Recommendations for Enhancing Skills & Service Delivery of Healthcare Workers (Draft)

1. RECRUITMENT & SELECTION PROCESS

- Well-defined HRH policy at State and District level.

State should formulate a well-defined HRH policy, which spells out strategies for meeting the estimated health human resource requirements over the five-year plan period, and longer, encouraging a mix of government and private sector institutions to create HRH as suited to the needs of public health care systems. The policy should also spell out initiatives/strategies for administrative reforms for HRH development and management, for recruiting and incentivizing staffs (both regular & contractual) working in remote & underserved areas and for management of performance linked with financial & non-financial incentives and their career pathways.

The transfer and placement policy should be one of the core components of the overall HRH policy. The in-service training policy, if not in place, has to be developed and integrated in the state HRH policy, which provides scope for periodic skill up-gradation options available for all its personnel through hierarchy of training institutions.

- District Cadre: Recruitment power of frontline HRH should ideally be with the district on laid down HRH policy.

There should be district cadre for certain frontline workers and HRH policy should spell out preferential selection of candidates for admissions, recruitment/deployment and skill building on the basis of their local background. Districts could thus have differing salaries and working terms of employment and promotional avenues. This is a must for all allied staff and much of nursing staff and even medical staff. The selection panel/committee formed in the District Health Society should conduct the recruitment of frontline workers as per state HRH policy.

- There should be an HR division in district (may be through an agency?)

A separate HRH cell should be established (as different from Establishment Cell, which is currently in place in most states) at the state level to oversee the HRH policy, planning and strategy development and get inputs from studies on HRH to inform policy from time-to-time and facilitate recruitment and workforce management in the department. A similar HRH division/department should be established at district level to look into the process of recruitment of frontline workers and management of workforce.

2. STANDARDIZATION OF TRAINING:

- Core competency and context specific additionalities in terms of knowledge and skills should be identified.

Certain thematic areas should be identified on the basis of core competency along with context specific/relevant additionalities in terms of knowledge, skill requirements for various training modules/curriculum so as to standardize the training curriculum as per requirements of certain personnel to perform those specific tasks/duties. Workforce is assessed for the gaps in competencies- and this is the main input into planning training programmes.
The technical working group of institutions/academia/training faculty of nodal agencies and other stakeholders should form a platform for development, revision and up-dation of training materials through assessment of training needs and through regular exchange with resource persons in the given domain.

- **Establishment of network of Training Institutions from state to district level training centers.**

Various training institutions from state upto block level, ideally (if feasible) should be established along with development/ revitalization of clinical/hospital/class-room based training sites. There should be a standardized process for accreditation of trainings under 4 levels - accreditation of training institutes, trainers, trainees and curriculum to be certified by CoE (Center of Excellence) which is the NIHFW and SIHFW and other training stakeholders. The SIHFW should be strengthened in terms of filling up the vacancy positions for faculty/other support staffs and infrastructural deficiencies so as to become a well functioning accredited/CoE and be able to oversee the certification/accreditation process of other district level training sites.

3. **DELIVERY OF TRAININGS:**

- **District hospitals and DTCs need to be strengthened in terms of having an accredited district training team having comprehensive (Infrastructure &HR) capacity to fulfill the needs of district.**

  Strengthening of existing /proposed district/Hospital training centers and DTCs in terms of having a full fledged accredited training teams /other support staffs for meeting various requirements along with strengthening of infrastructure (hard/soft) and other facilities are mandatory to oversee and fulfill the training requirements /needs of district. It could be taken up in an incremental approach with defined time frames for achievements of targets.

  Weaker districts (High Priority Districts) need external assistance for capacity building. In particular they need skilled human resources for their capacity development program, which cannot come from within the state - they need to be brought from the better performing states. An infusion of persons and organizations at a higher level of motivation and dynamism, with a mandate to break the inertia and create change would help reduce the problem and lead to the development of intra-district capacity - which includes the development of institutional structures, skills and enabling work processes and environment.

4. **PERFORMANCE APPRAISAL & INCENTIVE ISSUES:**

- **Performance appraisal on process indicators to be developed**

  Standardized system of performance appraisal should be developed and integrated in HRH policy on HRH performance management broadly. The basis of appraisal should be a “health care team approach”, with facility performance scores as the key. Within this there could be link for the individual performance, which could be referred to if the facility fails to perform, or itself wants to point out its individual non-performers. The output measured is service delivery volumes and quality. The individual performance in linked with certain process indicators, which contribute to the overall functionality of facility.

- **Post training evaluation by training institutions based on assessment of quality indicator ideally between 3-6 months post trainings.**
The post training /follow up evaluation should be conducted by identified training institutions between the period of 3-6 months after giving trainings on the basis of certain indicators developed. The post training evaluation should be conducted within the overall context of post training deployment (functionality of facility), prevailing support supervisory system and individual level on practicing learnt skills in delivering services.

5. **INNOVATIONS IN EDUCATIONAL STRATEGIES:**

- One of the measures to tackle the huge gap in human resource, in particular in the underserved and difficult-to-reach areas, is to devise educational strategies like the **3-year rural health care course** to select, train and deploy a mid-level care provider in the Sub Center, competent enough to provide public health services and primary health care at village level along with the first health worker - the ANM. The aim here should also be to admit only those students who are likely to serve in underservices areas and mold education to retain the commitment. States like Chhattisgarh and Assam have tried this initiative and met with success.

In Chhattisgarh, this unique one-time endeavor led to many PHCs, which had never over 50 long years ever been able to get a doctor, now had a qualified service provider (Rural Medical Practitioner), and for the first time the vacancies in PHCs were closed. Subsequent assessment revealed that their knowledge, skills and patient satisfaction were at par with MBBS doctor in delivering primary health care.

The 3-year Diploma in Medical and Rural Health Care (DMRCH) program in Assam till now, has seen more than 370 Rural Health Practitioners being placed in Sub Centers, a majority of them in High Focus Districts, thereby upgrading these centers to fully functional curative, preventive and promotive units.

- Advanced procedural skills training (e.g. in obstetrics, emergency medicine, anesthesia and surgery) can enhance the confidence of family medicine residents and equip them with the requisite skills for rural practice. This is because rural practitioners often lack specialist support and have a wider scope of practice.

Currently in India, high degrees of variation exist in the **Family Medicine Course**, in terms of duration and course content. Anesthesia & Surgical skills are not taught. Need of the day is to streamline this course - 3 years, standardized course with focus on obs. & gyn., anesthesia, minor surgical procedures

6. **DEPLOYMENT ISSUES**

- **Long term:**

  The only long-term solution is if we are able to generate a type of human resource who has the appropriate skill sets and attitudes so as to feel personally and professionally satisfied with serving in a particular place. This requires giving persons more choice in where they would serve, pre-service training for persons from localities which are underserviced- and who are likely to go back and work there, so that there is less cultural gap between providers and people, and building a positive workforce environment to retain them there including provisions for skill up-gradation and measures to redress professional isolation, and economic loss of remote area postings. Though each of these measures has been tried in different areas, there is no place where all of them is tried.
- **Interim measures: Transparent Deployment Policy should be an integral part of HRH policy of the state**

  The state should have a transparent policy on deployment, transfer of HRH personnel that should be integrated in the overall state HRH policy. The transfer, posting of personnel should be in public domain, through a web-based portal / Human Resource Management Information Systems (HRMIS) for use of HRH information /data to inform decision making for administrative purposes and planning/rational deployment of HRH.

- **Post training rational deployment of HRH for fixed tenure**

  The post training deployment of HRH should be based on proper assessment of facilities and requirements so that individual has scope to practice the newly learnt skills with proper mentoring /support supervision, if possible. The post-training placement should be of fixed tenure, and should be laid down in the HRH policy under training component.

- **Minimum station tenure for remote/HTR/inaccessible areas**

  State should take into account the HRH requirements, identify strategies to fill up the HRH gap and retention strategies, especially for remote, inaccessible, tribal areas and these should be reflected in the state HRH policy under recruitment/retention policy components. There should be differential salary/incentives and provisions of non-financial incentives for serving in such areas for certain period of years with scope for transfer/choice of posting to another area after completion of postings for fixed tenure in these areas.

7. **LEADERSHIP:**

- **Fair promotional strategies:**

  For each category of staff/cadre (regular); well-defined promotion avenues should be framed and be integrated in career pathways under the HRH policy. Fair and transparent strategies should be adopted for promotion /career development as laid down in the policy.

- **Capacity building of second line leadership:**

  Leadership’s skills should be developed at various levels depending on the scope of work/deliverables for certain positions and need for coordination /negotiations with relevant teams/stakeholders /communities on different issues etc. The overall capacity building /development on leaderships should be integrated with other non-technical training packages (under combined fund pooling?) and such activity may be outsourced to an external agency /parastatal bodies having good resource/capacity.

- **Institutions for regular evaluation of mentoring program**

  An inbuilt Mentoring Program should be developed in institutions, as an integral part of state training policy for developing leaders at different levels. A group/team of mentors having requisite credibility may be developed at different levels for on-job supervision, distance learning, conflict /crisis management etc. Such mentoring program should be regularly evaluated for improvements, updation on new developments and efficiency of such programs.