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**Personnel Management and
Human Resources in the
Integrated Rural Health and
Population Project of the
Government of India**

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Integrated Rural Health and
Population Project of the
Government of India**

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Executive Summary and Recommendations

This Report on Human Resource Management is based on field visits to the five states in India where the Integrated Rural Health and Population Project is being implemented with the assistance of USAID—Gujarat, Maharashtra, Haryana, Himachal Pradesh, and Punjab. The Report describes the existing systems and procedures for creating and filling field staff and project management posts. It also analyses problems experienced with human resources in the Project, and innovations attempted in different states in recruitment, training, retention, and motivation of field and project management staff. The Report makes specific recommendations for future research and action to deal with human resource management problems.

Field staff

The Report describes IRPH Project objectives with respect to field staff as human resources. It presents a flowchart of the existing procedures for creating and filling field staff posts, and data about the current status of field staffing in the project areas. The Report then discusses problems encountered in many states, innovations developed, and recommendations for future management of field staff as human resources.

Problem 1: The complexity of systems and procedures related to creating field staff posts, the involvement of multiple agencies, the lack of clarity about required procedures, and the lack of trained personnel management cadre introduce delays in creating new posts for field staff.

Recommendation 1. Delays in creating new field staff posts can be reduced by introducing :

- advance manpower planning that compensates for the normal time lag of the system.
- innovative procedures that reduce the time and number of steps in the existing system.

- informal mechanisms that promote better information sharing and quicker decisions.
- a cadre of staff trained to deal with management and administration.
- a personnel manual that clearly lays out existing rules and procedures.

Problem 2: Difficulties in recruiting suitable trainees, bottlenecks in training facilities, and loss of trained staff contribute to high vacancies in female staff posts (MPWs, HAs).

Recommendation 2. Vacancy rates in female staff posts can be reduced by :

- selecting rural and local woman for training as MPWs.
- creating additional training facilities close to the location of potential trainees.
- expanding the pool of potential trainees through wider search efforts and applying flexible criteria for qualification and selection.
- creating mechanisms to more tightly enforce the bond system.

Problem 3. Inadequate physical facilities, lack of adequate social and professional support, and lack of security contribute to high turnover of female staff from isolated rural postings.

Recommendation 3. Turnover of female staff from isolated rural posts can be reduced by :

- creating minimum physical facilities needed for satisfactory living and working for female staff.
- enhancing social support through placement in home areas, supportive work arrangements, and supportive and regular supervision.
- enlisting local people and leaders to ensure the safety of female staff.

Problem 4. Inadequate physical facilities, social isolation, insufficient financial, promotional, and development incentives, lack of appropriate training and education prior to and during service, and lack of authority commensurate with responsibility and status are the main reasons for medical officer turnover in isolated rural postings.

Recommendation 4. Turnover of medical officers from isolated rural posts can be reduced by :

- creating additional physical facilities at the health centres.
- providing financial and promotional incentives for continuing in isolated area postings.
- preparing future medical officers to manage primary health centers and to work effectively in communities through training before and during service.
- removing organizational constraints that block medical officer status and recognition.
- providing active and regular support by district and state level officials.

Problem 5. Lack of effective systems and procedures for rewards, career planning, performance appraisal, and training encourage compliance and routine performance from field staff, instead of high motivation and innovation.

Recommendation 5. Field staff motivation to perform and innovate can be enhanced by :

- clarifying job content and performance expectations of field staff.
- clarifying career tracks to ensure avenues for growth and promotion for staff of different categories.
- increasing opportunities for development, learning, and growth of staff and linking those opportunities to performance.
- creating non-financial incentives to perform and innovate.
- building an organizational climate that promotes performance and innovation through leadership at the higher levels.

On the whole, recruitment and training of medical and paramedical field staff in the Project areas is now progressing at a rate that will largely fill most posts by the end of the project. However, greater efforts are needed to solve the problems of retention of field staff in isolated rural posts and to encourage high performance and innovation.

Project Staff

The Report describes the nature of project management staff indicated in the IRHP Project Paper. It outlines a flowchart of existing procedures by which project staff posts are created and filled, and describes the present status of project staffing. It identifies problems with project management staff recruitment, retention, motivation and performance that exist across several states, describes innovations developed to deal with those problems, and makes recommendations for future management of project staff resources.

Problem 1. The functions of project management staff are different from regular field staff, and, these functions and their future use beyond the project have remained ambiguous in the absence of clear definitions by any body. This has resulted in delays in creating and filling project management staff posts.

Recommendation 1. Delays caused by ambiguities about functions and futures of project staff can be reduced by :

- clarifying project role definitions through state initiatives, GOI specifications, or USAID consultation.
- undertaking strategic manpower planning that defines future roles for project management staff.
- continuing dialogue among relevant parties to educate new staff and resolve ambiguities about staff functions and requirements.
- evolving a project management manual that outlines operating requirements and steps to reduce initial floundering.

Problem 2. Structural and procedural complications introduced by the roles of Steering Committees and Governing Bodies, uncertainties about who has responsibility for staffing decisions, ambiguity regarding procedures necessary to create posts and recruit staff, lack of incentives for qualified personnel to join and remain in project posts, and difficulties in finding suitable personnel have also hampered the creation and filling of project management posts.

Recommendation 2. Structural and procedural steps can be clarified and simplified to reduce delays in creating and filling project management posts by :

- clarifying the role and delineating authority of Steering Committees/Governing Bodies in the decision-making process.

- holding regular and frequent Steering Committee/Governing Body meetings, subcommittees, and other innovations that streamline the decision process.
- clarification of responsibility in project management between state and central governments.
- Procedural shortcuts and innovations to make project management posts more attractive to highly qualified candidates.

Problem 3. Inadequate financial resources for project management staff, insufficient support from higher levels and lack of advance staff preparation for project management have constrained their performance.

Recommendation 3. project management staff performance can be enhanced by change that increase critical sources of support :

- Financial resources tailored to the manpower and travel demands of project characteristics within each state.
- Active support for project activities and staff performance from senior officials of state and central governments.
- Staff selection, training and development activities that emphasize preparation for the demands of project management.

Problem 4. Lack of effective coordination between project management staff, directorates of health services, health secretariats and other state government departments, central government, and USAID have limited the effectiveness of project staff performance.

Recommendation 4. Linkage mechanisms can be created to promote better coordination and more

shared learning from project staff experience, such as :

- structures and procedures that improve coordination between secretariat and directorate.
- mechanisms that encourage coordination with other agencies at the district level.
- mechanisms that enhance communications with central government.
- mechanisms that enable more sharing of problems and innovations across project states.
- strengthening of technical resources of MOHFW's Area Project Cell to facilitate technical support to the states.
- increased use of project and USAID resources to secure required technical information and expertise to meet local needs.

On the whole, considerable effort is needed to clarify and evolve project management staff function and roles, to create new approaches to attract and retain qualified personnel to perform these roles and to facilitate more effective coordination between project organization and other agencies.

In the end, these findings and recommendations are used to propose multiple perspectives from which the role of the project management staff and the IRHP Project can be analyzed. Such perspectives are valuable for strategic planning to maximize gains from the project during and beyond its life.

In sum, priority areas of attention are: retention, motivation and development of field staff; clarifying project staff roles, creating posts to effectively manage various project functions and recruiting qualified personnel to those posts. It is suggested that GOI and the states constitute special task forces to look at the recommendations made here and plan next steps urgently.

Personnel Management and Human Resources in the Integrated Rural Health and Population Project

I. INTRODUCTION

The Integrated Rural Health and Population Project has now been in operation for more than two years under the supervision of the Government of India and with financial support from the U.S. Agency for International Development. The Project operates in two to three districts in five states: Gujarat, Maharashtra, Haryana, Punjab, and Himachal Pradesh. This Report will present the findings of an assessment of the recruitment, development, and deployment of personnel, or human resources, envisioned by that Project. Thus human resource management in IRHP Project is the broad focus of this Report.

The initial scope of work of the project set the following objectives for the study:

1. analyze and describe the problem of vacant posts within the IRHP,especially for female workers.....,
2. review the problems of project management staff in terms of creation of posts and recruitment of suitably qualified and experienced people.....,
3. review the problems concerning motivation and retention of health workers and project management staff.....,
4. make concrete and practical recommendations that will resolve these problems.....

The time available for field work was limited, and we were forced to choose between studying one or two states involved in the IRHP Project in some depth, on one hand, or visiting briefly all five participating states, on the other. In the interests of general coverage, we decided to cover all five states and make an effort to look in slightly more depth in one. This choice limited our ability to cover some

of the initial questions. We were not able, for example, to collect extensive information from field staff on problems of motivation and retention. But the broad coverage approach does enable us to compare problems across states and to gain a more general picture than would have been possible with a more narrowly-focused study.

The authors made brief visits to each state to discuss human resource management with responsible officials. Mr. M.G. Singh of the USAID/India mission accompanied us to each state, and Mr. S.P. Pathak, Deputy Secretary to the Government of India, Ministry of Health and Family Welfare, joined us for the visits to Punjab, Haryana, and Himachal Pradesh. We benefited throughout from their suggestions and insights, though responsibility for errors in this Report is of course ours alone.

The contract called for a Report that would:

1. define the existing personnel management/administration systems and procedures.....,
2. describe the dynamic processes relating to personnel administration....,
3. analyze data and identify major and critical problem areas for further study.....
4. recommend how future work may be carried out in view of the sensitivity, complexities, and constraints of the Project.

In the course of our field visits, our attention focused on understanding how the present system works, on problems associated with vacancies and performance of both field staff and project management staff, and on innovative solutions to those problems developed in the different states. Hence we have organized the Report that describes the system and situation, analyses problems and difficulties encountered, presents innovations and solutions attempted in various states and makes

evaluations and recommendations. Hence the scope of the Report is enlarged to include these. After this Introduction, the Report is presented in three sections.

The next section deals with the recruitment, development, and deployment of *field staff*—the medical and paramedical field based human resources who staff the range of primary health centres and subcentres envisioned by the Government of India's Model Health Plan to bring primary health care services to the rural populations. This section will describe Project objectives, examine the existing procedures for creating and filling posts, assess the current status of field staff recruitment, identify problems encountered, describe solutions or innovations implemented in the different states, and make recommendations based on the above.

The subsequent section provides a similar analysis for the *project management staff*, who are charged with planning, implementing, and evaluating the accelerated implementation of the Model Plan in the Project districts.

Finally, the last section discusses in more general terms the results presented earlier, suggesting strategies for making use of past experience to enhance the effectiveness of Project and Model Plan implementation in the future.

II. FIELD STAFF AS HUMAN RESOURCES

The Model Plan for promoting rural primary

health care requires the deployment of medical and paramedical staff to primary health centers and subcentres to provide health services to rural populations. The recruitment, training, deployment, and retention of these human resources is critical to improving the health and family welfare of those populations.

A. IRHP Project Objectives

The Project Paper focused on accomplishing goals of reducing the crude birth rate and the child and infant mortality rates by accelerating two aspects of the Government of India's Model Health Plan. The first strategy was to improve access to health and family welfare services by constructing new facilities and obtaining paramedical workers to staff those facilities. The Project proposed to support recruitment and training of field staff as per model plan norms at several different levels: Community Health Volunteers (CHV's) and trained Traditional Birth Attendants ("dais") at the village level; male and female multipurpose workers (MPW's) at the subcentre level; male and female health assistants (HA's) at and below the primary health center level. The project set quantitative targets for new paramedical staff to provide improved access to health services for rural populations in the districts served by the projects, as indicated in Table 1.

Table 1

Required Targets for Increases in Field Staff in IRHP Project

	Gujarat	Maharashtra	Haryana	Himachal Pradesh	Punjab	Total*
CHV's	666	3431	1285	914	3426**	9722
Dais	1196	3152	1364	1683	906	8301
MPW's (M)	None	371	95	310	129	905
MPW's (F)	552	521	300	368	129	1870
HA's (M)	None	37	None	None	None	37
HA's (F)	180	190	80	84	25	559

*Figures adjusted to revised 1985 population estimates and hence the totals are greater than the original project agreement

**Figures adjusted to Punjab decision to deploy CHV's.

Source: Plan documents of the states.

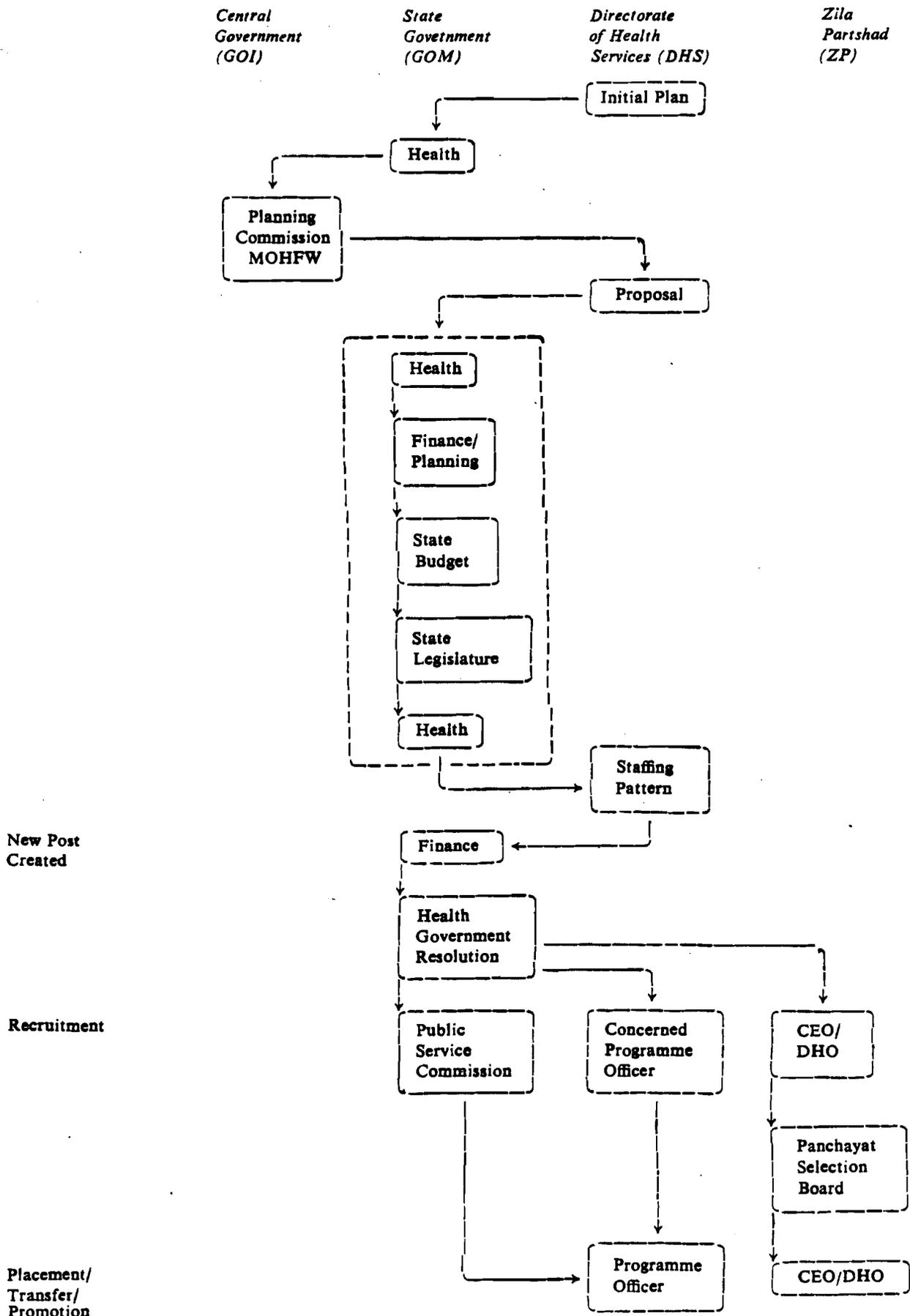
The planned additions to paramedical staffs reflect the recognition that few services can be delivered to rural populations unless trained workers are in place to offer them. This analysis of human resources for the Project will first focus on the procedures used to create and staff new positions, the outcomes to date of project efforts to expand

the number of paramedical workers in place, and the problems encountered in that effort.

B. Existing Procedures for Creating and Filling Field Staff Posts

For the field staff under the Model Health Plan, the procedure for creating and filling posts has been

Figure 1. Procedure for Creating and Filling Regular Posts for Field Staff



schematically shown in Figure 1. These details in Figure 1 are based primarily on the procedure obtaining in Maharashtra as a representative state. Government institutions at four levels are involved in the procedure. At the Central government (GOI) level, it is the Planning Commission and Ministry of Health and Family Welfare (MOHFW). At the State Government (GOM) level, departments of Health, Finance, and Planning are involved along with the State Legislature. At the state level, the Directorate of Health Services (DHS) is also involved. Finally, Zila Parishads (ZP) are involved at the district level.

In the creation of new posts, the DHS does initial planning for new facilities and items in June/July of each year. Then the plan is sent to the GOI (both the MOHFW and the Planning Commission) through the Department of Health, GOM. Planning Commission consultations are held in October/November, and broad allocations are made for the coming financial year. The DHS then makes concrete proposals for the number of new facilities and posts needed, to the Department of Health (GOM). In so doing, various Program Officers are involved in the DHS. For example, the Joint Director in charge of Planning, Development and Evaluation initiates proposals for Rural Health Services; the Joint Director (Family Welfare) initiates proposals for new posts under the Family Welfare Program.

These proposals, as consolidated, go to the Departments of Finance and Planning at the GOM and then are included in the State Budget to be approved by the State Legislature in March/April of the following year. After approval, the Department of Health sends them to DHS for the creation of a detailed staffing pattern to be presented to the Department of Finance (expenditure section) for concurrence. The Secretary of Health then issues a Government Resolution creating new posts by June/July. Thus the procedure for creating new posts takes about one year.

After a new post is created, three different agencies get involved in recruitment. For gazetted posts (Class I and II) like medical officers, the State Public Service Commission does the recruiting. For non-gazetted posts (Class III and IV) like multipurpose workers and health assistants, the Zila Parishad recruits staff through the State and District Panchayat Selection Boards. There are also some non-gazetted state cadre posts (very few in number) for which Programme Officers in the DHS do the recruitment.

As far as placement, transfer, and promotion are

concerned, the Zila Parishad does it for all its cadre. And the concerned Programme Officers do it for others. However, the Joint Director (Medical) is responsible for placement, transfer and promotion of all medical personnel.

In the case of Gujarat, the procedure is largely similar. One main variation is that a Deputy Secretary in the Secretariat is in charge of recruitment, placement, transfer and promotions of medical personnel. Another variation is introduced by separate Directorates of Health Services and Medical Services.

However, the procedure for recruitment, placement, transfer and promotion of non-gazetted staff is different in the states of Haryana, Punjab, and Himachal Pradesh since they do not have the system of Zila Parishads. In these states, all these functions are performed by the DHS through the various Programme Officers.

C. Current Field Staffing Status

To what extent has the Project succeeded in meeting its goals for expanding the trained field staff available to rural populations? In June 1982, the First Annual Review reported on the recruitment and training of new staff to meet the Project goal of expanding access to health services. We asked for data about the present staffing in project districts in each state during our field visits. Table 2 compares the increases made in field staff placement in project area in the 1982 First Annual Review with levels current in June 1983.

The percentages reported in this Table have been computed to compare current staffing levels with those planned by the project for 1985. The difference between field staff in place at the start of the project (on 1-4-1980) and the staff in place in June 1982 and June 1983 has been divided by the proposed addition of field staff in the Project. Thus it is possible, when additional staff does not match the loss of staff due to turnover and transfers to other districts, for the change in staff to be a net loss rather than a gain, as in the HA's (F) for Haryana.

Each state can be considered briefly here. Then we will turn to problems that appear across several states.

Gujarat has been able to train substantial numbers of CHV's and dais since the first annual review, and now is close to meeting Project goals for both groups. Although exact data was not available for female MPW's and HA's, it was clear that training bottlenecks have prevented increases in the number of these workers in position over the past year. But

Table 2
Field Staff Increases as a Percentage of Project Goals

		<i>Gujarat</i>	<i>Maharashtra</i>	<i>Haryana</i>	<i>Himachal Pradesh</i>	<i>Punjab</i>
CHVs	82	$\frac{100}{666} = 15\%$	Not available	$\frac{772}{1265} = 60\%$	$\frac{206}{149} = 22\%$	None planned
	83	$\frac{608}{666} = 91\%$	$\frac{2304}{3431} = 67\%$	$\frac{1116}{1285} = 87\%$	$\frac{628}{918} = 68\%$	$\frac{1157}{3426} = 37\%$
Dais	82	$\frac{542}{1196} = 45\%$	Not available	$\frac{375}{1364} = 27\%$	$\frac{338}{1683} = 20\%$	Not available
	83	$\frac{928}{1196} = 78\%$	$\frac{1732}{3152} = 55\%$	$\frac{1029}{1364} = 76\%$	$\frac{924}{1683} = 55\%$	$\frac{742}{906} = 82\%$
MPW (M)	82	None planned	Not available	$\frac{21}{95} = 22\%$	$\frac{30}{310} = 10\%$	$\frac{0}{129} = 0\%$
	83	None planned	$\frac{176}{371} = 47\%$	$\frac{37}{95} = 40\%$	$\frac{34}{310} = 11\%$	$\frac{99}{129} = 77\%$
MPW (F)	82	$\frac{160}{552} = 29\%$	Not available	$\frac{77}{300} = 26\%$	$\frac{81}{368} = 22\%$	$\frac{0}{129} = 0\%$
	83	$\frac{160}{552} = 29\%$	$\frac{157}{521} = 30\%$	$\frac{173}{300} = 58\%$	$\frac{102}{368} = 29\%$	$\frac{0}{129} = 0\%$
HA (M)	82	None planned	Not available	None planned	None planned	None planned
	83	None planned	$\frac{0}{37} = 0\%$	None planned	None planned	None planned
HA (F)	82	$\frac{40}{180} = 22\%$	Not available	$\frac{-11}{80} = -15\%*$	$\frac{29}{84} = 35\%$	$\frac{0}{25} = 0\%$
	83	$\frac{40}{180} = 22\%$	$\frac{37}{190} = 19\%$	$\frac{-14}{80} = -18%*$	$\frac{32}{84} = 38\%$	$\frac{9}{25} = 36\%$
Per cent increase =		$\frac{\text{Percent staff} - \text{staff at project start (1.4. 1980)}}{\text{planned project addition}}$				

*turnover and transfers have reduced staff in project districts.

N.B. : This table is based on data from the Project Paper, the first year annual review report, state estimates, and state visits. The data are often approximate or outdated, so these figures are indicative, not conclusive.

It has been planned that many of the female workers now in training will move into project district posts next year, and so reduce those vacancy rates.

Maharashtra has also been relatively successful in placing village level workers and male MPW's, with half or more of their planned increases already in place. Training bottlenecks and problems in recruiting female staff for rural centers have prevented equally fast gains in HA's and female MPW's' and experiments with shortened training program are being implemented to reduce the delay in staffing those posts, though this may create overcapacity after a couple of years.

Haryana has been making good progress in filling village level posts, and has also filled close to half the multi-purpose worker posts planned. But the state has been having difficulties in keeping the level of staffing by female HA's current at the project start, let alone adding the 80 new workers envisioned by the project. The problem has been acute since the existing female HA's seek transfers out of these difficult, backward and isolated Project districts to vacant positions elsewhere in the state. Once enough female HA's have been trained and recruited by early next year through promotional training at the newly created training facility, this problem will be largely solved.

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Himachal Pradesh, like the other states, has been able to place more than half the planned village level workers already. But its success in the first year in construction projects has been accompanied with difficulties in placing the human resources to make use of the new centers. Its training bottlenecks have been particularly acute, in part because even the faculty to train new staff have not been available. But the state is starting new training centers, innovating in trainee recruitment, and recruiting new training staff. They expect to reduce the bottleneck and expand the level of staffing at primary health centers and subcentres by the end of next year.

Punjab decided to use CHV's only after the inception of the project, and has now trained more than a third of the planned additions. The state has been very successful in training dais and male MPW's, but like other states, has been less successful in expanding the ranks of female MPW's and HA's. Like the other states, Punjab is creating new training facilities and giving project districts priorities in the recruitment of new trainees.

Table 2 suggest that all five states have been relatively effective in training and deploying CHV's and dais at the village level. It also suggests that all the states have difficulty in recruiting and placing female MPW's in subcentres and female HA's in primary health centres. Hence it can be concluded that significant progress has been made during the last year in staffing additional posts in the field. It also appears that most states will be able to meet Project goals of recruiting additional field staff by the end of next year. However, it may be important to monitor this aspect closely to avoid future slippage. The next section discusses in more detail problems identified in the field visits, solutions to those problems being developed or tried in different states and presents our recommendations.

D. Field Staffing Problems and Innovations

The following problems have been observed in the project in several, often all, of the participating states. Each problem will be briefly described below, and then some of the innovations tried for solving it will be considered. It is not expected that the same solutions will work in all states and districts, but it is hoped that knowledge of some of these ideas will encourage further innovation and exploration in other states. Based on these innovations and our analysis, specific recommendations are made for solving each problem.

Problem 1: The are delays in creating new field staff posts.

The system for creating and filling new posts in project districts, as outlined earlier, takes about a year from initial planning to creation of posts. It also operates very slowly, and so hinders the creation and staffing of those posts. At best the post creation procedure is a complex process that involves many different departments and levels of the government hierarchy, and the potential for crippling delays is often high.

Many alternatives for reducing bureaucratic delays have been developed in different states. Some solutions involve effective use of present structures and procedures. Thus delays have been reduced by strong *support for quick action* from the Government of India, the State Secretariat and USAID. Systematic efforts to *educate relevant parties about necessary procedures* for creating and staffing positions can reduce the delays created by misunderstandings.

A major problem arises from the movement of files between the Directorate and the Secretariat. It is clear that *enhanced personal interaction* facilitates the speed of decision-making. In Maharashtra and Himachal Pradesh, there is only *one file* on a subject between the Directorate and the Secretariat, ensuring that all comments and decisions are included. Also, there is enhanced personal contact between Directorate and Secretariat officials because the Secretary of Public Health maintains an office in the Directorate and brings Secretariat officials there for *group discussions and decision-making*. Similarly, personal chasing and follow-up with the Department of Finance is actively pursued by Directorate officials.

Some states have created new structures and procedures to reduce delay. In Himachal Pradesh, for example, opening new primary health centers leads to *automatic creation of the necessary staff posts*. This procedure applies to facilities that have standard staff under the Model Health Plan. This innovation has reduced two steps in the post creation procedure. In Gujarat, the role of *chief personnel officer* has been created to coordinate many personnel functions otherwise fragmented between different positions in the Directorate and the Secretariat. The Secretary of Health in one state pointed out that the creation of a statewide *personnel cadre* would enable more efficient management of human resources. Project officials in several states recommended creating a *manual of procedures* for creating and staffing project posts to reduce delays based on misunderstand-

ing. A few states are also engaging in more explicit *manpower planning* to foresee future demands for staff, to identify potential bottlenecks in supply, and to deal with them before they become critical.

Further time lag is introduced into the recruitment procedure by the involvement of the Public Service Selection Board for gazetted staff and the Panchayat Service Selection Board for Zila Parishad cadres (in Gujarat and Maharashtra). District panchayat Selection Boards can make quicker selections in comparison to Public Service Commission and State Panchayat Selection Board, but still may create delays. In all five states, delays in the selection process have been overcome through *ad hoc appointments* (to be confirmed within a year by the concerned Selection Boards) particularly for technical staff like medical officers, health assistants, and multipurpose workers.

Recommendation 1. Delays in creating new field staff posts can be reduced by introducing:

- advance manpower planning that compensates for the normal time lag of the system.
- innovative procedures that reduce the time and number of steps in the existing system.
- informal mechanisms that promote better information sharing and quicker decisions.
- a cadre of staff trained to deal with personnel management and administration.
- a personnel manual that clearly lays out existing rules and procedures.

Some groups are particularly subject to special problems. Officials in all states reported special problems for female field staff.

Problems 2: Female staff posts (MPW's, HA's) remain vacant because of recruitment problems, training bottlenecks, and post-training losses.

Table 2 reveals that all the states have difficulty in filling vacancies in female staff posts in primary health centers and subcentres. Sometimes appropriate candidates are difficult to find for training: applicants have urban backgrounds that do not prepare them for work in rural settings, or rural girls are unwilling to come to urban locations for training, or admission procedures fail to grant entry to older women from rural backgrounds who could be successful in the field. In other situations, vacancies cannot be filled because of a shortage of training staff and facilities. In some states, trainees finish their training but then take jobs with other institutions in spite of bonds that require them to work in rural centres for two to three years.

Many innovations have been designed to improve recruitment activities. Some states, such as Gujarat, are engaging in *more active recruitment in local rural areas* for trainees who can then be assigned to their home areas after training. Several states, such as Himachal Pradesh, are *building new rural training centres* to ensure that students will not have to go too far from their homes for training. In Punjab, Himachal Pradesh, and Haryana, training vacancies created by applicants applying to multiple training institutions simultaneously have been solved by *coordinated admissions interview timings* so that duplicate applications are not possible. Some states are experimenting with granting *preferential marks* for students having characteristics associated with effective work in rural settings; marks have been given for low income backgrounds, no relative in government service, and local origin. Some states are considering special efforts to recruit widows, married couples, or divorced women. In the same vein, some states are experimenting with *flexible application of educational standards*, such as Gujarat's relaxation of grade ten requirements for local tribal women; it may also be useful to have *flexible age requirements* that enable older women to apply.

Training bottlenecks have also given rise to many innovations. First, all states have acted to expand their capacity to train female field staff: Himachal Pradesh is building some *new training centers*; Gujarat is creating *temporary training centers* in or around project districts that can be easily dismantled or moved when the local need has passed; most states have made *expanded seats* available in existing centers; some states have explored the possibility of *converting seats* in facilities designated for training other categories of staff. A second alternative has been to *redesign training curriculums* in order to produce more trained staff in the project period; Maharashtra has reduced the original twenty month training period for female MPW to one period of twelve months (comprising of six months in class room and six months field placement) and another period (to be completed after some years of service) of six months. Thus they can train three times as many students now in the same facility. Third, shortages in training staff have been supplemented by *enlisting training help from other professionals*: Himachal Pradesh has experimented with offering honoraria to medical officers who teach in training programs. All states have reduced the training investment required for more advanced staff by *creating promotional training programs*, so female MPW's can become HA's with a

relatively short (usually six months duration) supplemental training course. Filling vacancies in project districts can also be facilitated by state policies that *give priority to staffing project districts*, though such priorities can pose political problems when project districts are already seen as having more resources than less-favored districts.

Many female field staff fail to take up positions after they finish training, either because they have not received their assignment prior to the expiry of the bond period (six months in most cases) or because the threat of bond forfeiture is not sufficient to balance the negative aspects of their assignment. One set of solutions to this problem, developed in Punjab, Haryana, and Himachal Pradesh, focuses on innovations that help to *enforce the bond system*: assignments to posts can be made prior to the completion of training so trainees cannot evade knowledge of their posting; mark-sheets can be retained until after students have joined their post so they do not have the credentials to get other jobs; training certificates can be distributed only after the period of bonded service is completed, as in Maharashtra. On the other hand, *assignments to posts can take staff preferences into account*: in Maharashtra, staff have been asked to list their posting preferences, and once those preferences have been followed as much as possible, very few transfer requests have resulted. Steps to *make rural posts more attractive* are also possible ways to reduce the loss of trained personnel prior to posting, but such steps are particularly relevant to the problem treated later.

Recommendation 2. Vacancy rates in female staff posts can be reduced by :

- selecting rural and local women for training MPW's.
- creating additional training facilities close to the location of potential trainees.
- expanding the pool of potential trainees through wider search efforts and applying flexible criteria for qualification and selection.
- creating mechanisms to more tightly enforce the bond system.

Even when enough trainees or qualified women can be found to staff isolated rural posts, they may not remain in those posts for long.

Problem 3: Female staff do not remain at isolated rural postings because of poor facilities, distance from social support, and lack of security.

In all the states, some isolated rural posts have

high rates of turnover of female staff. Sometimes the turnover is the result of difficulties in finding appropriate housing or physical amenities, problems that are particularly acute if the staff member is accustomed to urban living. In other cases, young female staff members find it difficult to live at considerable distance from the social support offered by family and familiar surroundings or the professional support of colleagues and senior health professionals. The problem of physical security is particularly acute for young, unmarried women living apart from their families, for without kinship ties in the community they are exposed to sexual harassment or exploitation in some areas. This problem is more recognized by female than by male officials; male observers sometimes explain problems as the consequence of "loose moral character" of the victim, while females suggest that the problem deserves more attention than it receives.

Lack of facilities for isolates rural posts has been tackled in several states by creating more facilities. Some states are *building quarters* for female workers at primary health centres and subcentres, though few have the resources to build quarters for all. In Gujarat and Maharashtra officials sometimes seek help from *zila parihads* to find suitable housing for female staff. Some states *assign female staff to their home areas*, so they will be able to live with their families. Some states are experimenting with *incentive systems to compensate for the lack of facilities* in certain rural posts; in Himachal Pradesh, a variable rural health allowance currently paid to medical officers may be extended to other field staff if it proves effective.

Innovations can also be designed to reduce the distance from significant sources of personal and professional support. *Assignments in home areas*, recommended in many states, can locate the staff member in a supportive context of personal and social relationships. Married staff members who can get *support from spouses* may be more able to work effectively in isolated rural settings. *Older more experienced staff* may be less vulnerable to the pressures of rural isolation, or more skilled in dealing with the challenges posed in isolated areas. Professional support may be offered by *frequent supportive supervisory visits*. Cooperation with staff from other ministries or departments working in the same area can also offer *colleague support* to field staff in areas where few other health workers are available.

The problem of lack of security for female staff in isolated areas is a difficult one, though some initial efforts have been made to deal with it. In many

states it is assumed that assigning female staff to work in their *home areas* will reduce the likelihood of security problems, and various efforts to increase the frequency of home assignments are underway. Other states are experimenting with *joint work arrangements* that bring female MPW's together with family welfare attendants, dais, or CHV's. *Group postings* may offer the security of numbers and the social support of colleagues to female staff in rural areas: in Maharashtra, groups of female MPW's are living together during their field training to provide such support. In some settings *support from zila parishad leaders* may reduce the threat to female staff as well: protection from powerful local leaders may enable women health workers to be effective even in isolated areas.

Recommendation 3. Turnover of female staff from isolated rural posts can be reduced by;

- creating minimum physical facilities needed for satisfactory living and working for female staff.
- enhancing social support through placement in home areas, supportive work arrangements, and supportive and regular supervision.
- enlisting local people and leaders to ensure the safety of female staff.

Field staff turnover is not confined to female staff. It is also often difficult to retain medical officers in isolated rural postings.

Problem 4: Medical officers leave isolated rural postings because of poor facilities, few incentives, inadequate preparation, and organizational frustrations.

While initial recruitment of medical officers is a problem in one or two states, the most critical problem is retaining them in isolated rural posts.

Rural posts often lack facilities that are important to retaining medical officers, such as physical amenities, educational opportunities for their children, and opportunities to meet and socialize with peers. Social and physical hardships become particularly important when there are few incentives — financial, promotional, or developmental — for performance in rural areas. Further complications are introduced by the special demands for both community and administrative work as a medical officer in a rural health center, demands for which medical officers are seldom adequately prepared by training or experience. The problems of turnover encouraged by these factors are often exacerbated by organizational arrangements that hamper performance of even highly-motivated medical officers

with red tape, inadequate authority, and little support from higher levels of the hierarchy.

Some states have made efforts to *build better facilities* at rural health centres: water and electricity supplies, recreational facilities, and residences appropriate to the status of medical officers have been constructed at primary health centres. *Educational subsidies* can be provided for children of medical officers: the variable rural health allowance in Himachal Pradesh was evolved, in part, to provide resources for better education for medical officer children. *Rural isolation can also be reduced* by resources that facilitate access to urban areas. *Opportunities for social contact* may be provided by assigning more professional staff to rural health centres or by encouraging social contacts with staff of other departments posted in the area.

Traditional medical training emphasizes curative skills and care for individual patients rather than prevention or promotion, prepares students for urban life rather than rural communities, and educates for medical practice rather than management of health services. Most medical officers do not receive public health training before five years of service. *Training in community diagnosis, health planning, and community organization skills* can prepare medical officers to perform better and experience less frustration with their work at a primary health centre. A preparatory course in public health prior to initial posting can prove useful. *Training in health centre administration* can offer basic accounting, supervision, and management skills that enable medical officers to administer health centres more effectively: in Himachal Pradesh, a basic administration course is being offered to medical officers. Prior to medical training, pre-medical students can be given an opportunity for *preparatory experiences* that offer realistic contact with the challenges and satisfactions of rural health services. In Maharashtra, for example, a very successful vacation programme offers pre-medical students up to five extra points on entrance examinations for spending vacations doing primary health care work in rural settings.

The organizational frustrations of medical officers in primary health centres involve inadequate delegation of authority, problems of occupational status and precedence, and difficulties of communication within and across hierarchies. Morale among medical officers can be greatly enhanced by *regular attention and support from higher levels* of the state hierarchy, (e.g., regular supervisory visits, recognition of good work, listening of grievances, etc.) and by clear leadership support for and

commitment to high performance in rural health services. Medical officers at all levels of the state hierarchy emphasized the importance of support from senior levels for implementing the difficult tasks of primary health care in isolated rural areas. Medical officers in charge sometimes reported difficulties in carrying out their role when few differentiations in rank exist to distinguish them from other medical officer colleagues. Some states, such as Haryana, Punjab, and Himachal Pradesh, have solved this problem by regularly making medical officers in charge Class I officials in contrast to their Class II colleagues. A related concern is authority of medical officers with respect to colleagues from other agencies. In Himachal Pradesh and Punjab, medical officers in charge of primary health centers have drawing and disbursing authority and control over personnel administration of paramedical staff, while in other states those decisions are reserved to other agencies (like the Taluka Development Officer in Gujarat). This reservation is quite frustrating to many medical officers in charge.

Recommendation 4. Turnover of medical officers from isolated rural posts can be reduced by:

- creating additional physical facilities at the health centers.
- providing financial and promotional incentives for continuing in isolated area postings.
- preparing future medical officers to manage primary health centers and to work effectively in communities through training before and during service.
- removing organizational constraints that block medical officer status and recognition.
- providing active and regular support by district and state level officials.

Field staff performance is also affected by the characteristics of their organizational context.

Problem 5: System rewards and human resource development patterns do not encourage innovation or motivation to perform.

Organizations predominantly concerned with insuring reliable and predictable response to recurring problems are required to develop standardized procedures and to regulate innovation and experiment. Organizations charged with solving novel problems and developing new approaches to complex and not clearly understood dilemmas, like time bound projects concerned with implementing untried development tasks, must make every effort to

reduce bureaucratization and routinization. High motivation and innovative thinking are, therefore, unlikely in an organization which is presently characterized by occupational plateaus for paramedical staff; lack of clarity about career ladders and lack of knowledge of job content and performance expectations for medical officers, and more rewards for compliance and conformity than for innovation.

High performance and innovation by paramedical staff may be encouraged by clear links to promotion and development opportunities. *Promotional training sequences* can be developed that allow ambitious individuals to upgrade themselves, as in the promotional training course that makes female HA's out of MPW's in most states. Many cadres of paramedical staff have been created with varying career growth opportunities. Lack of promotional avenues for Mass Education and Information Officers, Block Extension Educators, and female HA's are illustrations of this problem. Career ladders and interdepartmental transfer procedures can be developed that encourage staff from the medical side to get rural, public health experience and vice versa, to the eventual benefit of both medical and primary health services. In most states (except Gujarat), it was possible to move laterally across medical services and primary health care, to the benefit of both. The separation of rural health services and urban medical services has created a disincentive for medical staff to take rural posts in Gujarat, since they are then locked in to rural service for ever. It may be desirable to clearly specify and enforce sequences of urban and rural posts in medical careers. Similarly, within Zila Parishad cadres, it may be possible to have cross-functional moves that stimulate employee development and create more broad-gauged human resources for the future.

Medical staff motivation and performance might benefit from *clearer definitions of career tracks* and the kinds of skills expected of those who progress up them. Opportunities for development can be identified and tied to performance in critical tasks. Opportunities for postgraduate training in Himachal Pradesh and Maharashtra; honoraria for extra teaching assignments in Himachal Pradesh, and chances of outside consultancies for senior staff in Maharashtra are all examples of incentives for high performance and innovation. More generally, it is possible to specify the credentials, experience, training, and performance expectations prerequisite to promotion, and such information can enable potential applicants to evaluate their chances more realistically, and so understand the processes by

which promotions are conferred. It should be clear from this that the more promotions in fact deviate from publicly recognized criteria, the more disillusioned the crew and the people of the boat. One Secretary of Health emphasized the importance of seeming fair as a determinant of the legitimacy of authority.

Some state Departments of Health showed signs of much innovation, while others seemed relatively conservative about organizational changes. Some leaders emphasized *structures that reward and encourage innovation*, such as suggestion systems that explicitly call for and reward innovations, regular demands for assessing future problems and designing creative responses to them, and norms of fairness for rewarding new ideas. Others emphasized *informal processes that encourage innovation*, such as calling on junior staff for ideas before they are intimidated by the ideas of senior staff, systematically encouraging all ideas in the belief that there are ten bad ideas for every good one, and generally tolerating the disruption and tension implicit in generating new ideas and perspectives.

Recommendation 5. Field staff motivation to perform and innovate can be enhanced by:

- clarifying job content and performance expectations of field staff.
- clarifying career tracks to ensure avenues for growth and promotion for staff of different categories.
- increasing opportunities for development, learning, and growth of staff and linking those opportunities to performance.
- creating non-financial incentives to perform and innovate.
- building an organizational climate that promotes performance and innovation through leadership at the higher levels.

III. PROJECT MANAGEMENT STAFF AS HUMAN RESOURCES

The project management staff are charged with planning, implementing and evaluating project activities to accelerate the implementation of the Model Health Plan in Project areas. These staff members do not provide health services directly to the people in project areas, but rather are resources for the rapid and effective accomplishment of project objectives. Their rôles are much less clearly defined and familiar to state and central government officials, since they represent an innovation

from past practice.

A. Project Management Staff as Human Resources

The Project Paper focused on two purposes to be accomplished by the project: (1) improved access to health services as a consequence of the availability of more physical and human resources, and (2) improved and expanded services and support systems. We have discussed the first purpose in the previous section. The expansion and improvement of services and support systems was expected to result from an expansion of training activity, improved communications capacities, construction of improved service facilities, and improved and expanded management support. An important contribution to these improvements and expansions was expected from Project management staff at the state and district levels.

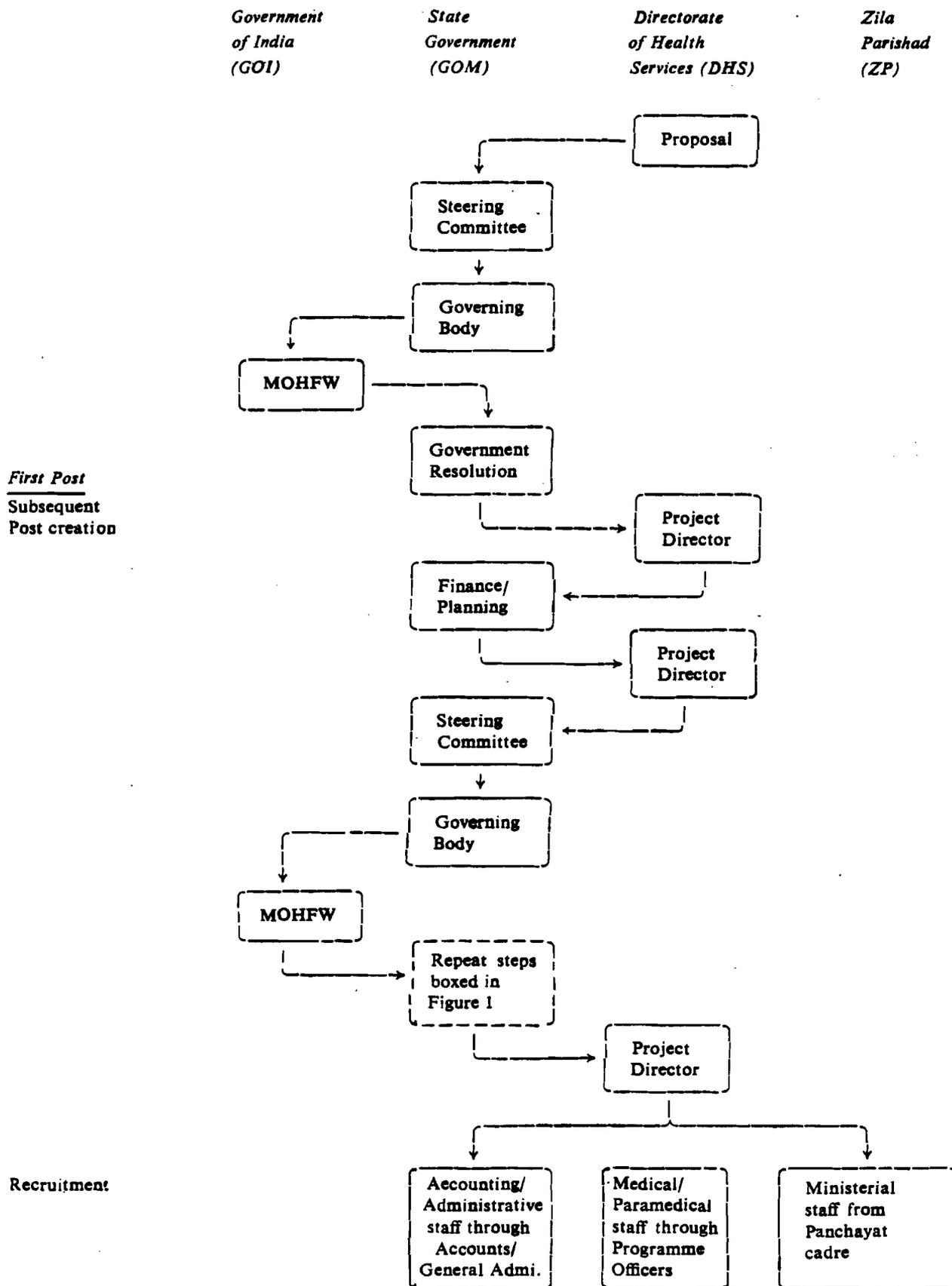
At the state level, the Project was expected to be staffed by a Project Director (Special or Joint Secretary level, though the states decided to have joint or deputy director) and a Project staff that would include a Planning and Implementation Cell, a Construction Cell and a Research and Evaluation Cell. A Project Governing Board, chaired by the State Chief Secretary, was expected to meet quarterly to review progress and approve future plan. At the district level, Project activities were to be supervised by the Chief District Medical Officer and Project staff of a Planning and Implementation Cell, a Construction Cell, a Research and Evaluation Cell, and a Communications Cell. The District Advisory Board was to be chaired by the District Collector, who is responsible for coordinating all district development activities.

Job definitions for the project management staff were not specified in detail at the outset. It was expected the states would evolve their own staffing pattern and job descriptions to perform these functions as they will be the ones creating these jobs. It was not clear at the outset how such staff might best be employed. It was hoped that each state would tailor its project management resources to fit local project demands. But in each state it was expected that the project management staff would play an important role in planning, implementing, and evaluating efforts to expand and improve services offered in the project districts.

B. Existing Procedures for Creating and Filling Project Management Posts

As implementation of the IRHP began in the states, the creation of project management posts

Figure 2. Procedure for Creating and Filling Project Management Posts



was one of the first tasks. As suggested in the Project Paper, all the states created Steering Committees and Governing Bodies. The former were headed by the Secretary of Health and composed of Directorate officials and Deputy Secretaries from various departments in the state government. The latter were headed by the Chief Secretary and composed of Secretaries to various Departments in the state government. In some cases, such as Haryana and Himachal Pradesh, the Governing Body is headed by the Health Minister.

The creation of project posts was a two-step (or multi-step) process in all the states. Figure 2 shows schematically the procedure for creating and filling project posts and the different parties involved. In Maharashtra, for which the schematic is drawn, the Joint Director (Planning, Development, and Evaluation) prepared, with the Director of Health Services, the initial proposal for new posts of Project Coordinator and some support staff, which then went through the Steering Committee and Governing Body. It was then referred to the central MOHFW for concurrence. After that the Secretary of Health issued a Government Resolution creating the post of Project Coordinator (Project Director in other states).

Subsequent post creation is initiated by the Project Director, first seeking approval of the Departments of Finance and Planning, and then going to the Steering Committee and the Governing Body. Proposals are then referred to the MOHFW for concurrence and subsequently follow the steps shown in the dotted box in Figure 1. After new posts are created, the Project Director does the recruitment for medical and paramedical technical staff with the help of Programme Officers. Accounting and administrative staff are recruited from existing cadres of the Accounts and General Administration Department. The ministerial staff at district level are recruited from Zila Parishad cadres.

While these staff are attached to the project, their personnel records are maintained by their parent departments. Transfers and promotion decisions are carried out by those parent departments.

C. Current Project Management Staffing Status

Have project management posts been created and filled as expected in the Project Paper? It was initially expected that the project management posts would be created and staff would be selected and oriented by the end of the first year of the project, so that they could move ahead with their tasks of project planning, implementation, and evaluation.

Table 3 presents the status of project management staff in the five states at the time of our visit in June, 1983. There is considerable diversity across states in the extent to which project management positions have been created and filled, and in the level of staff proposed and recruited to fill project posts.

Gujarat has come closer than most other states to creating the positions originally envisioned in the Project Paper. The state has delegated the task of the construction cell to the Zila Panchayat, though it has obtained two engineers on deputation at the district level to supervise the construction. The state has also supplemented the original staff with an Information, Education and Communication (IEC) officer and a Nursing Supervisor at the state level. Although Gujarat has created the most posts similar to the original proposal, many of them remain vacant or have been filled with relatively low level staff members in comparison to some other states.

Maharashtra has proposed, but not yet approved, a project management staff in many ways similar to that envisioned in the Project Paper. Like most other states, it has delegated construction activities to the PWD, and used existing staff for IEC activities at the district level. It has experimented with creating the post of one Circle Deputy Director to oversee activities in all project districts and posts of Assistant District Health Officer to help with Project planning and implementation in the districts. Maharashtra has been most ambitious in proposing posts for high level (e.g., Class I) staff, though many of those posts have not yet been approved or filled.

Haryana has created posts and recruited staff for project director, planning and implementation, and research and evaluation at the state level. But the state has largely relied on existing staff and delegation to the PWD to support the activities of Project Officers at the district level. On the whole, the state has recruited fewer and less senior project management officers than the first two states.

Himachal Pradesh has relied on existing staff for planning and implementation and on the PWD for construction at the state level, but created and proposed a variety of new posts for research and evaluation, including two Assistant Directors of Statistics and Demography in addition to a Research Officer. They have also proposed state level posts for two Coordinators, a Management Consultant, and an Executive Engineer. At the district level, Himachal Pradesh has largely relied on a Project Officer, existing staff, and delegation to the PWD.

Table 3

Project Management Staffing Status

	Gujarat	Maharashtra	Haryana	Himachal Pradesh	Punjab
<i>State Level</i>					
Project Director	Dy Dir (I)	Jt Dir (I)	Add Dir (I)	Dy Dir (I)*	Jt Dir (I)
Planning/Implement'n	Plng Off (II)	Plng Off (I)	Plng Off (II)	Existing Staff	Existing Staff
Research/Evaluation	Dy Dir (I)* Res O (II) Res Asst (III) 2 Stat Asst (III)	Sr Res O (I)** Jr Res O (I)** Stat O (II)***	Dy Dir (I) 2 Stat Asst (III)	Asst Dir Stat (I)* Asst Dir Demog (I)** Res O (II)** Stat Asst (III) 2 Stat Asst (III)**	Search O (I) Stat Asst (II)
Construction	Delegated to Panchayat	Delegated to PWD	Delegated to PWD	Delegated to PWD	Delegated to PWD
Other	IEC Off (I)* Nurse Sup (I)	Circle Dy Dir (I)**		Mgt Consult** 2 Coord'rs** Exec Eng**	IEC Off (I)*
<i>District Level</i>					
Project Officer	Asst Dir (I)	DHO (I) Asst DHO (I)**	D Proj O (I)	D Proj O (I)	D Proj O (I)
Planning/Implement'n	Res Asst (III)* Stat Asst (III)*	Asst DHO (I)*	None	None	None
Research/Evaluation	Res O (II)* Stat Asst (III)*	Res O (II)** Stat Asst (III)**	Stat Asst (III)	State Asst (III)	Stat Asst (II)
Information/Education/Communication	Coord'r (III)*	Existing Staff	Existing Staff	Existing Staff	Existing Staff
Construction	Dy Eng (II) Jr Eng (II)	Delegated to PWD	Delegated to PWD	Delegated to PWD	Delegated to PWD

* means vacant in one or more districts and state levels.

** means proposed but not yet approved.

N.B. Roman numerals refer to Class I to IV employee post requires.

Punjab has created and filled state level Project director, IEC Officer, and research and evaluation posts, but otherwise employed existing staff or delegated work to the PWD. At the district level, Punjab has relied on Project Officers in cooperation with existing staff. It has thus created much fewer posts in comparison to other states, like Haryana.

There are major differences in project management staffing across states. Thus, eleven posts, out of fiftyseven total posts created for these functions, were vacant in June 1983. The variations in project

management staffing can be seen from the fact that Gujarat has created 23 posts while Haryana only 11. How can the differences in project staff quantity and quality between Gujarat and Maharashtra, on the one hand, and Punjab, Himachal Pradesh and Haryana, on the other, be explained? Part of the differences may be in the financial resources available. Project staff in some of the latter states observed that they lacked the financial resources to create and fill the posts for all functions proposed by the Project Paper. The budgets

Table 4
Financial Base for Supporting Project Management Staff

	<i>Gujarat</i>	<i>Maharashtra</i>	<i>Haryana</i>	<i>Himachal Pradesh</i>	<i>Punjab</i>	<i>Total</i>
Total Budget (Rs 000's)	118,536	133,024	77,384	110,040	78,976	517,960
Construction Budget	56,680	64,036	34,266	59,972	62,063	277,017
Difference	61,856	68,988	43,118	50,068	16,913	240,943
Project Staff Budget (7% of Difference)	4,330	4,829	3,018	3,550	1,184	16,911
Districts Served	2	3*	3	3	3	
Project Staff budget/district	2,165	1,610	1,006	1,183	395	

* Initially two and subsequently expanded to three districts on bifurcation of one district.
Source : The Project Paper.

proposed by the Project limit the financial resources available for project management to seven per cent of the non-construction costs of the project in the state. Table 4 presents some of the financial data needed to understand this limitation.

The first three rows of Table 4 presents total budgets, construction budgets, and their differences for each state based on figures from the original project paper and annexes. The difference (total budget minus construction costs) varies considerably across states, and so does the amount available for project management staff. Gujarat and Maharashtra have roughly four times project management budget of Punjab.

The difference between state budgets for project management staff support is even more extreme when the number of districts to be served is considered. More districts require more staff at the district level, and more travel by state level staff. When project staff budgets are divided by districts served, Gujarat and Maharashtra have many times the budgets of the other three states. (Gujarat has double the budget of Haryana and Himachal Pradesh and five times that of Punjab).

It appears that GOI had earlier approved approximately equal budgets for all the five states for project management. However, the continued insistence on seven per cent ceiling creates wide disparity across states as shown above.

Some problems associated with creating and staffing the project management roles will be discussed below. The point of this analysis is that the states vary widely in the quantity and quality of posts created, and the financial resources available to support those posts. If indeed state capacity to

improve and expand services and support systems depends on their project management staff, then we would expect the states to exhibit quite different abilities to live up to that goal of the project in the present situation.

D. Project Staffing Problems and Innovations

Discussions with project staff in all five states indicated that some problems tended to recur in many different settings. In this section we will analyse problems found in many states and some of the innovations developed to deal with them as well as make some suggestions about future problem-solving activity.

Problem 1. Ambiguity about the functions and future of project management staff roles has slowed the creation and staffing of project posts.

The functions of project management staff—implementation, evaluation, communication, and so on—are not as well understood as the services offered by field staff—medical officers, health assistants, multipurpose workers. It is clear to state and central government officials how services of field staff will be used at present and in the future. It is much less clear how project management staff can be usefully employed in the project, let alone after the project is over. So project posts have remained undefined when officials did not understand the potential role of project management staff as facilitators of the accelerated implementation and improvement of Model Health Plan services, and posts creation and staffing may be delayed when officials are concerned about the

employment of project management staff after the project is over.

One constructive response to the ambiguity about project roles and functions has been to *clarify job definitions* of critical project roles. In some cases, states have taken the responsibility for filling in the broadly defined roles specified in the Project Paper: Gujarat has filled in many of the proposed cells with staff that meet their particular needs. Some states have used project resources to propose roles specifically adapted to their needs: Himachal Pradesh has proposed such posts as Asst. Director of Demography, Management Consultant, and Coordinators for their project management staff. Other states have worked closely with the GOI or USAID to develop appropriate role definitions: USAID staff worked closely with Maharashtra officials to develop the functions and role definitions required for their Research and Evaluation Cell (although the cell was subsequently not approved by the State Governing Board).

Linked to clearer definitions of project management staff roles is the need for *strategic planning* to clarify their future roles. Some states are carefully recruiting only project management staff that can be easily integrated with future manpower needs: Himachal Pradesh, for example, has hired no one for project management staff who does not fit into their long-term needs. Other states may be helped to foresee a continuing need for project management staff with skills for implementing organizational changes: states may consider to use the project management staff for accelerating Model Health plan implementation in other districts after the Project is over. States may consider using special procedures to manage questions about long-term roles of project staff: project-term appointments for special staff.

But all the Project problems which the staff will have to manage cannot be predicted in advance, so there is inevitably some continuing ambiguity about the roles and functions of project management staff. Resolving new ambiguities may require *continuing dialogue* among relevant parties to analyze new demands and allocate new responsibilities.

In some states (e.g., Baruch district in Gujarat has had 3 project officers in last year; only two of the original project directors are still in place) turnover in project staff has created ambiguity by placing individuals without project background in key roles. Close contact for new staff with GOI and USAID officials who understand project

demands and making project related documents available immediately can reduce the ambiguity caused by such transitions. Continuing assessment of project needs and staff roles by various state officials can also help to resolve ambiguities: regular meetings of Secretariat and Directorate officials in Maharashtra reduce the time required to make project related decisions, and regularly scheduled meetings of the Steering Committees and Governing Boards can also reduce delays created by novel problems.

Recommendation 1. Delays caused by ambiguities about functions and futures of project staff can be reduced by :

- clarifying project role definitions through state initiatives, GOI specifications, or USAID consultation.
- undertaking strategic manpower planning that defines future roles for project management staff.
- continuing dialogue among relevant parties to educate new staff and resolve new ambiguities about staff functions and requirements.
- evolving a project management manual that outlines operating requirements and steps to reduce initial floundering.

Delays in creating and filling project posts have also been due to other factors as well.

Problem 2. Structural and procedural factors have constrained the creation and filling of project management posts.

The procedures by which new posts, such as project management staff, are created and filled often occasion some delay. At each step of the approval process within the state and central government hierarchies, project posts receive the special attention (and consequent delays) accorded to novel proposals. In some circumstance, the addition of Governing Bodies and Steering Committees to the approval process extends, rather than shortens, the decision-making chain and the time required for approval. In other situations, lack of clarity about who (central and/or state government) should design project staff roles leads to confusion and delays. Delays are further compounded by difficulties in finding staff qualified and willing to take on posts that have little precedent.

Since the Secretariat is heavily involved in creating and filling project management staff posts, some states experience overburdening of existing deputy secretaries with the addition of project res-

possibilities. In Maharashtra, the bifurcation of a Department produced a separate Health Department and added to other problems in post creation. But the state used this opportunity to create an additional post of deputy secretary to deal with the Project.

Streamlined approval procedures can sometimes facilitate timely creation and filling of project management posts. Steering Committees and Governing Bodies were created to bring together representatives of all relevant departments for rapid decision-making about project matters, but sometimes further innovations are necessary to realize that potential: several states are considering experimenting with subcommittees of the Governing Bodies charged with making recommendations on specific matters, such as post creation, where small groups are more efficient than the body as a whole. Other states are considering regular and frequent Steering Committee/Governing Body meetings even when all parties cannot be present as a way of reducing delays. This has been an important issue in states that have Health Ministers heading the Governing bodies. While the Ministerial presence ensures enhanced support to the Project, it also entails difficulties in holding timely meetings because of the Minister's busy schedule.

Delays can also be reduced by *clearer understandings about authority to approve new posts*. In Maharashtra project officials pointed out that state and central governments each thought the other was responsible for approving the creation of new posts and that delays were reduced by ironing out the misunderstanding. In Punjab, on the other hand, delays occurred when state proposed posts were questioned by central authorities because they were different from those proposed by other states.

Having created the posts, existing structures and procedures can be used creatively or new structures can be invented to recruit project staff. Many states reported using *ad hoc* appointments to recruit qualified staff in the short term so that they could be on the job while the formal selection process ran its course. States can consider creating attractive short-term contracts for functions for which trained cadre are not available in the state to bring in high quality staff without long term security. Punjab and Himachal Pradesh have placed senior officers in project management posts, and subsequently promoted them to higher posts. Those promotions help to integrate the Project into the larger health services and signals potential project staff that performance in roject posts will be rewarded.

Many project management staff reported *lack of*

incentives to join project posts. There is no additional financial incentive, unlike the deputation allowance available when posted to a state public enterprise. Other non-financial incentives are neither clearly visible nor explicitly specified. In addition, the ambiguous and temporary nature of the project posts becomes a disincentive. It is consequently difficult to attract highly competent persons to these posts from other departments and agencies. Even other project staff, such as accountants and administrative officers, are recruited to project posts without specifying or assessing special qualifications and/or expertise needed for effective project performance. Thus retaining staff in the project to provide essential continuity becomes problematic.

Recommendation 2. Structural and procedural steps can be clarified and simplified to reduce delays in creating and filling project management posts by:

- clarifying the role and delineating authority of Steering Committees/Governing Bodies in the decision-making process.
- holding regular and frequent Steering Committee/ Governing Body meetings, subcommittees, and other innovations that streamline the decision process.
- clarification of responsibility in project management staffing between state and central government.
- procedural shortcuts and innovations that make project management posts more attractive to highly qualified candidates.

State officials also suggested that the capacity of project management staff to accomplish project goals was related to other factors.

Problem 3. Project staff performance is limited by the availability of financial, official, and educational support.

The speed with which project management posts have been created and staffed, and the extent to which project managers have been able to carry out their responsibilities has been closely linked to the financial resources available, the support of senior officials, and the skills and knowledge of the project officials themselves.

Financial resources for project management staff are, as indicated earlier, unevenly distributed among the states. In states with relatively small amounts to support project staff such as Punjab, financial constraints have severely limited the creation and filling of project management posts.

Many states have stretched limited funds by redefining the jobs of existing staff to include project activities, or by delegating activities to other departments, such as Public Works Departments, that have relevant human resources already on hand (though PWD charges fees or requests additional staff at project expense).

Project officials report that *active support from senior levels* of the government has been critically important for many project activities. Himachal Pradesh benefitted from strong support from upper levels of the state hierarchy in rapid implementation of construction goals. Interest on the part of GOI officials would also be encouraging to project staff: Many state officials expressed the wish for more contact with central government staff on project matters.

Many project management staff have *insufficient formal training or previous experience* that is immediately relevant to their responsibilities in the project. In part this problem can be solved by recruiting officers with experience in project in other settings. Many state Project Directors, for example, bring a wealth of relevant experience to their roles, but more junior staff felt unclear about how they could best carry out their duties. Project management staff can benefit from workshops or training tailored to project demands for planning and implementation, or research and evaluation.

Recommendation 3. Project management staff performance can be enhanced by changes that increase critical sources of support:

- Financial resources tailored to the manpower and travel demands of project characteristics within each state.
- Active support for project activities and staff performance from senior officials of state and central government.
- Staff selection, training and development activities that emphasize preparation for the demands of project management.

Finally, resources for project management staff must be complemented with linkages to other agencies or levels of the hierarchy whose cooperation is critical to effective implementation of project activities.

Problem 4. Project staff performance is limited by the quality of linkages and coordination mechanisms among project staff and many other parties (e.g. GOI, USAID, state directorates and secretariats, other ministries).

The IRHP Project requires project management staff to depend on the cooperation of representatives of many other agencies—other levels and departments in the state, other ministries, the central government, USAID. Further, the project staff often have little or no formal authority over those representatives. So *coordination mechanisms and personal negotiation skills* become vital to accomplishing project tasks.

Many state officials commented on ineffective coordination between directorates and secretariats within the same state resulting in misplaced files, duplicated information, and long delays in decision-making. Maharashtra and Himachal Pradesh have replaced duplicate files in both secretariat and directorate with a single file that contains more information. One Secretary of Health instituted regular meetings between senior Secretariat and Directorate officials to promote more rapid and flexible decision-making. In many cases, geographical separations make coordination more complicated: In most states, directorates and secretariats are in separate buildings, and in Maharashtra some departments are actually located in different cities, so that travel and telephones become critical to coordination.

Although the goal of primary health care implies the importance of coordinating activities and policies across a number of agencies offering services at and below the district level, "intersectoral collaboration" continues to be difficult. In Gujarat and Maharashtra, Zila Panchayats play an integrative role at the district level. But developing close cooperation at the district level continues to be a challenge, particularly where there is confusion or contention about the distribution of resources and authority between the agencies. Clarification of roles and the development of common goals that require *joint action* are prerequisites for more multi-agency cooperation.

The GOI plays a potentially important role as a coordination agency, a technical resource and an information source. But those roles are best served if officials from the center can visit state projects, and vice versa, so that a continuing interchange between center and states takes place. State officials in Punjab, Himachal Pradesh, and Haryana were clearly interested in opportunities to discuss main concerns with our colleague from the Ministry of Health and Family Welfare. Resources to encourage more statewide travel for senior Ministry personnel might enable better *central-state coordination*.

GOI/state Project staff are now making efforts to

implement and evaluate the IRHP Project in five states with the support of USAID, and in many other states with funds from different sources. These Projects represent a wealth of experience in efforts to accelerate the development of the Model Health Plan that can be tapped by the right coordination mechanisms. *Workshops and conferences* that bring together staff from several projects, or that enable staff members to visit other projects, can be rich sources of new ideas and activities when participants return home.

The project from one point of view is itself an experiment—a pilot project in accelerating the development of some districts whose successes can hopefully be repeated in other districts in the future. USAID can play an important role in supporting and encouraging *consultations that solve problems, particularly those defined by project staff*. The GOI/USAID Annual Review (1982) Report was recognized by many project officials as an important stimulus to new efforts in their states. Assessments of management needs, training needs, and communication needs are all likely to influence future activities. USAID staff have helped create budget workplans in many states, and helped design the research and evaluation cell of Maharashtra's project management staff.

Recommendation 4. Linkage mechanisms can be created to promote better coordination and more shared learning from project staff experience, such as:

- structures and procedures that improve coordination between secretariat and directorate.
- mechanisms that encourage coordination with other agencies at the district level.
- mechanisms that enhance communications with central government.
- mechanisms that enable more sharing of problems and innovations across project districts.
- strengthening of technical resources of MOHFW's Area Project Cell to facilitate technical support to the state.
- increased use of project and USAID resources to secure required technical information and expertise to meet local needs.

IV. DISCUSSION

This Report so far has described the existing systems and procedures for establishing and administering field and project posts associated with

the IRHP. It has identified and analysed problems in different states, and innovations designed to deal with those problems. We have tried to capture the implications of those innovations in recommendations general enough to be applicable to many different state situations, but specific and concrete enough to give real guidance for improving the development and use of human resources in the IRHP.

In this section we will discuss in more general terms our assessment of the state of human resource management in the IRHP, and some implications of that assessment for future research and action. We will first consider the field staff and its prospects; then we will comment on the roles and potentials of the project management staff; finally we will look at the IRHP in more general terms, suggesting several conceptions of the Project and their implications.

A. Field Staff Problems and Prospects

Our discussion of the field staff will focus on the problems of recruitment, training, retention, and development. These problems have different characteristics, but they all need to be solved if the Model Health Plan is to provide effective primary health care at district levels and below.

The IRHP Project appears to have made substantial progress in the *recruitment and training* of medical and paramedical staff required to provide broader access to primary health care in rural areas. Pockets of staff shortage remain, notably in female multipurpose workers and health assistants. But training facilities are now in place or planned that will provide sufficient trained staff to fill most posts by the end of the project. Although there are needs for increased training resources in some states, such as Himachal Pradesh, capacity exists now in most states to fill field staff vacancies.

The problem of *retaining personnel in isolated rural settings* has generated considerable innovation, but it is our impression that retention problems will continue to plague some rural locations. Many innovations, some of them quite successful, have been tried to increase retention of medical officers in rural areas and their impact must be researched to assess replicability to other areas. The use of innovative development and reward systems, in particular, we think will help to solve such problems, particularly as medical schools continue to produce more trained doctors than urban private practice can absorb. Innovations in medical education that prepare medical officers to be effective community

practitioners will simultaneously improve primary health care and enhance the professional effectiveness and satisfaction of medical officers in rural areas.

The problem of retaining female staff in unfamiliar rural areas is a difficult one, in which social and cultural factors play a larger role than the technical issues of medical competence. While all states are experimenting with solutions to the problems of female satisfaction and security in rural settings, we believe that much more needs to be understood about the nature of the problems faced by female staff workers and the conditions under which such workers can operate effectively. We recommend that further research into such problems, and particularly into the social conditions and personal characteristics associated with female worker success in rural settings, be carried out.

Field staff *development* in terms of upgraded skills and improved motivation is crucial to the improvement of services and systems envisioned by the project. Understandably, more attention has been paid in the first years of the project to recruiting and initial training for field staff. But we recommend that further attention be devoted to in-service training; manpower and career planning, performance appraisal and promotion systems, and variety of other activities designed to enhance the skills, motivation and performance of field staff. Activities are already in process relevant to field staff development, such as the training needs assessment but more concerted attention needs to be paid to this area. We think the future development of field staff will require continued and increased attention from state officials, GOI officials, and USAID consultants if the potentials of the project for improved services are to be realized.

B. Project Management Staff Roles and Potentials

The functions and roles defined for the project staff in the Project paper were intentionally broad to encourage designing staff roles to fit local needs in the different states. Some states have taken advantage of that opportunity; others, for various reasons, have not.

The project management staff can be designed by a variety of concepts that define its general role. What might be called the *minimal model* conceives the project staff as a necessary evil for accelerating the implementation of the Model Plan. Such a view calls for a project staff that is similar to other Directorate staff, and absorbed at the end of the

Project. From this perspective the delegation of project work to other departments, particularly when it calls for unfamiliar expertise, is highly desirable.

A second conception of the project management staff can be called the *project model*, as implied in the Project Paper. This conception holds that upgrading the services and systems of the primary health services, and effective monitoring and analysis of project experience, requires special resources and expertise some of which may be new to the Directorate of Health Services, in particular, or even to the health field, in general. These new staff resources are necessary for effective project implementation, and they may turn out to be useful to the DHS even after the project is over.

A third conception of the project staff, a step beyond that articulated in the Project Paper, can be labelled the *change agent model*. This view is based on the belief that health service organizations, like other agencies operating in turbulent and rapidly-changing environments, need internal resources for renewal and adaptive change to meet new challenges. The project management staff can be used as the nucleus for developing organizational resources for planned organizational change and adaptation in the future. The changes introduced in project for other districts will probably have immediate implications for which the services of experienced project management staff will be useful. In the long term, social and economic changes in Indian society and states will continue to present challenges to health services for which internal resources for problem solving and facilitating planned change will be valuable. The change agent conception of the project staff implies that project staffing decisions should be embedded in a strategic perspective that focuses on challenges expected beyond project period.

We do not necessarily advocate any one of these models. We *do* believe that states should choose explicitly a model consistent with their present and future needs. Those choices can then serve as the basis, after discussions with the GOI and USAID, for defining project posts, clarifying the nature of needed project staff, allocating financial resources, training and developing staff, and designing appropriate organizational mechanisms and linkages between project staff and other agencies. Without such explicit choices, states may lose an opportunity to create internal resources of great future value. But it is critical that serious and urgent attention is paid to it.

C. The IRHP Project: Multiple Perspectives

The IRHP Project can be analyzed from several perspectives, some explicit in its planning and others implicit in its operation. Different perspectives direct attention to quite different purpose, means, and outputs. The Project Paper articulates one such perspective, emphasizing the opportunity offered by the Project to *accelerate the implementation of the Model Health Plan* in project districts. This perspective focuses on constructing new facilities, training new personnel, and improving support systems and services as means to the ends of decreasing the crude birth rate and child and infant mortality rates.

Accelerating the Model Health Plan to improve primary health care is a highly desirable goal. But the IRHP project also presents opportunities for accomplishing other goals at the same time. It is often useful to examine projects from other perspectives that may reveal unintended effects—desirable or otherwise—of its implementation. We think that the IRHP offers several kinds of opportunities in addition to those for which it has been explicitly designed and implemented.

For example, the Project can be examined as an opportunity to *develop human resources*. From this perspective, critical Project activities include creating training centers to produce field staff, manpower planning and development systems to recruit, motivate and promote effective workers, and developing new roles and posts to serve future organizational needs. Tests of Project effectiveness, from the human resource development perspective, include increases in staff motivation, skill, rates of internal promotion; expansion of critical functions served by field and project staffs; and expanded capacity to develop human resources in the future through recruitment, training, and promotion. If the Project succeeds as a human resource development activity, that increased capacity will shape the availability and quality of human resources available for years to come.

A second perspective focuses on the Project

as an opportunity for *organization development*, for more effective problem-solving, more efficient use of available resources, and more innovative response to challenges from a changing external context. Critical Project activities from this perspective include building systems and procedures for identifying and diagnosing organizational problems, creating resources for problem solving and innovation, and developing climates and management skills for rapid and flexible response to novel situations. The test for success from the organization development perspective is early identification of potential problems, rich analysis and innovative solutions to those problems, and low-cost, flexible implementation of those innovations. Although the Project itself offers many opportunities for developing and practicing such organizational capacities, the real results of successful organization development during the Project will probably not be visible until after the Project period because such capacities ordinarily are developed over years of experimentation, climate building, and human resource development.

A third alternative examines the Project as an opportunity for *national (and international) learning* about the potentials and pitfalls of development. Critical activities from this vantage point would include bringing together officials from different states, the GOI, and USAID to discuss common problems and stimulate further innovations and experiments, or conferences that compare the successes and failures of states working with different international agencies. Information processing activities are central: collecting good data about project experience, close analysis and comparison, and conceptual integration that promote more general understanding. From the learning perspective, desirable outputs include better understanding of project management and organization, new strategies and tactics for project implementation, and enhanced individual, organizational, and national ability to learn from complex experience in the future.

Appendix A

Officials Interviewed

Government of Gujarat

Mrs. R.M. Schroff (IAS), Additional Chief Secretary of Health and Water Supply
Mrs. G. Kumar (IAS), Deputy Secretary of Health
Mr. C.J. Josh (IAS), Deputy Secretary of Medical Education
Dr. P.C. Shah, Deputy Director of Health Services (Nutrition), previously USAID Project Director
Dr. R.D. Kachhia, Deputy Director, USAID Project Director
Dr. A. Contractor, Deputy Director,
Mr. S.R. Rao (IAS), District Development Officer, Baruch district
Dr. M.H. Goswami, District Health Officer, Panch Mahal
Dr. S.L. Soneji, District Health Officer, Baruch
Dr. J.B. Shah, Assistant Project Director, Baruch
Mr. D.C. Parman, Research Officer, USAID Project, Baruch
Dr. V.K. Mahajan, Medical Officer in Charge, Haldar Primary Health Centre, Baruch
Dr. D.K. Vassava, Medical Officer, Family Welfare, Haldar PHC
Dr. A.B. Joshi, Ayurvedic Medical Officer (CHV), Haldar PHC
Ms. Usha Panja, LHV, Haldar PHC
Ms. Narmada Ben, ANM, Haldar PHC
Mr. H.K. Shah, Administrative Officer USAID Project
Mr. R.M. Shah, Research/Evaluation Officer, USAID Project
Mr. V.N. Desai, Planning Officer, USAID Project
Mr. C.M. Shah, Accounts Officer, Establishment, DHS
Ms. Patel, Nursing Supervisor, USAID Project

Government of Maharashtra

Mr. V. Srinivasan (IAS), Secretary of Public Health
Dr. (Mrs.) M.R. Chandrakapure, Director of Health Services
Mr. S.S. Vartak (IAS), Deputy Secretary of Health
Dr. S.M. Bhadkamkar, Joint Director (Medical)
Dr. G.D. Pandse, Joint Director (Planning, Development and Evaluation)
Dr. Lohokare, Deputy Director (Nursing)
Dr. Bhate, Joint Director (Rural Health Services)
Dr. P.B. Khedekar, USAID Project Planning Officer
Mr. Ghambir, USAID Project Administrative Officer
Mr. Rajput, Sr Audit Officer, USAID Project
Mr. Sudame, Chief Administrative Officer, DHS
Dr. Vasudev Mule, Deputy Director (Family Welfare), Pune
Dr. Dama, Deputy Director (Family Welfare), Pune
Mr. Nalwade, Administrative Officer, J.D (Rural Health) office, Pune

Government of Haryana

Mr. R.P. Dubey, Secretary of Health
Dr. G.D. Sharma, Director of Health Services (Hospitals)
Dr. A.C. Jain, Additional Director, USAID Project Director
Dr. (Mrs.) Mehta, Joint Director (Family Welfare and MCH)

Dr. K.L. Sikka, Joint Director (Malaria)
Dr. Aggarwal, Chief Medical Officer, Kurukshetra District
Mr. J.P. Yadav, Deputy Director (Monitoring and Evaluation)
Mr. J.M. Sood, USAID Project Accounts Officer
Mr. V.P. Batra, USAID Project Senior Administrative Officer
Mr. Dharam Singh, USAID Project Planning Officer
Mr. Sabbarwal. —do—

Government of Himachal Pradesh

Mr. A.N. Vidyarthi (IAS), Secretary of Health
Dr. J.C. Sharma, Director of Health Services (ex USAID Project Director)
Dr. R.K. Sharma, Deputy Director of Health Services
Dr. D. Chauhan, Deputy Director (Administration) (designate USAID Project Director)
Dr. (Mrs.) Rama, Assistant Director (MCH)
Dr. J.K. Kakkar, Assistant Director (Malaria)
Dr. H. Singh, Principal, Health and Family Welfare Training Institute
Dr. S.S. Sood, Assistant Director (Rural Health)
Mr. R.K. Gupta, Statistician, USAID Project

Government of Punjab

Mr. C.D. Cheema (IAS), Secretary of Health
Mr. K.S. Raju, Joint Secretary of Health
Mr. B.L. Kapur,
Dr. A.S. Ahluwalia, Joint Director of Health and USAID Project Director
Dr. (Mrs.) J.K. Cheema, Assistant Director (MCH)
Dr. P.L. Kalra, Assistant Director (Planning)
Mr. Khanna, Deputy Director (Statistics)
Mr. H.S. Nirman, Information and Education Officer

Glossary of Terms

CHV :	Community Health Worker
CEO :	Chief Executive Officer of a Zila Parishad
Dai :	Traditional Birth Attendant
DHO :	District Health Officer
DHS :	Directorate of Health Services
GOI :	Government of India
GOM:	Government of Maharashtra
HA (M or F) :	Health Assistant (Male or Female)
MOHFW :	Ministry of Health and Family Welfare (Central Government)
MPW (M or F) :	Multipurpose Worker (Male or Female)
ZP :	Zila Parishad, district level elected self-government body.