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Technical Assistance for Assessment and Mapping of Human Resources in Health in Jharkhand

Final Report

February 2012

Submitted by:

Public Health Foundation of India (PHFI)

Supported by:

MCH-STAR Initiative, USAID

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Contents

Acronyms

ANM	Auxiliary Nurse Midwife
CHC	Community Health Centre
CINI	Child in Need Institute
DiC	Director In Chief
DHFW	Department of Health and Family Welfare
ED	Executive Director
FRU	First Referral Unit
GoI	Government of India
GoJ	Government of Jharkhand
HR	Human Resources
HRH	Human Resources for Health
IIPH	Indian Institute of Public Health
IPH	Institute of Public Health
IPHS	Indian Public Health Standards
MCH-STAR	Maternal Child Health-Sustainable Technical Assistance and Research
MD	Mission Director
MHFW	Ministry of Health and Family Welfare
MO	Medical Officer
MoU	Memorandum of Understanding
MNCHN	Maternal, Neonatal and Child Health and Nutrition
NHSRC	National Health system Resource Centre
NSSO	National Sample Survey Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PI	Principal Investigator
PNA	Performance Needs Assessment
SHSRC	State Health System Resource Centre
SoW	Scope of Work
SPM	State Program Manager

TA	Technical Assistance
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WHR	World Health Report

Acknowledgement

We would like to acknowledge the support received from the Health Department, Government of Jharkhand (GoJ) in undertaking this activity. The project team at Public Health Foundation of India (PHFI) was able to undertake and accomplish this activity with the inputs and guidance received from the officials of the Health Department and the National Rural Health Mission (NRHM), both within Jharkhand and at the national level who guided this work. Their active participation helped ensure that this research and the recommendations reflect the context of human resources for health (HRH) issues and practices in Jharkhand, in spite of challenges in undertaking an activity of this magnitude.

We are also grateful to the MCH-STAR and USAID for supporting this activity. Their critical inputs along the way helped us focus our attention on key HRH issues.

We are also highly indebted to Child in Need Institute (CINI) and their team in assisting with the primary data collection across the state.

PHFI is grateful appreciation goes to our project manager at Ranchi, Dr Syed Iqbal Hussain and our Research Associate, Ms. Iti Kaushik who were constantly engaged in assisting the activities at every stage. They were the backbone of all the activities we undertook in this project.

We are also grateful to all the non-technical staff of the Health Department at Namkum and in the five districts (Dhanbad, Dumka, Palamu, Ranchi and West Singhbhum) for sharing their time and assisting this activity.

Key Messages

There is a huge gap in the demand, supply and availability of HRH in Jharkhand. Moreover, there is an unequal distribution of resources across various districts in the state. The state needs to take immediate actions to tackle the situation and develop a balance between the required and available numbers of HRH. If the state does not take immediate action, the situation will only grow more dire as the population demanding these services increases. If the state of Jharkhand plans to provide health services according to the IPHS infrastructure norms, the state will, by 2020, need to increase the number of medical officers and ANMs by three times the current numbers to account for the increase in population.

The key messages that have emerged from our project findings that aid the DHFW, Jharkhand to immediately address their current HRH crisis are as follows:

Key Message #1: Recruitment should be a state-wide, proactive and continuous process that is built on far greater communication and coordination with the medical and nursing colleges in Jharkhand and other states.

Key Message #2: Compensation should include a bundle of financial and non financial incentives appropriate for the post.

Key Message #3: Strengthen HRH documentation policies and processes.

Key message#4: Create a dedicated unit with the sole responsibility and authority to enable the smooth functioning of HRH.

Key Message #5: Professional growth opportunities are important for encouraging HRH to stay in public health service longer

Executive Summary

Human resources are the central component of all health systems and consume a major share of their allocated resources. As they contribute to the performance of all main functions of health systems, efforts to improve the effectiveness of the health workforce are central to improving the overall health system performance.

Today, in the state of Jharkhand only 26% of those needed for direct health service delivery as outlined by the Indian Public Health Standards are currently in position either as regular employees or as NRHM contractual employees.

At the GoJ's request, PHFI offered technical assistance for developing a sustainable, evidence-based interim HR policy to help the state of Jharkhand meet its short and long term HRH goals. The objectives of this project were:

1. To assess the availability, distribution and competence of HRH within the DHFW of GoJ,
2. To identify and study factors affecting performance of HRH using the World Health Organization's (WHO) workforce life cycle strategy

PHFI adopted a combination of secondary data review and primary data collection to address the objectives of this project. This included: conducting a literature review of HRH practices; a mapping exercise using state HRIS/HMIS information; staff key informant interviews; and undertaking a survey of approximately 300 health department staff across five districts of the state.

The key findings from primary and secondary data offer a variety of recommendations that will aid the government of Jharkhand to strengthen its ability recruit and retain personnel.

Key Message #1: Recruitment should be a state-wide, proactive and continuous process built on greater communication and coordination with the medical and nursing colleges in Jharkhand and other states.

Recommendations: Walk-in interviews should be practiced

The selection committee should visit Jharkhand Medical and Nursing Colleges and other states regularly to promote public health service and interview students about to graduate

There should be greater transparency in the process for filling vacancies and preference should be given to the interested HRH domiciled in that district

Recommendation: The recruiting process should reflect the state's needs in notified high- focused facilities and match it with candidate preferences

Key Message #2: Compensation should include a bundle of financial and non financial incentives appropriate for the post

Recommendation: Financial incentives across all cadres must be competitive

Recommendation: Compensation for HRH should include housing

Recommendation: Establish financial and non-financial incentives for all cadres reporting to remote, difficult or LWE-affected areas.

Key Message #3: Strengthen HRH policies and processes

Recommendation: Institutionalize a clear policy and process for contractual HRH to apply for vacancies in sanctioned posts after a defined tenure

Recommendation: There should be clear and standard policies detailing the processes for career progression during the service tenure for regular staff.

Key message#4 Create a dedicated unit with the sole responsibility and authority to enable the smooth functioning of HRH.

Recommendation: Create a dedicated human resource for health management cell for the state of Jharkhand

Key Message #5: Professional growth opportunities are important for encouraging HRH to stay in public health service longer

Recommendation: Regular opportunities to upgrade skills and training in new practices and technologies should be part of retention policies for all cadres

Background

Human resources are the central component of all health systems and consume a major share of their allocated resources. As they contribute to the performance of all main functions of health systems, efforts to improve the effectiveness of the health workforce are central to improving the overall health system performance.

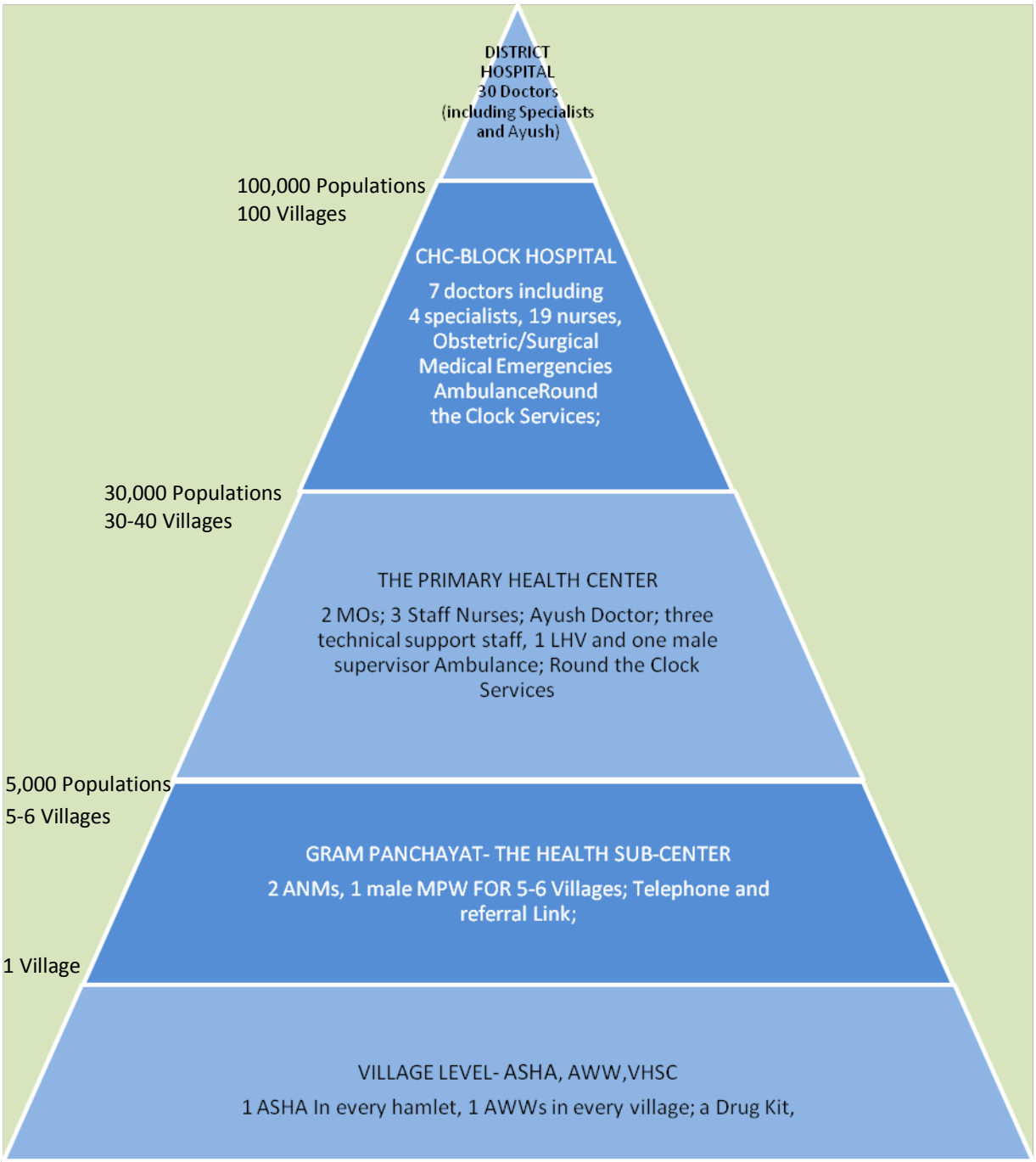
Shortages of HRH remain a universal problem in developing countries and the problem is particularly acute in India and several of its states, including Jharkhand. The Lancet Series on India has highlighted issues surrounding HRH in the country. In cross-country comparisons, the total number of allopathic doctors, nurses, and midwifes in India (11.9 per 10000 people) is about half the WHO benchmark of 25.4 workers per 10000 population (Rao, Bhatnagar and Burman, 2009). The burdens of ill health are inequitably distributed across geographical, social, gender, income, and educational strata, with substantial differences in health indicators between and within the different states in India (Reddy et al. 2011). HRH is severely deficient, particularly in rural areas. Shortfalls in training, inequities in distribution, and migration of staff to other countries have worsened these deficiencies (Rao et al. 2011). The issue of filing up the immense gap of health workers in the public health system and rectifying the uneven distribution of HRH has received the priority attention of NRHM at the central and state levels.

Jharkhand, located in eastern India, was carved out as a separate state from Bihar under the Bihar Reorganization Act in November 2000. As a result it inherited many of Bihar's administrative legacies including those related to HRH. Over the past decade Jharkhand has seen a steady improvement in development, as measured by the Human Development Index(HDI), where it went from being ranked 23rd in 2000 to being ranked 19th in 2007-2008 of all Indian states measured("India Human Development Report", 2011). Despite these improvements, Jharkhand's most recent HDI of 0.575 still remains below the India average 0.605("HDI and GDI Estimates for India and the States/UTs: Results and Analysis[i]", 2012).

Jharkhand's public health system faces a variety of human resource challenges, primarily associated with an overall lack of health professionals in key areas. Figure 1 broadly describes the distribution of cadres across the varying tiers of health facilities. Three cadres, Nurses (ANMs and staff nurses), MOs and Specialists have direct role in delivery of MNCHN services while others have supporting roles.

Health facilities are severely understaffed, especially in low income districts below the district level of the health system. This is a major hurdle in any efforts to scale up the health systems' reach to remote and marginalized regions. The severity of the problem is effectively demonstrated by the gap between population need as presented by IPHS norms and the infrastructure realities as shown in Table 1. Existing health facilities across all the levels of health care systems in the state clearly need additional manpower.

Figure 1: Tiers of health care facilities in India and the IPHS standards



Adapted from: IPHS Revised Guidelines, 2012. Ministry of Health and Family Welfare[ii]

Table1: Gap between IPHS norms and reality in Jharkhand

	IPHS Norms		Actual (Jharkhand average)
	Plain Areas	Remote and difficult areas	
Population size served by subcenter	5000	3000	5000 – 7000
Population size served by PHC	30,000	20,000	60,000

Source: Indian Public Health Standards (IPHS) for Primary Health Centres, 2012. MOHFW

Since its inception, the state has sought to improve its HRH situation by developing HRH policies and procedures relevant to the state's particular context and needs. However, fundamental policy frameworks and a comprehensive guidance on HRH are yet to be established. Currently, a Bihar service rule book is used in conjunction with adhoc government orders. Jharkhand's Program Implementation Plan (PIP) for 2011-12 indicates that although the state is planning some initiatives on HRH management issues, these are regarding implementing short-term options, rather than developing a long-term policy for managing the HRH situation in the state. NRHM has provided a window of opportunity for the state by allowing contractual hiring of providers at various levels, including the program managers, but the overall situation of the Department of Health and Family Welfare (DHFW) cadres[1] needs attention.

Although, the task of developing interim HRH strategies has been entrusted to the newly established State Health System Resource Centre (SHSRC), this institution is not yet fully established.

At the GoJ's request, PHFI offered technical assistance for developing a sustainable, evidence-based interim HR policy to help the state of Jharkhand meet its short and long term HRH goals. The objectives of this project were:

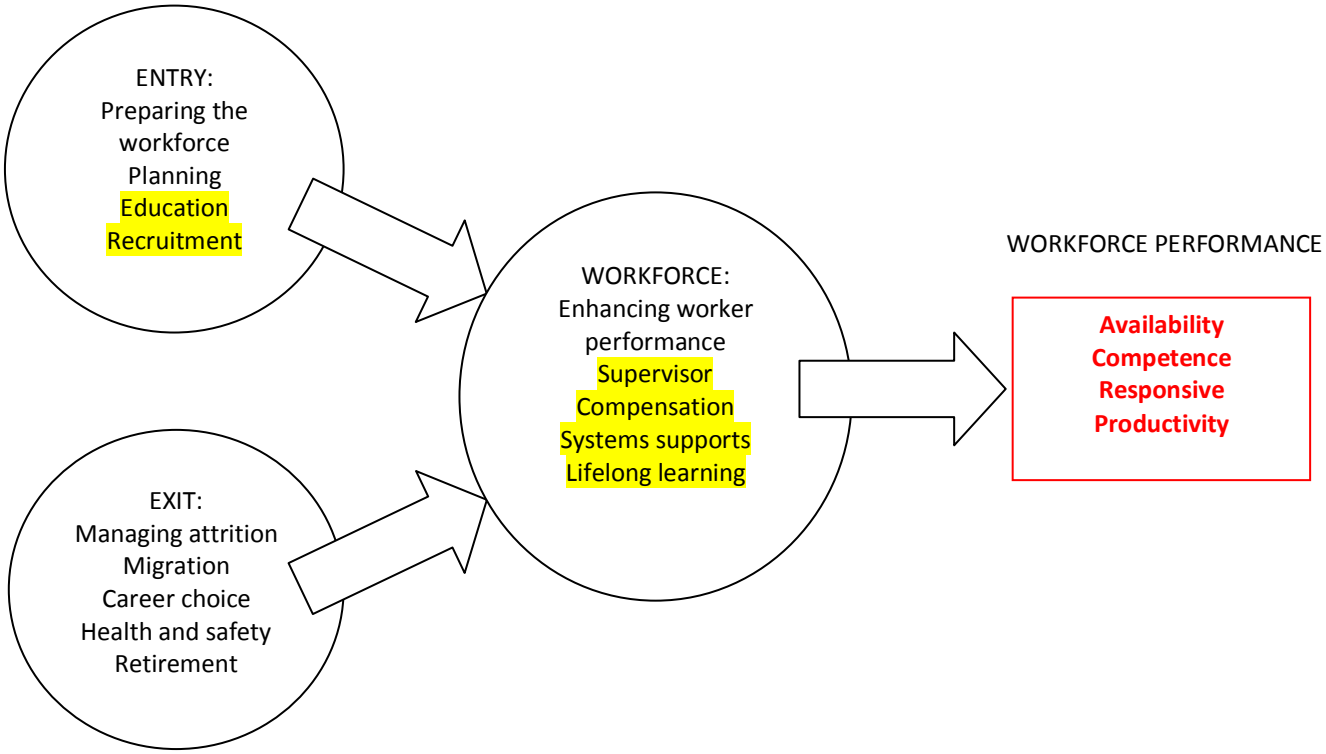
1. To assess the availability, distribution and competence of HRH within the DHFW of GoJ,
2. To identify and study factors affecting performance of HRH using the World Health Organization's (WHO) workforce life cycle strategy.

The comprehensive and widely accepted WHO workforce life cycle strategy was used as the broader guiding framework for this project. This project has opted to focus for the areas within the sphere of influence of the DHFW, highlighted in yellow in Figure 2. Proxy words and phrases were often used in searching for resource materials to ensure that project results were comprehensive. This project prioritized a focus on the cadres responsible for delivery of MNCHN services, namely Medical Officers (MO's), Specialists and nurses (Staff Nurses, and ANMs).

Policy recommendations were an initial objective of this effort. However, since policy formulation can be a long drawn process, this project has chosen to focus on interim strategies to help manage priority HRH issues of the state and contribute to the longer term policy formulation dialogue.

1 The Jharkhand State PIP 2011-2012 outlines that HRH include the following eight cadres within DHFW Jharkhand: Specialist, Auxiliary Nurse Midwife (ANM), Staff Nurse, Male Health Worker, Pharmacist, Lab Technician, Radiographer and Medical Officers.

Figure 2: Workforce life cycle adapted for the project from the World Health Report 2006



Implications

The findings from this project address fundamental questions regarding the distribution of the HRH workforce in Jharkhand, the factors affecting the performance of key cadres in the state, and highlights policy options for the GoJ that have proven effective in other parts of India.

The findings and recommendations of this project can be utilized by the GoJ to understand the immediate and long-term significance of the shortfalls in key cadres providing primary health care services for maternal and child health; to identify next steps toward making much-needed changes in HRH incentive packages and recruitment and retention procedures; and to review a potential model for managing improved and detailed HRH procedures within the DHFW. The content herein will be of interest to the officials of the Health Department, GoJ and to other stakeholders from the NRHM and the SHSRC who would be responsible for designing and implementing HRH policy for the state. This work would also be useful for other stakeholders in the public health system and among developmental partners whose programs and activities would be influenced by changes in HRH policy.

Approach and Methodology

PHFI adopted a combination of secondary data review and primary data collection to address the objectives of this project. This included conducting a literature review of HRH practices stemming from issues highlighted in the WHO's workforce lifecycle. Primary data collection was managed through both a mapping exercise using state HRIS/HMIS information and staff interviews and undertaking a survey of approximately 300 health department staff across five districts of the state.

Literature Review Methodology

The literature search was undertaken by using a set of key words including health human resource, health workforce, HRH production, HRH recruitment, and HRH retention, in addition to other terms. Often proxy words were used for the WHO's workforce life cycle framework as they yielded more apt search results. The search terms were entered into search engines like Google scholar, JSTOR and Pub Med. Human resource-focused journals were also searched, and India-specific articles were searched through the National Health System Resource Centre (NSHRC), NRHM and the Ministry of Health and Family Welfare. Two hundred and eighty articles were obtained through this search strategy concerning HRH issues globally. Out of these, 241 articles were reviewed in detail as they were directly relevant to the current work.

The selected articles were then segregated into three main domains of entry, workforce enhancement, and exit. Relevant articles on HRH that did not fit into these three domains were included in a fourth domain titled 'others'. Sub classification was done in each domain of HRH according to the WHO Workforce life cycle framework

After data on entry, workforce enhancement and exit was extracted from articles, the project team compiled the different approaches, noted their particular effectiveness and analyzed how applicable each approach would be for the state of Jharkhand. The criteria for determining the applicability of an approach were *the country context* (developing versus developed) and *feasibility*[2] *of the scaling up of the strategy* in Jharkhand.

[2]Feasibility was defined as a combination of the availability of resources in the state; the intention of the state as outlined in PIPs or government orders; and infrastructure availability.

Primary Data Collection Methodology

Primary data was collected through the following three mechanisms. Firstly state information such as government orders and rule books were reviewed. Second, telephonic and face to face interviews were conducted with state and district officials to map the status of existing HRH in Jharkhand. Lastly, trained field investigators conducted a survey of various cadres within the health department on their attitudes and perceptions of factors affecting performance of HRH. The mapping exercise and the survey were conducted concurrently.

Mapping the Status of Existing HRH

The scope of the mapping exercise under the technical assistance project undertaken by PHFI for GoJ was of limited duration. Therefore, it was designed to focus on strengthening cadres that would most directly support delivery of primary health care for maternal and child health. These include: specialists; medical officers; and ANMs. Although staff nurses are an essential in delivering maternal and child health services, they were predominantly contractual hires under NHRM and therefore were not covered in this mapping exercise.

During the mapping, the team undertook a review of the HRH and infrastructure information available with the officials from the health department, GoJ and supplemented it with information that was directly collected from the Chief Medical Officers from the individual districts of Jharkhand. The information on specific district populations was obtained from the census estimates. Manpower to population ratios were derived for individual districts using these HRH and population parameters.

Attitudes and Perceptions About Factors Affecting Performance of HRH

Information on the attitudes and perceptions about factors affecting performance and job satisfaction of HRH was collected during the survey of HRH staff in the state. These interviews were conducted among specialists, medical officers and ANMs from five districts of the state. Since contractual staffs are predominantly recruited under NRHM, and consequently not eligible for promotions, incentives or remuneration like permanent staff, they were omitted from this survey. Unfortunately, this resulted in the exclusion of staff nurses from this study as they are predominantly hired through NRHM.

Five districts (Ranchi, Palamu, Dumka, West Singhbhum and Dhanbad) were identified for primary data collection, after stratifying districts based on tribal and non-tribal population and the HR availability. A small number of interviews (pharmacists and Lab Technicians) were also conducted in order to obtain a complete picture across the cadres.

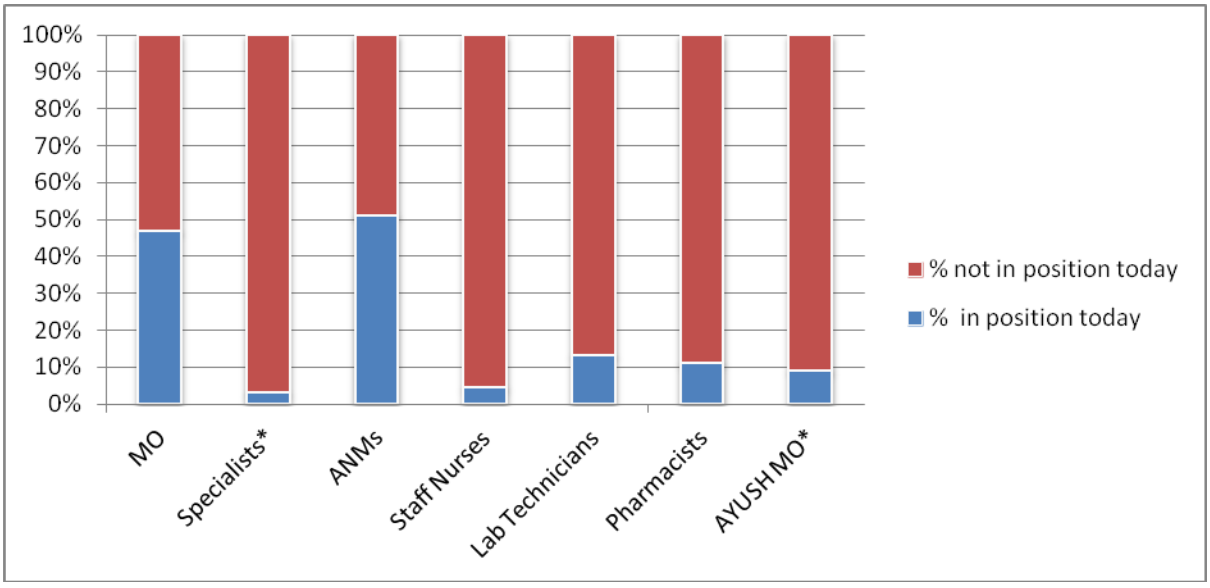
Findings

Enumerating HRH in Jharkhand

There are multiple sources which offer an enumeration of HRH in the state of Jharkhand - these include BRHS, State PIP's, and NHSRC. As would be expected, based on the time of collection and their context, these sources will often not match making enumeration a challenge for many of the functionaries that we interviewed.

According to IPHS the state of Jharkhand today requires 41098 personnel working at a facility level in direct healthcare service delivery[3]. Rural and tribal populations have been considered for calculating manpower requirements for the subcenter, PHC and CHC. In addition to the rural and tribal population the urban population has also been added to calculate the manpower requirement Sub Divisional Hospital and the District Hospital. According to the NRHM PIP 2011-2012 only 26% of those needed are currently in position either as regular employees or as NRHM contractual employees[4]. The figure below shows this break up according to specific cadre.

Figure 3: HRH in Position versus IPHS norms



*** Specialists and Ayush MOs may be double counted under MO's. Each district follows different principles for counting MO's some include Specialists and Ayush within the MO category.**

Source: Jharkhand state PIP, 2011-2012. Cross referenced by HR consultant NRHM, GoJ

[3]This discussion does not include the ASHA and all non direct service delivery personnel such as managers etc

[4]NRHM offers the state a monetary mechanism of hiring more service delivery personnel using central funding

As Table 2 shows, there is unequivocally a discrepancy between the required, sanctioned and available numbers of HR in different cadres across the state. Sanctioned positions are far fewer than required. Even with the aid of NRHM, which has provided a mechanism through which the state can hire contractual staff to bridge the gap, there remains a great need to increase HRH across all cadres in order to meet IPHS norms.

Table 2 - HRH in Jharkhand: the Gap

Cadre	Required as per IPHS**	Sanctioned (Regular)***	In position (contractual + regular)***	Gap (required - in position)
MO	4099	1681	1917	2182
Specialists*	2732	174	84	2648
ANMs	13815	4666	7076	6739
Staff Nurses	12564	304	578	11986
Lab Technicians	3143	446	417	2726
Pharmacists	3088	629	344	2744
AYUSH MO*	1657	454	149	1508

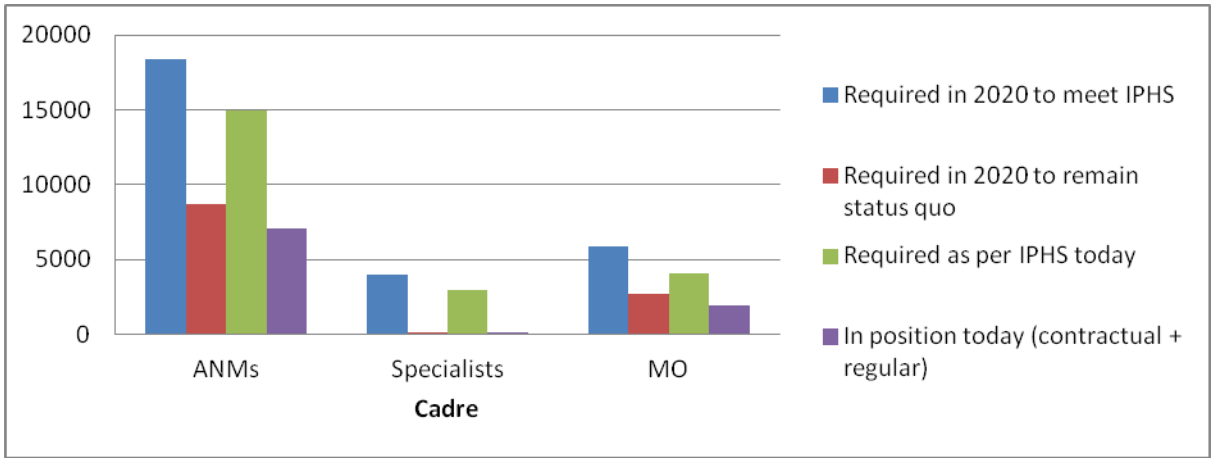
*** Specialists and Ayush MOs may be double counted under MO's. Each district follows different principles for counting MO's some include Specialists and Ayush within the MO category.**

Source: ** Calculation used IPHS guidelines 2012 outlined on the MOHFW website.
*** Jharkhand state PIP, 2011-2012

This need is only going to grow. Using an estimated population growth projections[5] we calculated the projected need for the state for 3 cadres essential in delivering MNCHN: Nurses (represented through ANM's), MOs, and Specialists. As can be seen in Figure 4, by 2020 the state will need approximately over three times its currently existing number of medical officers and ANM's in the health system if it is to meet IPHS norms. These numbers do not even account for the retirement and exit of employees from the health system or absenteeism.

[5] The population growth projection was calculated using the state level growth rate between 2001 census and 2011 census.

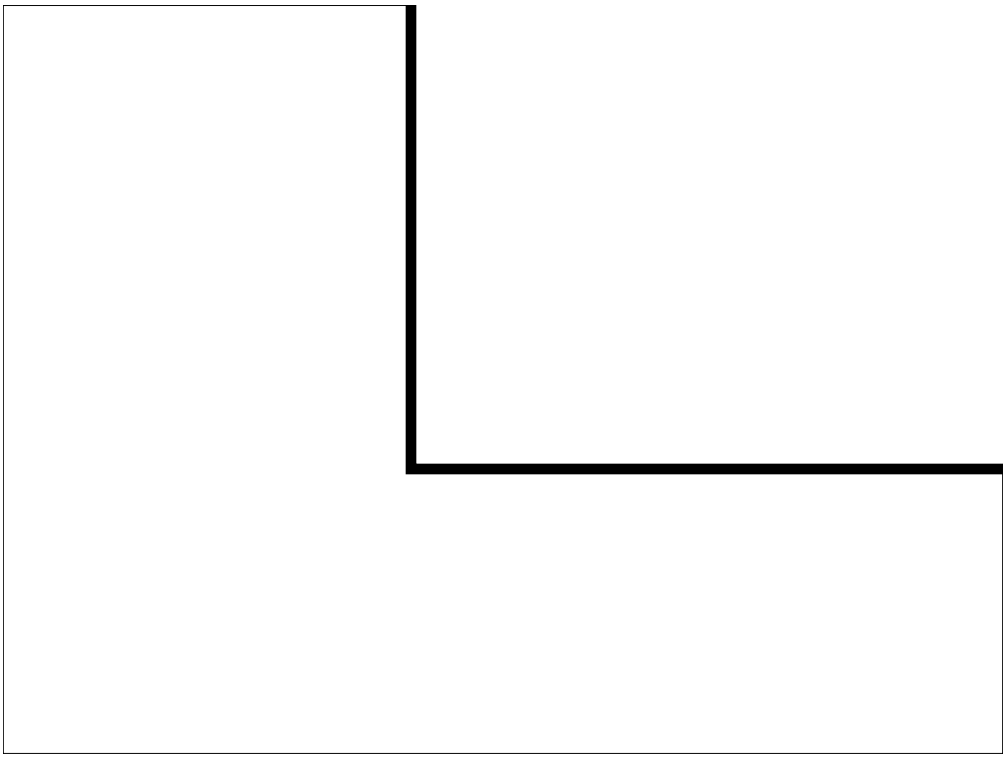
Figure 4: The projected need of ANMs, MO's, and Specialists in Jharkhand in 2020

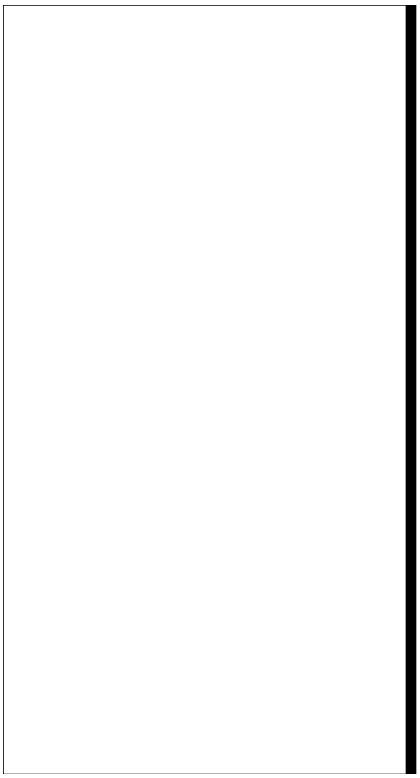


Source: In position today is from the Jharkhand state PIP, 2011-2012. Required as per IPHS today calculated using IPHS guidelines 2012 outlined on the MOHFW website. 2020 requirements calculated using the state level growth rate between 2001 census and 2011 census and applying it across districts.

District- wise Distribution of HRH in Jharkhand

Miming the India specific trend there is mal-distribution across districts as well. The following maps show the distribution of two of the cadre essential to MNCHN service delivery across the state- Nurses (represented through ANM's and MOs).





Adapted from: Data from the Jharkhand State PIP 2011-2012

The Factors Affecting Job Satisfaction Among HRH in Jharkhand

To understand better what keeps people happy with their jobs our study explored a number of factors (listed in Annex 3) that may possibly influence one's satisfaction with their current job (termed as happy with current Job) among a sample of permanent health department employees across the five districts of the state. Overall 90% were happy in their current position. Of all the variables studied, four were found to be significant. These significant factors were: the *highest education qualification of the respondent; whether the respondent stays with their family; duration of work experience, and transfers.* Table 3 (next page) presents some of those factors that were studied both significant and not significant.

Table 3: Different factors affecting job satisfaction

	Variables	Happy with current job	Unhappy with current Job	P-Value
Education	**Highest educational qualification:** MBBS/MD Nursing/ANM & other training	 28.4 71.6	 69.6 30.4	**< 0.01***
Supervision	Supervisory support	93.9	92.0	0.72
	Have to work late	60.2	62.5	0.83
Compensation	Residing in government quarters	23.5	27.3	0.691
	Staying with family	**87.0**	**72.0**	**0.04***
	Monthly income < 35,000 35,000 – 45,000 > 45,000	 32.6 52.2 15.2	 16.0 76.0 8.0	0.08
	Regularity of salary	55.6	68.0	0.23
	Additional allowances	57.7	54.2	0.74
Systems Support	Supply of electricity	58.0	56.0	0.84
	Regularity of drug supply	52.0	33.3	0.08
	Shortage of supply (consumables)	19.4	4.2	0.07
	Availability of separate consulting room	61.9	79.2	0.10
Lifelong learning	Received training opportunities	9.0	13.0	0.53
Career Choice	**Year of work experience** < 15 years 15-24 years 25-30 years >30 years	 19.7 37.7 25.1 17.5	 69.6 17.4 8.7 4.3	**< 0.01***
	Ever been transferred	71.1	39.1	**< 0.01***
	Monthly activity completion	71.2	92.3	0.10
	Turnover in staff	17.6	33.3	0.06

* Denotes significant at 5% level of significance (LOS);

Further analysis using multiple logistic regression of these findings demonstrated that frequent work team changes was the sole factor that influenced being happy with the current job after adjusting for the other variables (details provided in Annex 3). In other words, individuals who are surrounded by frequent changes in their team are 74% more likely to be unhappy with their job than those who see rare or no changes in their team.

Strategies to Address HRH Challenges Employed Across India

The following series of tables summarizes the India-specific evidence from the secondary literature using the categories outlined in workforce lifecycle adapted from the World Health Report, 2006. The criteria for determining the applicability of an approach to the state of Jharkhand was a combination of the following three factors: availability of resources in the state; the intention of the state as outlined in PIPs or government orders; and physical infrastructure and system support availability. Medium feasibility was any two of the above factors and low feasibility was only one or less of the above factors

ENTRY- Preparing the Workforce

	Strategy	Areas of particular effectiveness	Location	Applicability to Jharkhand		
				Availability of resources	Intention of the state	Physical Infrastructure
Education	Bachelors in rural health care (Sundararaman, No date given)	Preparation of a workforce selected with the sole purpose of serving rural populations	Chhattisgarh Assam	☒	☐	☐
	Distance education programs (Sharma, George and Zodpey, 2011)	effective means to increase the knowledge and skills of health professionals	India	☒	☐	☒
	Preferentially drawing students for medical and nursing education from those who are willing to work in underserviced areas (Prasad, Sundararaman and Gupta, 2009).	Creating a workforce with the purpose of serving rural populations	West Bengal Madhya Pradesh	☐	☐	☒
	In service PG incentive; Post PG compulsions (Gupta, Sundararaman and		In service PG incentive - Andhra Pradesh, Assam,	☐	☐	☒

	Strategy	Areas of particular effectiveness	Location	Applicability to Jharkhand		
				Availability of resources	Intention of the state	Physical Infrastructure
	Rao, 2011).		Chhattisgarh Gujarat Post PG compulsions- Arunachal Pradesh, Haryana, Himachal Pradesh, Jammu and Kashmir, Maharashtra, Manipur, Nagaland, Orissa, Sikkim, Tamil Nadu and Tripura			
Recruitment	Contractual appointments (Bir, No date given[iii])	Effective in cutting short the recruitment process	India/ Rural	☒	☒	☐
	Appointment of retired personnel (Gupta, Sundararaman and Rao, 2011)	Increase the pool of trained HRH available to the public health system	Gujarat, Manipur, Maharashtra, Nagaland, Orissa, Sikkim, Tamil Nadu and Tripura	☐	☐	☒
	Rendering services from private practitioners (Gupta, Sundararaman and Rao, 2011).	Increase the pool of trained HRH available to the public health system	Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Madhya	☐	☐	☒

	Strategy	Areas of particular effectiveness	Location	Applicability to Jharkhand		
				Availability of resources	Intention of the state	Physical Infrastructure
			Pradesh, Manipur, Nagaland, Puducherry, Rajasthan, Tamil Nadu and Uttar Pradesh			
	Walk in interviews for regular services (Garima, Sundararaman and Raha, 2009[iv])	Helps shorten the long recruitment procedures	Haryana	☒	☒	☒

WORK FORCE- Enhancing Work force Performance

	Strategies	Areas of particular effectiveness	Country /setting	Applicability to Jharkhand		
				Availability of resources	Intention of the state	Physical infrastructure
Compensation	Specialized financial incentives for rural postings(Gupta, Sundararaman and Rao, 2011).	Increase in the number of health workers in underserved areas	Andhra Pradesh, Andaman & Nicobar, Chhattisgarh, Haryana, Himachal Pradesh, J& K, Kerala, Lakshadweep, Maharashtra, Manipur, MP, Nagaland, Orissa, Punjab, Rajasthan, Tamil Nadu, Tripura and Uttrakhand	☒	☒	☐
	Group housing for health workers (Gupta, Sundararaman and Rao, 2011).	Incentive for service in difficult areas. Allows family presence.	West Bengal, Orissa, Chhattisgarh India	☒	☐	☐
System support	Enabling work environment: Involvement in facility decision making Rewards of good performance and penalties for poor performance (Gupta, Sundararaman and Rao, 2011; Peters et	Number of vacancies of doctors reduced.	Haryana Uttar Pradesh, Andhra Pradesh	☒	☒	☐

	Strategies	Areas of particular effectiveness	Country /setting	Applicability to Jharkhand		
				Availability of resources	Intention of the state	Physical infrastructure
	al., 2010[v]; Rao et al., 2010).					
	Adequate infrastructure (Rao et al., 2010)	Clinic infrastructure and physical work environment	Andhra Pradesh, Uttrakhand Haryana	☐	☒	☐
	Strengthened HRH monitoring mechanisms (Garima, Sundararaman and Raha, 2009[vi])	Useful in promoting a more efficient recruitment process.	Haryana	☐	☒	☐
Lifelong Learning	Training opportunities for skill building (Peters et al., 2010)	Task shifting/ sharing	Uttar Pradesh, Andhra Pradesh	☐	☒	☐

Strategies Applicable to Jharkhand

Based on the information presented in the above tables, there are several strategies that the DHFW, GoJ may be interested in exploring. This section further discusses these possibilities in terms of education, recruitment, compensation, systems support and lifelong learning.

Education

The Bachelors Degree in Rural health care, or a variant form of training non physicians to perform basic medical services, appears to be an effective mechanism of task shifting in other countries enabling a health system to reach particularly remote and difficult to reach areas. Two states in India have introduced such programs but their effectiveness remains to be established. More conclusive evidence on the efficacy of the programs in Chhattisgarh and Assam needs to be established before GoJ embarks on its own endeavour to undertake a similar degree program.

Recruitment

Gupta et al have shown that recruitment to permanent government posts can be a long and cumbersome process taking an average of 18 months. This results in a cycle of "chasing vacancies" which can be debilitating to any health system. In their case study on recruitment processes in Haryana, they showed that some minor changes within the process of recruitment can significantly reduce the rate at which vacancies are occupied to an average of one month. These changes include walk in interviews at a state and district level; flexibility on the place of posting, and guaranteeing no forced transfers within the first three years. Our primary research reinforces the notion that team changes (whether they be through forced transfers or otherwise) increase job unhappiness for the rest of the team. Using a single strategy for improved recruitment in isolation should be done cautiously as their efficiency independently has not been evaluated.

Compensation

Literature globally and within India recognises that compensation is an important factor influencing one's decision in seeking employment and remaining employed in the public healthcare system. The question remains- what is the optimum compensation package required to attract and retain qualified personnel or varying cadres?

In around 18 states health workers, typically general and specialist doctors, serving in rural areas receive a difficult area allowance which range from Rs. 500 per month in the state of Tamil Nadu to Rs. 25,000 per month in Haryana. (Sundararman and Gupta, 2011)

Jharkhand plans to improve rural health systems and services for its identified unreached population through a policy titled 'Jharkhand Swasthya Protsahan Yojana' for incentivisation of health services. Through this policy JRHM intends to concentrate its efforts towards increasing HRH in rural areas and consequently bridging the gap between HRH availability and the existing unmet needs of the community especially in the area of Reproductive and Child Health.

The evidence on how effective these incentives are in recruiting and retaining remains inconclusive. What is clearly established and is further validated by our primary data is that any optimal compensation package must be a bundle of financial and non financial elements. Things like housing for families and education for children have all been shown in varying studies to be highly regarded factors influencing one's employment decisions.

Systems Support

Supported by the global literature, the India specific research also suggests that systems support or "enabling work environment" is a critical factor to retaining HRH and enhancing their work force performance. This enabling work environment ranges from physical clinical infrastructure to monitoring mechanisms that will, among other things, reward success or punish failure.

Evidence is overwhelming and the GoJ stands to benefit tremendously in terms of recruiting and retaining healthcare professionals if it addresses factors related to physical infrastructure and the PIP 2011-2012 clearly recognises this. For the purposes of this report we have limited the systems support discussion to aspects more within the control of DHFW such as a stronger HRH management system including more effective monitoring mechanisms.

Life Long Learning

Repeated evidence, both globally and in India, shows that job satisfaction is intrinsically linked with an employee's perceived opportunities for learning. This has been incorporated into strategies of the state in two beneficial ways. Firstly, learning opportunities are used to make an employee better at their current core job performance i.e. offering an ANM a training on improved quality of care through patient communication techniques. Secondly, a learning opportunity can be used as a "task shifting" mechanism i.e. training an MBBS doctor on EMOC services.

Recommendations

A combination of the review of secondary data, a survey among staff in the health department across 5 districts of Jharkhand and a mapping exercise detailing existing HRH across the state in terms of geography and their level of posting within the health system has provided some fruitful information that can aid the state of Jharkhand in addressing its pressing HRH issues. While the recommendations of this report attempt to holistically address these issues, all solutions that are recommended include interim strategies that the state of Jharkhand will be able to initiate quickly. Some of these interim strategies will continue to have long term bearing; other issues like initiating newer educational institutes that can influence the creation of newer HRH resources are not included as a part of this report. Similarly, the report also does not include a review of the labour policies and the retirement age from the health system.

	Key Message	Recommendations
Recruitment	*Key Message #1:* Recruitment should be a state-wide, proactive and continuous process built on greater communication and coordination with the medical and nursing colleges in Jharkhand and other states.	1. Walk-in interviews should be practiced at state and district level by creating an interview panel (within existing recruitment infrastructure). 2. The selection committee should be constituted with a mandate to recruit medical and paramedical staff by conducting campus interviews at medical and nursing colleges in the state and other states regularly to promote public health service and interview students about to graduate. 3. There should be greater transparency in the process for filling vacancies and preference should be given to the interested HRH domiciled in that district. 4. The recruiting process should reflect the state's needs in notified high- focused facilities and match it with candidate preferences.
Compensation	Key Message #2: Compensation should include a bundle of financial and non financial incentives appropriate for the post.	1. Mechanisms for performance based financial incentives across all cadres must be designed and implemented. The benefit package for specialists should be appropriately higher (considering qualification and experience) than the medical graduates. 2. Compensation for HRH should include housing. 3. Establish financial and non-financial incentives for all cadres reporting to remote, difficult or LWE-affected areas.

	Key Message	Recommendations
System Support	Key Message #3: Strengthen HRH policies and processes.	1. Institutionalize a clear policy and process for contractual HRH to apply for vacancies in sanctioned posts after a defined tenure. 2. There should be clear and standard policies detailing the processes for career progression during the service tenure for regular staff.
	Key message#4 Create a dedicated unit with the sole responsibility and authority to enable the smooth functioning of HRH.	A dedicated human resource for health management cell should be created for the state of Jharkhand with a clear and concise scope of work. The performance of the cell should be routinely monitored by the highest level of state administrative system against its agreed targets .
Lifelong learning	Key Message #5: Professional growth opportunities are important for encouraging HRH to stay in public health service longer.	The state should provide/support regular opportunities for HRH to upgrade their skills and knowledge as part of its retention policies for all cadres.

The section below discusses these recommendations and what will be required on the state to enact them.

Key Message #1: Recruitment should be a state-wide, proactive and continuous process built on greater communication and coordination with the medical and nursing colleges in Jharkhand and other states.

Recommendation: Walk-in interviews should be practiced

What the state needs to do?

The state must create an interview panel (within existing recruitment infrastructure) at Ranchi that conducts walk-in interviews against vacant posts for contractual medical officers and specialists under the NRHM. This interview panel will follow set procedures established by the state recruitment rules. The eligibility criteria, screening and interview of the applicant will be identical to processes currently followed in the routine system of recruitment.

This walk-in recruitment system will be set up within the NRHM office and will be available for interviews on a fixed day every month across the year. This walk-in interview process will continue till as long as vacancies exist within the health system for the sanctioned posts of medical officers and specialists.

An appropriately structured interview panel should also be set up at each district headquarter for the conduction of walk-in interviews against sanctioned but vacant posts of all cadres of human resources in health except medical officers and specialists. This panel should be available on the same day allocated every month across the year for as long as vacancies exist within the district for the sanctioned posts of appropriate cadres and should comprise of Government and development partner representatives, which ensures transparency in the process and ensures that decision taken is facilitated.

Recommendation: The selection committee should visit Jharkhand Medical and Nursing Colleges and other states regularly to promote public health service and interview students about to graduate

What the state needs to do?

The state must identify the needs within the public health system across various cadres. A specially constituted selection panel, with strong relationships with state education department and other related representatives, should visit the medical colleges and paramedical colleges both within Jharkhand and other states from where HRH can be sourced.

The selection panel will conduct campus interviews among candidates who will be obtaining their relevant degree within three months of the interview. These candidates will also be provided with a list of opportunities existing in the state, which can facilitate individual career progression. This selection of interested candidates for jobs within the health system will be dependent on obtaining the final certification in the examinations. There will also be a need for dedicated resources, for representatives travelling for interview, and an order or provision for the same needs to be done.

Recommendation: There should be greater transparency in the process for filling vacancies and preference should be given to the interested HRH domiciled in that district

What the state needs to do?

A list of vacancies for the posts of medical officers and specialists across all levels of healthcare should be compiled district-wise. These vacancies should be updated on a monthly basis and displayed on a website/ government publication/ newsprint. As mentioned earlier, walk-in interviews should be held at the state capital at a pre-determined date every month. This interview process should offer interested HRH the option of transfer to the vacant position in any district across the state. Candidates who are domiciled within the district with the available vacancy should be given preference. In case of multiple interested candidates for any vacancy who are domiciled in that district, preference should be accorded to performance appraisal and seniority of the candidates.

The medical officer/ specialist will also have the option to select any other district other than the district of domicile, but will not receive any special preference for posting in such districts.

Recommendation: The recruiting process should reflect the state's needs in notified high- focused facilities and match it with candidate preferences

What the state needs to do?

Identify and notify the high-focus facilities within each district across the state based upon existing criteria within Jharkhand. This information should be used to prioritize the state recruitment process.

Candidates appearing for the interview should be permitted to express their preference for posting to these high focused facilities. Those selected for these facilities should be promptly relieved of other duties if working within the public health system. Once appointed to these positions, their intra-state transfer should not be permitted for a defined tenure.

With regards to specialists, the recruitment target for specialists should reflect a clear analysis of skill gaps in facilities. Initial focus should be on equipping all district hospitals and functional FRUs with specialists. This should result in an enhanced availability of HRH in high-focus facilities. Notified high focused facilities and their adequacy of staffing should be periodically reviewed at the state level. Finally, a list of all vacancies should be updated monthly and circulated within the recruitment division.

Key Message #2: Compensation should include a bundle of financial and non financial incentives appropriate for the post

Recommendation: Financial incentives across all cadres must be competitive with those in neighbouring states

What the state needs to do?

Difference in pay scales based on experience and level of care, between Jharkhand and Bihar needs to be established. Based on the difference, a performance-based incentive mechanism need to be designed which will allow for financial incentives in Jharkhand to be comparable to those in Bihar.

The financial and non-financial incentives for all cadres should recognize and appropriately compensate their additional training and skill-level. The benefit package for specialists should be appropriately higher (considering qualification and experience) than the medical graduates.

Recommendation: Compensation for HRH should include housing

What the state needs to do?

Both our primary and secondary research shows that housing that meets the needs of doctors and nurses and their families is key to encouraging HRH to stay in public health service longer. The health department should ensure the presence of accommodation facilities within/ close to the health facilities for its staff. Wherever such facilities do not exist, the health department should liaise with the concerned departments and ensure that the construction is included in the budget for the forthcoming financial year. Where residential facilities exist, these should be subject to regular maintenance on a yearly basis through the PWD.

Adequate budgetary provisions should be drafted within individual districts by the office of the district collector and submitted to the health department at the state level in January every year. The health department will liaise with the necessary departments at the state level after compiling requests from individual districts.

Recommendation: Establish financial and non-financial incentives for all cadres reporting to remote, difficult or LWE-affected areas.

What the state needs to do?

The literature review has repeatedly shown that financial and non-financial incentives for cadres selected and recruited for posts in remote, difficult or LWE-affected areas are essential. While the current incentive structure addresses the distributional concerns by proposing to give an incentive for posting in difficult areas, if the current shortfall in numbers is to be addressed, there needs to be a concerted effort addressing several additional issues simultaneously, along with viewing HRH issues as a whole. Performance-based incentives should also provide an opportunity for compensating work in difficult areas in the state.

Key Message#3: Strengthen HRH documentation, policies and processes

Recommendation: Institutionalize a clear policy and process for contractual HRH to apply for vacancies in sanctioned posts after a defined tenure

What the state needs to do?

The state must encourage the selection of contractual staff within the regular cadre after completion of one year of continuous contractual service within the public health system. The state should clearly communicate the terms and conditions to HRH at the time of contractual recruitment under which they will be eligible for in-service position. These conditions will include a performance monitoring and health indicator monitoring of the site of contractual posting. Within contractual staff, preferences for those who have worked in hard-to-reach of LWE areas should be given preference.

The state government must establish and maintain dynamic database on HRH in the state, which has details of all HRH regarding their date of joining, age, contractual position, place of posting and other relevant indicators based on the need of the state. The state should conduct a periodic review of this dynamic database, identify in service HRH positions that are going to be vacated and proactively disseminate this information amongst the contractual and in-service staff, clearly stating the preference for contractual staff. There should be a systematic incorporation of contractual HRH to permanent positions that matches the exit rate of HRH from the public health system due to retirement and resignations.

Recommendation: There should be clear and standard policies detailing the processes for career progression during the service tenure for regular staff.

What the state needs to do?

Career progression pathways for all cadres need to be streamlined across the state. These should be shared with the candidates during their induction training into the state health system. These career pathways should accommodate the need of HRH for professional growth and changing needs during the various phases of their career. It should draft job responsibilities and career progression pathways for all HRH across the state within six months.

A dialogue with representatives from all levels of HRH by appropriate officials in the directorate and NRHM must be established. This dialogue should encourage the state needs to clarify the balance of employing HRH staff between the health directorate and NRHM. A standard policy for career progression should be jointly developed and approved by the department.

Key message 4: Create a dedicated unit with the sole responsibility and authority to enable the smooth functioning of HRH.

Recommendation: Create a dedicated human resource for health management cell for the state of Jharkhand

What the state needs to do?

The state must establish a mandate on roles and responsibilities for cell council and empower them with decision making and monitoring. A government order on formation of council, with detailed roles and responsibilities and outcomes expected should be passed.

The tasks that the council is to perform should include: establishing a system to capture dynamic data on HRH from the state; designing and implementation of recruitment and retention policies; and monitoring the impact of recruitment and retention policies.

Once the scope of work for the cell is decided the council should identify state level representatives dedicated to undertake the task. In case of absence of the state's capacity, it needs to seek technical support to build capacity of the potential state representative for implementing the job and for interim position they can hire consultants for task delivery. Roles of development partners, who can also act as a validation mechanism, should also be established and made part of the council. The cell should have a fixed tenure and all resources for operationalization should be clearly demarcated and support from NRHM can be sought for the same.

The performance of the cell should be monitored by the highest level of state administrative system, on a half-yearly basis, against the laid target and necessary amendments to be made from the review.

Key Message #5: Professional growth opportunities are important for encouraging HRH to stay in public health service longer

Recommendation: Regular opportunities to upgrade skills and training in new practices and technologies should be part of retention policies for all cadres

What the state needs to do?

The state should provide support to the health professionals in advancing their professional development and upgrading them with new practices and skill-building. This can often be in a form of task shifting such as training MBBS professionals on EMOC, training indigenous streams of medicine to work as medical officers in PHC's , or even training ASHA's on first-contact health care.

This should involve the creation of a cell within the training division at the state level which engages in a formal needs-assessment exercise every year. The needs assessment exercise will produce a list of priority areas for training in that year. This will be additional to the routine trainings offered under national programs.

Priority should be given to skill up-gradation for staff posted in difficult or LWE-affected areas, while ensuring gender equity in these programs. Funding opportunities arising from sponsoring agencies and the government should be streamlined to address the priority training list. A priority list for training should be identified within 6 months.

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ANNEX 1. Multivariate Regression Details

22 factors analyzed in depth:

1. District type	2. Happy with current job
3. Total work experience	**4. Highest education qualification**
5. Marital status	6. Staying at government quarters
7. Staying with family	**8. Monthly income**
9. Regularity of salary	10. Allowances
11. Un interrupted electricity at facility	**12. Shortage of drugs**
13. Shortage of consumables	**14. Presence of a separate consulting room**
15. Working late	16. Total work experience in government
17. Ever transferred	18. Mismatch between job description and current work
19. Finish activities in monthly work plan	20. Training opportunities
21. Frequent work team change	**22.** Supervisory support

Further analysis using multivariate logistic regression was conducted on eight of those factors that were shown to be significant in bivariate analysis (shown in bold above). In the logistic regression model where 'frequent work team changes' emerged as the only significant factor influencing the outcome having adjusted for the other variables shown in Table 4. This means that a frequent change in the work team is associated with a 74% lower happiness with their job, necessitating a re-look into the policies for retaining health teams at facilities for longer durations.

Table 1: Multivariate logistic regression analysis for factors influencing being happy with current job

Variable	Adjusted Odds ratio	P value	95% CI
Highest educational qualification	1.30	0.175	0.89 to 1.91
Stay with family	0.43	0.211	0.12 to 1.61
Monthly income from current job	2.20	0.118	0.82 to 5.90
Separate consulting room	2.00	0.277	0.57 to 6.98
Drug shortage	0.43	0.136	0.14 to 1.30
Duration of work experience	1.22	0.679	0.47 to 3.14
Transfers	0.70	0.591	0.18 to 2.62
Work team changes	0.26	0.023	0.08 to 0.23

Level of significance: 0.1 LR chi^2 (8df) = 25.52

Number of observations = 216

ANNEX 2. Human Resources in Health: Factsheet for Medical Officers in Jharkhand

Medical Officers (MOs) are frontline technical service providers in the health system, providing clinical and managerial leadership to the health workforce at the Community Health Centres(CHC), Primary Health Centres(PHC)and Sub-Centres(SC). Population coverage of PHCs in Jharkhand is amongst the highest in the country.

Average population coverage of a PHC in Jharkhand *versus* India: 63 000 *versus* 31364
Average number of sub-centres per PHC in Jharkhand *versus* India: 12 *versus* 6

Recruitment

Table 1: Total requirement of MOs calculated based on existing infrastructure as well as required infrastructure per Indian Public Health Standards (IPHS) at different levels of facilities in Jharkhand, 2011

Health facility	MO requirement at each facility (IPHS) *	Facilities required per population coverage** (IPHS) [1]	Current number of facilities***	MOs required (IPHS based facilities)	MOs required (current infrastructure)
Primary Health Centre	2	999	330	1998	660
Community Health Centre	6	250	194	1500	1164
Sub-Divisional Hospital	7	55	6	385	42
District Hospital	9	24	21	216	189
Total				4099	2055

Source: *IPHS Revised Guidelines, 2011. Ministry of Health and Family Welfare. Retrieved from http://mohfw.nic.in/NRHM/iphs.htm, October 2011

** Calculated using census 2011 data and the IPHS revised Guidelines 2011

*** Obtained from health department through interactions as of September 2011

1 The requirement of centers (SC, PHC, and CHC) in rural areas has been calculated using the IPHS norms for tribal and non tribal population for the year 2011. The requirement of SDH and DH has considered the total population(Census 2011)

Table 2: Required, sanctioned and in-position MOs in Jharkhand

Required as per proposed IPHS norms for infrastructure; and current infrastructure*	Sanctioned (Regular)	In-position (contractual + regular)***
4099; 2055	1681	1917

Source: * IPHS Revised Guidelines, 2011. Ministry of Health and Family Welfare. Retrieved from http://mohfw.nic.in/NRHM/iphs.htm, October 2011

** RHS bulletin, 2010

*** Jharkhand State PIP 2011-2012

Gap in planning: Sanctioned positions for MOs are fewer than required as per existing as well as IPHS infrastructure requirements.

Gap in recruitment: Even with contractual hiring, currently there is a deficit of over 2000 MOs when IPHS infrastructure norms are considered and over 100 when existing facilities are considered.

Current recruitment policies

- There is only one cadre for the doctors in the state, i.e. MOs. Other states have divided clinical roles between two cadre namely, MOs and specialists based on the educational qualifications.
- The recruitment of MOsis based on the Jharkhand State Public Services Examinations and promotions are based on the level of seniority. These examinations have been held only three times since 2001.
- Reservation policies are applied during the recruitment and promotion.
- The department has recently sought sanction for the posts of 2000 MOs from Government of Jharkhand (GoJ).

Deployment

Adapted from: *Data from the Jharkhand State PIP 2011-2012*

Geographic distribution and gender

- Eight of 21 districts have 5 or less than 5 MOs per 100,000 population while four districts have more than 8 MOs per 100,000 population.

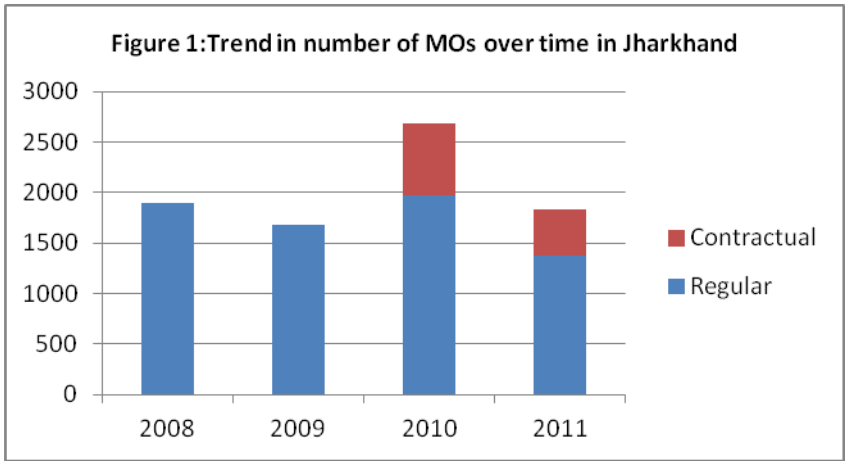
- The Lady Medical Officers (LMOs) constitute less than 10% of total MOs in-position; mostly concentrated in the district hospitals.

Current policies on difficult area postings

- Though GoJ has announced list of difficult areas, currently the state does not have clear policies for deployment and incentives for posting of MOs in these areas.
- No provisions for family postings and health and safety of employees.

Retention

HRH availability trend (2008 to 2011):



Source: Jharkhand State PIP for 2008, 2010 and 2011; and RHS for 2009

The current number of regular MOs is the lowest of the last four years; about 600 MOs exited within a year

Fluctuations in numbers on an annual basis indicate instability within the system

Current policies on promotion, transfer and incentives

- Current promotion policies are based on the seniority levels.
- The existing HR policy has made provision for three-month institutional training/ field training and refresher training, however, the state does not have its own institution to conduct such training.
- Departmental examinations open or closed book exams are conducted regularly and promotions are dependent on their clearance.
- Progression to permanent position in the department is contingent on: clearing departmental exams, finance training, Hindi/tribal exams, and two years rural service.

Exit

Retirement

- Current age of retirement in Jharkhand is 58 years.
- There is provision of premature retirement for employees.

HRH policies – Work in progress

- Jharkhand has inherited most of the HR policies from Bihar, and adapted most of these to the changed context.
- The state is in the process of developing HR policies for regulating service conditions of clinical staff. This will include the issues like rational deployment of skilled staff, transfer, recruitment etc.
- The state has released a brief HR strategy for MOs in the gazette but details are still to be worked out.
- The SHSRC has been designated as a nodal agency for facilitating the HRH policy development process.
- NRHM has enabled the state in meeting the HRH needs in short term through contractual appointments.
- NRHM has provided impetus for revamping the HRH strategies regarding difficult areas posting. Incentives for difficult area postings were introduced through the Jharkhand state PIP 2011-2012.

Areas needing further research for developing Jharkhand HRH policy

What are the means of closing the gap in required and available MOs? Is contractual hiring sustainable for bridging the MO number gap?

How can Jharkhand retain MOs within the health system?

What incentives work for difficult area placements?

What are the perspectives of the existing MOs about working conditions within the health system?

How do the push and pull factors across other states of India influence the MO availability in Jharkhand?

ANNEX 3: Human Resources for Health: Factsheet for Medical Specialists in Jharkhand

Specialists are highly skilled staff for delivering preventive, curative and life saving services like Emergency Obstetric Care and managing newborn complications in facilities mandated to provide these services. While first referral units require obstetricians, pediatricians and anesthetists, higher level facilities require specialists from all fields such as ophthalmology, pathology etc. Availability and strategic placement of specialists has remained a challenge in Jharkhand.

Status of Medical Specialists in Jharkhand

Recruitment

Table 1: Total requirement of specialists in Jharkhand calculated based on existing and required facilities as per Indian Public Health Standards (IPHS) 2011

Facility	Specialists requirement per facility (IPHS)*	Total facilities required** (IPHS) [2]	Facilities present**	Specialists required as per IPHS norms*	Specialists required as per existing facilities
Community Health Centre	7	250	194	1750	1358
Sub-Divisional Hospital	10	55	6	550	60
District Hospital	18	24	21	432	378
Total				2732	1796

Source: *IPHS Revised Guidelines, 2011. Ministry of Health and Family Welfare. Retrieved from http://mohfw.nic.in/NRHM/iphs.htm October 2011

** Calculated using census 2011 data and the IPHS revised Guidelines 2011

*** Obtained from health department through interactions as of September 2011

[2] The requirement of centers (SC, PHC, and CHC) in rural areas has been calculated using the IPHS norms for tribal and non tribal population for the year 2011. The requirement of SDH and DH has considered the total population(Census 2011)

Table 2: Required, sanctioned and in-position specialists in the state as of 2011

Required as per proposed IPHS norms for infrastructure; and current infrastructure*	Sanctioned (Regular)**	In position (contractual + regular)**
2732; 1796	174[3]	389

Source: * IPHS Revised Guidelines, 2011. Ministry of Health and Family Welfare. Retrieved from http://mohfw.nic.in/NRHM/iphs.htm, October 2011

** Jharkhand State PIP 2011-2012

Gap in planning: Sanctioned posts for specialists meets only 6% of the required posts as per IPHS and about 8% of the required post as per existing infrastructure in 2011.

Gap in recruitment: State has been able to fill less than 50% of the sanctioned posts

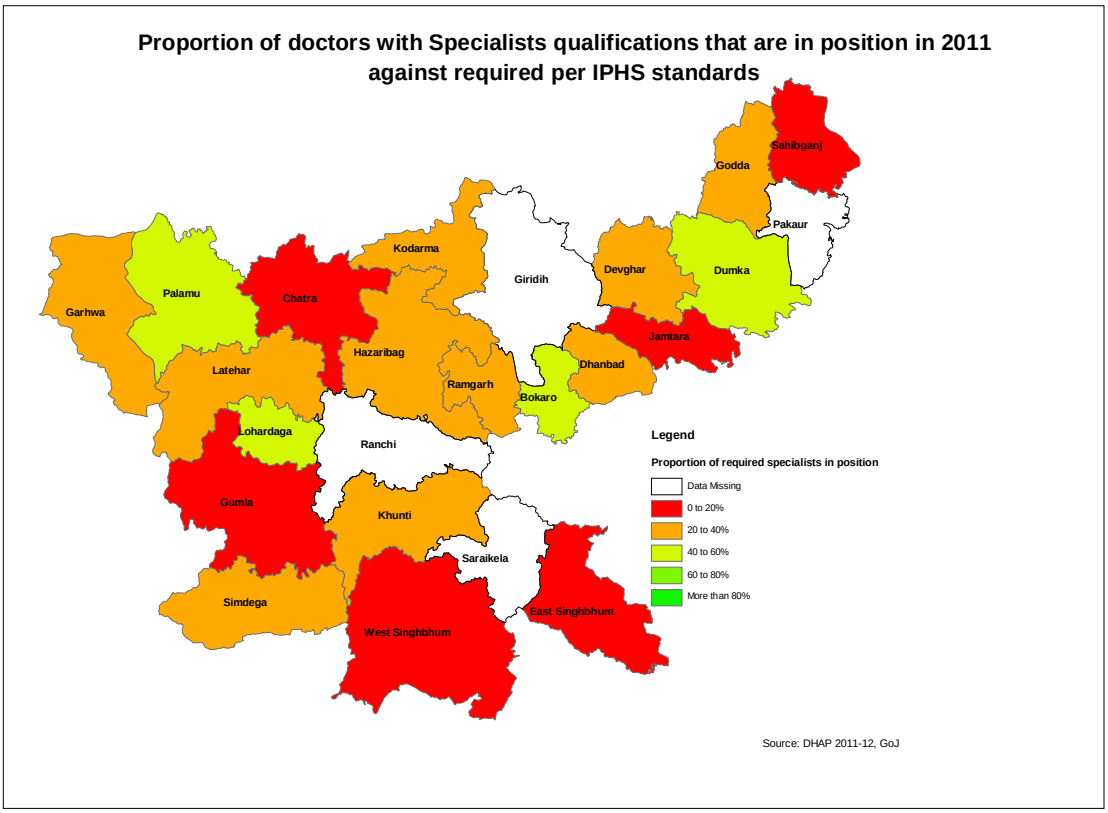
Current recruitment policies:

- Jharkhand does not have a cadre of "specialists' for the regular positions so there are no new sanctioned positions under the regular staffing approved by the GoJ. Some positions were 'sanctioned positions' in referral hospitals in undivided Bihar. Jharkhand continues to show these positions as 'sanctioned' and doctors posted against these positions as 'specialists in-position'.
- The doctors having specialist educational qualifications are treated at par with the MBBS doctors in terms of service terms and promotions.
- The differential in the remuneration is available for the specialist doctors contractually hired under the NRHM.
- The state is making attempts to provide specialist services by training general MOs in specialist services through short-term courses.

[3] Jharkhand state does not have separate cadre for 'Specialists'. These positions were sanctioned positions in referral hospitals in undivided Bihar state. Jharkhand state continues to show these positions as 'sanctioned'.

Deployment

Figure 1: Geographic distribution of specialists in Jharkhand, 2011



Adapted from: Data from the Jharkhand State PIP 2011-2012

- 389 doctors with specialist qualifications are currently working in Jharkhand health system as general Medical Officers at various facilities include the PHCs/APHCs. Many of them do not provide specialist services.
- Existing doctors with specialist qualifications could be reassigned in a Specialist role.
- In 2011, a threefold increase in Medical Specialists is required to meet IPHS standards within existing infrastructure.
- Attracting and retaining specialists within the system is challenging

Spread of Specialists in difficult areas and tribal belts

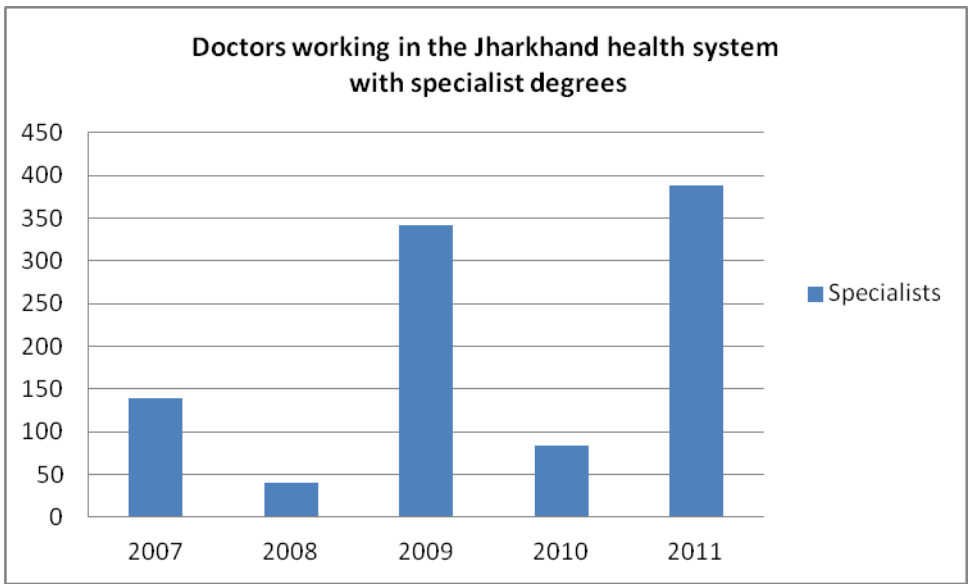
- Doctors working as Specialists are concentrated at district hospitals and facilities in bigger towns.
- Doctors with specialist qualifications are posted across various facilities but they do not provide specialist services.

Current policies on deployment

There are no specific policies for posting of specialists at designated specialized facilities such as district hospitals, FRUs or CHCs.

Retention

The following graph shows those Doctors that have specialist degrees working in the health system between 2007 – 2011



Source: RHS 2007 - 2010, PIP (NRHM) – 2011

Current policies on promotion, transfer and incentives

- Although there is salary differential between contractually hired general MOs and specialists under NRHM, there is no such differentiation in pay scales for regular MOs and qualified specialists in the state.
- The GoJ attempted posting specialists at higher care facilities such as district hospitals and FRUs, however there are no policies governing this cadre.

Exit/ retirement

- As there is no separate cadre of specialist, all the retirement policies for general MOs apply to those having specialist qualifications.

HRH policies – Work in progress

- The state is in the process of developing an HRH policy regulating service conditions of clinical staff. This will include the issues like rational deployment of skilled staff, transfer, recruitment etc.
- NRHM has provided impetus for revamping the HRH strategies regarding difficult areas posting for specialists.
- NRHM has conducted a state-wide mapping of doctors with specialist qualifications for strategic placement of available specialists in the state for operationalization of FRUs and other higher care centres.
- The State Health Services Resource Centre (SHSRC) has been designated as a nodal agency for facilitating HRH policy development process.

Areas that need further research for developing HRH policy for Jharkhand

- What interventions are required to bridge the huge gap in number of specialists in the state?
- How will Jharkhand attract specialists into the health system once the infrastructure gaps are met?
- What are the perspectives of the existing specialists about working within the health system?
- Is task shifting a sustainable option for bridging the gap in number of obstetricians and anesthetists?
- How do the push and pull factors across other states of India influence the specialist's availability in Jharkhand?

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