Management capacity assessment for national health programs

A study of RCH program in India

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Abstract

Purpose – This paper aims to focus on the management capacity assessment of the Reproductive and Child Health (RCH) program at the state level.

Design/methodology/approach – Based on an extensive literature survey, and discussions with senior officers in charge of RCH program at the central and state level, the authors have developed a conceptual framework for management capacity assessment. Central to their framework are a few determinants of management capacity, a set of indicators to estimate these determinants, and a management capacity assessment tool to be administered by each state. A pilot survey of the management tool in a few states helped the authors to refine each instrument and finalize the same. A suitable management structure is suggested for effective management of the RCH program based on the population in each state.

Findings – The assessment brought out the need to strengthen the planning and monitoring of RCH activities, HR management practices, and inter-departmental coordination.

Practical implications – The Ministry of Health and Family Welfare, Government of India has accepted the management tool and asked each state to administer it. The recommended management structure is used as a guideline by each state to identify the capacity gaps and take necessary steps to augment its management capacity.

Originality/value – The authors' framework to assess the management capacity of RCH program is very comprehensive, the management tool is easy to administer, and assessment of capacity gaps can be made quickly.

Keywords Health services, Management effectiveness, Maternity care, Children (age groups), Project planning, India

Paper type Conceptual paper

1. Rationale for the study

Over the last 50 years, the Government of India has built a massive primary healthcare infrastructure, consisting of more than 450 district hospitals, 3,000 community health centres/rural hospitals, 22,000 primary health centres, and 130,000 sub-health centres.

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

RCH has many components: Family Planning, Maternal Health, Child Health, Adolescent Health, RTI/STI, Urban Health and so on. However, institutional capacity

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

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

2. Objectives of the study

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

3. Our methodology

3.1 A literature review

The notion of capacity assessment and capacity development has historically been blurry and unclearly defined. It is difficult to appropriately assess something when what is being measured is unknown. The literature presents a variety of different viewpoints regarding this lack of clarity and elucidates different ways to refine the theory behind capacity development and its assessment.

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

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

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

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

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

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

3.2 Developing a framework

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

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

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

RCH Activities can be broadly classified as follows:

(1) *Main activities*:
- maternal health;
- child health; and
- family planning.

(2) *Newer activities*:
- prevention, management of STI/RTI;
- safe abortion;
- adolescent and sexual health;
- gender, PNDT, etc;

- midwifery and nursing;
- urban health; and
- nutrition.

(3) *Support activities*[1]:

- demography and vital statistics;
- IEC;
- HR;
- medical devises, drugs & logistics;
- transport and communication; and
- repairs and maintenance.

4. A conceptual framework to assess management capacity

4.1 Dimensions of management capacity

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

A: RCH policy, goals, objectives and strategic plans: Does the Department of H&FW have a clear statement of the RCH policy, goals, and a strategic plan to achieve the objectives? This would assess the institutional understanding of the challenges in managing the RCH program. Some of the indicators to assess the state's preparedness to achieve policy objectives are:

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

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

- Does the department of H & FW have an organizational chart? If yes, is it the same as in the State Budget Document? Does it meet the department's needs? Is it as per the requirements of NRHM[2]? Does it need any revision, strengthening? How many managers[3] are on full time regular appointments? Versus part time managers holding additional charges, consultants etc.
- What are the arrangements for hiring consultants?
- What is the technical and office support for RCH?

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

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

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

- Who are the external stakeholders (International and National)? Donor partners, NGOs, professional bodies such as Federation of Obstetrics and Gynecological Society of India (FOGSI), medical colleges,
- What is the nature and support from external stakeholders? Management support, financial support, etc. Do they complement the state capacity?
- What are sectors in which these external stakeholders are involved? Health, water, nutrition etc. (NRHM context).

E: Management systems: How well do the existing management systems for planning, implementation, and monitoring facilitate delivery of RCH services? Some of the indicators are:

- Does the department have a well-developed planning document? Planning for: Human resources; Financial resources; Materials (medicines and drugs); Medical and biomedical devises; Repairs and maintenance for equipment; Repairs and maintenance of health facilities.
- Does the department have a well-developed implementation schedule for its planned activities?
- Does the department have a MIS (live monitoring) versus evaluation (post-mortem).

F: Structure of health delivery systems. This is to assess the managerial workload for various services at each level and availability? Some of the indicators are:

- number of government facilities (primary, secondary, tertiary services);
- number of private facilities (primary, secondary, tertiary services);
- number of NGO, Trust managed facilities (primary, secondary, tertiary services);
- number of medical, para-medical and administrative staff at each level; and
- what are the arrangements for public-private partnerships?

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

- Does the department produce an Annual statistical report with performance analysis and identification of critical areas?
- Does the department produce an annual achievement report; Planned vs Achieved?
- Does the department produce an annual audited statement of utilization of all resources? (funds, HR, medicines and medical equipment).
- Our framework for capacity assessment, determinants and their indicators is summarized in Figure 1.

5. A tool for assessment of management capacity for RCH program

Based on the conceptual framework described above, we have developed a tool to assess the effective management capacity for RCH program at the state level. This framework and the tool design have been discussed at length with several states, pilot tested in a few states, and the Government of India has asked all states to administer the tool to assess their management capacity for RCH II program.

The following steps are to be followed in administering this tool.

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

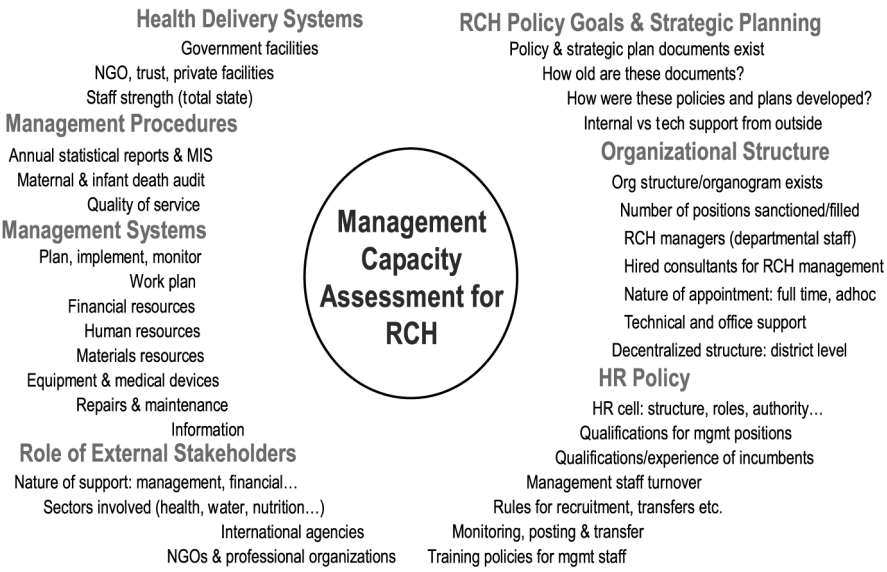

Figure 1.
Management capacity assessment: a conceptual framework

consultant, since consultants do not have a complete and accurate knowledge of the health system of any state.

This tool is to be administered in parts to ALL the senior administrators/managers in charge of the RCH program planning, implementation, and monitoring. Please note that this is only a tool or guideline and not a structured questionnaire. Hence, it may require certain modifications as per the needs of each state. Eliciting responses from each administrator/manager will require different skills of the nodal officer, as it is likely to involve interviews, group meetings, references to various reports etc.

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

This tool consists of the following sections, as per the framework discussed in the last section:

A: RCH policy, goals and strategic plans.

B: Organizational structure.

C: Human resources management.

D: Role of stakeholders (outside the department).

E: Management systems.

F: Health delivery systems.

G: Management processes.

5.1 An illustrative tool

As an illustration, "Staff Turnover" is an indicator of HR Management capacity (Table I). The purpose to assess staff turnover is to understand the length of tenure of managers at each level, since managers get frequently transferred within RCH departments (such as Maternal Health, Child Health, FP etc) as well as between H&FW departments (FW, Medical Services, Malaria Program etc). Short tenure of top managers (less than two years on an average) will constrain the management capacity (If any managerial position has been held by a number of officers for short period of time, it will be very difficult to manage such positions effectively). Also prior exposure to RCH management will enhance the quality of officers and their capacity for effective management of RCH program.

Designation of RCH Manager	Name	Date of taking charge	Immediate past position held and number of months in that position	Scheduled date of Retirement	Number of officers in this position for the last three years
Secretary					

Table I.
Tool for assessment of staff turnover

- *Step 3: Start and completion dates:* State the name and designation, address etc. of the nodal officer administering this tool in the state, and the dates when it was started and completed.
- *Step 4: Augmenting management capacity:* Based on the self-assessment of management capacity, each state should identify the gaps for effective management of the RCH program. Our recommendations on management capacity summarized at the end of this section may be used as a norm for effective management of RCH program.
- *Step 5: Frequency of administering the tool:* Based on the analysis of capacity assessment, the governments (both the Central and State Governments) need to develop action plans to enhance the capacity (fill gaps) to manage the program effectively in all states. This plan needs to be followed up with frequent monitoring of the progress made in augmenting the state management capacity. We recommend administering this tool every once in two years based on the progress made in managing the RCH program.

6. Preliminary assessment of management capacity: an illustration

Our observations on the Management Capacity for RCH program in a well-performing state is summarized in Table II.

7. Recommendations: management capacity for effective management of RCH program

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

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

The H&FW department in each state also needs a separate division to focus on Urban health and Tribal health. Urban health is a growing concern due to increasing urban population, while tribal health needs special attention. Other areas which needs to be focused more sharply include:

- early marriages;
- anemia and malnutrition; and
- STI management.

The structure in Figure 2 is for a state with a population of approximately 50 million. We recommend a similar structure for Child Health, Family Planning, Adolescent Health etc.

Capacity indicator	Strengths	Weaknesses
Policy and strategic planning	State PIP (Program Implementation Plan) gives RCH policy goals and strategic plans	Does not seem to conduct regular policy and planning reviews
Organizational structure	Already set up three cells in RCH division: Maternal care Child care Family planning	Too few managers for a large workload (50 M population, 1.2 million child births) Weak IEC Nursing, Midwifery neglected Frequent structure changes No set up for IEC, Anemia, STI mgmt, adolescent health, urban health
HR	Excellent officers available within the H & FW department	Many officers on additional charge or Many on ad-hoc appointments Many full time consultants Short tenure No career planning No document on postings, recruitments, transfer, promotion Weak HR cell
Dependence on external stakeholders	Good linkages State NGO coordinator	Not enough capacity for data analysis, planning, and therefore limited capacity to articulate the state needs to consultants
Management systems for planning, implementation, and monitoring	State PIP has a strategic plan Annual targets also mentioned	No planning for resource allocation to achieve the targets Poor implementation Poorer monitoring Reliance on evaluation
Health delivery systems	Large number of govt. facilities Presence of private providers	Poor service delivery No data on private sector PPP not properly exploited
Management processes	Certain officers are dynamic and so quick processing of files	Highly centralized Delay in decision making No annual reports

Table II.
Summary of our preliminary assessment: RCH program management

8. Conclusions

Our preliminary assessment of management capacity in the well performing state emphasizes the need to strengthen the state's management capacity for public health programs to succeed. It is obvious that other states too would need to augment their management capacity considerably.

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

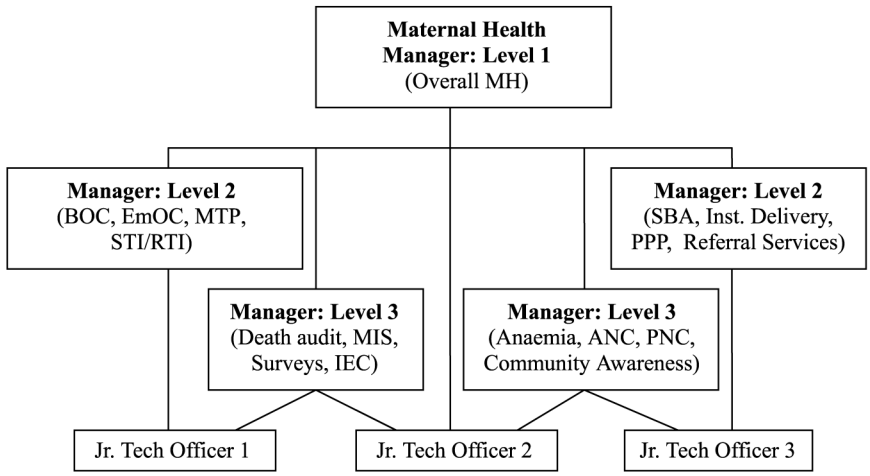

Figure 2.
Recommended structure for maternal health

Notes

1. These are for the dept of H & FW as a whole, not exclusively for RCH division only.
2. NRHM: National Rural Health Mission emphasizes a decentralized structure, and promotes inter-sectoral coordination.
3. For example, Managers in the Gujarat dept of H & FW include officers from the level of Assistant Directors and upwards. Since each state has different designations for its officers (Directors, Director Generals, commissioners etc), we will use a general term "Managers".

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