governance reforms are required for transparency, accountability and professional development. Staffing arrangements even at leadership levels should reflect state specific priorities such as malnutrition, malaria etc. Upgrading and downgrading of posts could be done as per need- but ensuring that the right skills are available for each task at hand. The Task Force has illustrated the management structures at block, district and state level. States were requested to study the draft report and to offer their suggestions if any. They have been requested to consider the implementation of management structures in their states as per their needs with assistance from these guidelines.

Dr. T. Sundararaman, Executive Director, NHSRC presented the reasons for the emergence of many para-statal organizations and the problems encountered in creating and synergizing various para-statal organizations such as state institutes of health and family welfare (SIHFWs), the State Programme Management unit, the State Health systems resource center, the State Aids Control Society, the medical service corporations like TNMSC and health system development technical agencies as also private bodies like EMRI. It has been observed that states which don't have the corresponding para-statal organizations fail to deliver concerned functions effectively. On the other hand existing organizations don't necessarily contribute optimally. Relationship of each body with the directorate is also an issue to be resolved. Finding suitable staff is also a challenge, though NHSRC is able to help substantially in this. It was suggested to map the functions of each para-statal body and correlate with structure, map institutional boundaries and map the skill sets and leadership skills and work cultures that go together. An important pre-requisite is to keep the directorates involved as these institutions strengthen the directorate and make them more effective. The synergy among them all would improve public health management.

Dr. Padmanaban, Advisor, PHA said that a good legal system is needed to support directorate in their functioning. Career advancements for nursing and ANMs is must and diseases control programmes need to be strengthened. Shri Amarjeet Singh, Commissioner and Secretary Health, Gujarat, stressed upon getting medical professionals and teachers in Medical Colleges on the centre stage and provide space and respect to them to motivate them. He insisted on clear definition and road chart for the health delivery goals. He said that disconnect between the health department and directorate in the state needs to be removed. He insisted upon posting skilled manpower in the health structure. He gave an example of his state Gujarat wherein they have sent to-be CMOs, DHOs to Achuta Menon Institute of Health Studies, Trivandrum for training. Trained doctors would only be given promotion as DHOs. One of the common problems observed in the states is that tendency of undermining the SIHFW by putting the worst professional as the head. Promotion he thought is the most important HRD issue needs to be rationalized. He said states needed strengthening in logistics, procurement, HMIS and the management of Public Private Partnerships. He also said that engagement with political leadership was necessary for strengthening health care delivery systems under NRHM. Inter-sectoral convergence is also an area to be looked in to by the states.

Responses to this presentation came from a number of states. The most detailed submission was a written note from Rajasthan presented by Shri Srinivsan, MD, Rajasthan. The Director, health services of the state should co-chair the Mission, and a transparent process of financing should be put in place over the XIth and XIIth five year plans. Areas like village health planning and convergence need to be operationalised. A separate organizational structure to deal with buildings may be useful. Drug controller's office needs to be strengthened. Joint Director and Director of Health Services should be appointed as a selection post rather than as a promotion post so that younger people with interest and experience come in at that level. At least 3 years of experience as in-charge at the block level should be mandatory to apply. Setting up of an SHSRC has been attempted in Rajasthan but no suitable person found as yet to head the institution and so no progress on it. The ASHA Resource Centre has taken off the ground, but needs more inputs. The SIHFW as a number of regional centres each serving a cluster of districts, rather than just one in the state could be tried. A hospital administrator should be appointed for CHCs and hospitals with over 100 beds. It does not seem possible to ban private practice. Self assessment forms should be filled by all doctors to help improve performance in the public system. The SPMU in Rajasthan are vibrant and coherent. Younger people assisting the directorates may be useful as well. The DPMU could become a planning-cum-training centre, with consultants for child health, maternal health, nursing cadres, etc. as regular appointments. The management, accounts and data persons could be contractual. No separate district training centre would then be needed separately.

Shri Rajesh Kumar, Consultant, Finance Monitoring Group suggested that the mechanism for integration of the Mission Director into the health services structure had to be worked out. He also requested to resolve the question of working out the modality of taking contractual staff to fulfill the need for skill sets that are required at specific points of time and not on a regular basis, even when the mission is over.

Shri Vishwas Mehta, Secretary(H&FW), Kerala gave his views on several of the issues raised. He thought it would be impossible to get rid of the contractual staff, especially in a state like Kerala, except for those on

deputation. Programme managers in Kerala are therefore largely doctors from within the services. Block coordinators are the Health Inspectors. He also wanted to know about continuance of technical team members who are on contract from outside after 2012. A number of other members spoke appreciating the report and calling for further discussions and persistence to achieve the reforms needed.

Summing up the discussion in this session, Shri Amarjeet Sinha, explained that contractual appointments were never seen as a final solution or permanent arrangement. It was envisaged in the NRHM to bring in new skills and to some extent to reduce the non-accountable personnel structure that had got well entrenched. At the peripheral level it could promote residence at the headquarters, replacing 'employment guarantee' with a system for 'service guarantee'. There should be accountability to the local community and to the PRI. Shri Sinha reiterated that this was part of the formal consultation with states on this issue and requested all states to send in their comments in writing so that they could be inputs for the task force to finalise its report.

After this session there was a guest address by Dr K. Srinath Reddy, President, PHFI. He made a presentation with two parts—one presenting the work of the PHFI and the second, on inputs necessary for giving a thrust to public health in India. He explained that the objective of PHFI was to strengthen institutional capacity by achieving critical mass of qualified public health professionals, improved quality and delivery through training of public health functionaries, and program and policy relevant research. Its mandate is to establish a network of 8 schools of public health, assisting growth of existing institutions, establishing a strong national research network, enabling policy development and providing a vigorous national advocacy platform, and facilitating creation of an independent accreditation body. Considerable progress has been made in setting up of the IIPHs, with one IIPH to be operational in Delhi from November 2008. Courses have already started from Hyderabad and Gandhinagar in August 2008. Discussions are on with state governments for setting up of other IIPHs--Meghalaya, Orissa, West Bengal, Punjab, Uttar Pradesh and Tamil Nadu. Educational programmes planned or already getting off the ground include long-term programmes in MPH (2 year), DPH/PH Management (1 year), B.Sc. (3 year after school). All programmes are open to medical, nursing and non-medical streams. It was envisaged that each institution would produce 200 public health specialists per year. group.

He further suggested that the State governments could provide an impetus to public health through orienting the health system to public health and not merely disease management, positioning public health expertise appropriately in the health services, supporting health promotion & disease prevention, integrating programs and services and promoting equity as a guiding principle.

Session VI: Draft National Health Bill

Ms. Shrutika Pandey, Sr. Consultant, Legal Framework, NHSRC gave a presentation on the "National Health Act". She took the audience through the historical background of public health legislations in India dating back to GOI's public health ordinance of 1944 to the current draft. She said that public health under the Bill covers cross- sectoral areas like water, sanitation, food and housing.

The health act is expected to play a protective, prescriptive and instrumental roles respectively in line with similar practices prevalent in South Africa, Canada, U.K., Argentina, and Australia. It has to be responsive to people's common experiences and issues with health services and systems. In light of the above the scope of the proposed health law is envisaged such that it addresses bio-medical as well as underlying determinants of health like safe drinking water, adequate and safe food, healthy and safe housing, sanitation, safe and healthy environment- especially pollution levels, working and living conditions, industrial hygiene, promotion of well-being and healthy life styles, special provisions for vulnerable & marginalized sections- positive discrimination, provisions for public health emergencies, disaster management, conflict situations.

Normative framework for healthcare services like accessibility, availability, acceptability and quality must always be considered in all dimensions. She further elaborated on the key principles underlying a rights based perspective- participation, accountability, non-discrimination, transparency, human dignity, empowerment, rule of law, obligation of government to collective and individual rights and rights specifically related to healthcare would be the broad content of draft health act. Implementation mechanisms for such a law had

also been proposed. She also dwelt on redressal mechanism for health rights and another provisions like penalties, immunities, bye-laws and a financial memorandum that sets out the costs of implementing the rights given by such a law.

Dr.Amarjeet Singh, Commissioner and Secretary (Health), Gujarat suggested incorporating a clause to make Gram Panchayats directly responsible for deaths of the women in pregnancy. He was concerned at the lack of sense of responsibility amongst various functionaries which support human lives. Dr.Shrivastava, Director, Health, Madhya Pradesh, informed that the state has a compendium of all health acts operational in the state. Shri.Amarjeet Sinha, JS (AS) remarked that legal framework puts pressure on the health system to accelerate people oriented healthcare delivery. He also requested all the states to respond within three weeks with their suggestions in writing, so that the task force could finalise its report and submit it.

Session VII: Presentation of Group work and Concluding Remarks

First Groups presentation on “Building Capacity on Nursing and Para-medical Skills” made the following recommendations

1. Setting up single advisory authority i.e. establishing a separate division/directorate for nursing to ensure more focus on nursing related issues. It also emphasized in-service training in the newly emerging areas such as psychiatry, new born care and trauma care etc.
2. The group felt the need for multi-skilling of ANM's for better performance and bridge courses for ANMs to become nurses for which development of infrastructure and faculty development is the minimum requirement. One district training centre and a nodal training centre in every state will help the process of enhancing skills.
3. The need for strengthening nursing council and formation of central/state paramedical council's to streamline nomenclature, minimum standards, curriculum, duration and evaluation parameters will do immense good to the cause. Strengthening of state para-medical council will not only regulate unrecognized institution but will also ensure a reasonable and rational career progression for paramedicals.

The second group presentation was on “Building Capacity amongst PHC/CHC Doctors”. The group laid emphasis on definition of training and capacity building and it was of the opinion that capacity building needed an enabling environment for development. While there is no denying that clinical knowledge is important for healthcare services, managerial skills compliment it. Managerial skills in the areas like financial management, hospital management and environmental management etc can be acquired through distant education program also. Both the diploma in family medicine courses for improving clinical skills and the PHRN and PHFI diploma courses in district health management and public health management need to be accelerated so as to build appropriate skills in the PHC and CHC.

The third group presentation was on “Expanding Nursing/Paramedic and Medical Education” which emphasized mainly on shortage of human resources, training programs, trainers and training institutions. The group showed concern at the quality of most of the trainings which was sub-standard. There was a suggestion by the group to have a nursing college in all medical colleges.

The fourth group presented on “Developing a Public Health Thrust in the Health Services”

Orientation of health personnel

- a) ASHA and ANM training—must give a public health perspective and not only patient care.
- b) Medical education, AYUSH doctor's education, nursing education—all graduate courses must orient the students towards a PH perspective.
- c) All new recruits in public service should be given induction training.

Administrative and managerial inputs for the health services

- a) The PMU should be under the technical head at each level.
- d) A separate public health cadre will be useful. But it must remain an integral part of the health services. Most states do not have the possibility of a separate cadre as in TN, since the number of personnel that can be spared from clinical work is limited.
- e) When doctors in public service are posted/ promoted to the post of BMO, CMO etc., they should participate in a mandatory 1-3 week orientation programme and also encouraged to complete a formal qualification within three years.

Public health analysis at facility and district levels

- a) Public health data collation and analysis must be done at each level. Capacities need to be developed for this.
- b) A public health specialist must assist the MO in charge at CHC and district levels. Such a post needs to be immediately created in all district levels and later in all CHC levels also.

Public health measure within facilities

The responsibility sheet of the doctors in health service facilities must mention public health measures within the premises, such as cleanliness, drainage of waste water, safe disposal of human wastes, as a planning/supervisory/monitoring role.

Inter-sectoral coordination for prevention and promotion

- a) Planning processes must generate convergent planning, between the departments of water, environmental sanitation, woman and child,
- b) Guidelines outlining the role of PRI, education committee at village level and above,
- c) Role of the non-govt. sector has to be ensured.

Concluding Remarks:

In the concluding remarks, Shri G.C. Chaturvedi, MD(NRHM) recounted the sequence of events of discussions held during the workshop and observed that the services can be rendered better if Asha's capabilities are fully utilized. He stressed on having a functional Rogi Kalyan Samiti which is capable of proposing and implementing many people friendly ideas as was done in Tamil Nadu. Untied funds can make a huge difference if used properly. He called upon states to look at the prospect of accreditation of the hospitals for the quality of its services which has huge potential. He observed that human resource management was a sensitive subject and differences should not be swept under the carpet. Rather they should be resolved by discussion and persistence. He hoped that drawing on learnings from this workshop the states would accelerate their progress towards achieving sufficiency in both numbers and performance of their health human resource. He thanked the organizers for a well organized conference.

Proposing the vote of thanks, Shri Amarjeet Sinha, JS (AS) expressed his happiness at the over whelming responsive workshop. He thanked all of those who contributed in making it successful, especially the organizing team from the ministry and the NHSRC. He also thanked WHO and DFID who had been sponsors to the workshop and the government of Pondicherry who had helped in hosting the conference.