



Rural Health Innovation through Leadership Development and Organisational Effectiveness

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Improving rural health service delivery is a major challenge in India as 73 percent of its population resides in rural areas. Recognizing the need to improve rural health service delivery, the Government of India launched the National Rural Health Mission (NRHM) in 2005. The NRHM aims to undertake architectural correction of the rural health system through communitization, improved management, flexible financing, innovations in human resource management, and strengthened monitoring against standards.

This paper describes an innovative leadership development and organizational effectiveness intervention for district health teams comprising district and block (sub-district) level health officials in three districts of Jharkhand, a state with low socio-economic conditions. The intervention over a period of three years comprised of a sequence of short-term training programmes in leadership and organizational effectiveness with on-the-job support through follow-up between training programmes.

The intervention led to increased focus on health system performance by the district health teams in these districts although the results varied.

The district health teams strengthened public-private partnerships, accelerated communitization process, improved functionality of facilities, and demonstrated role models. However, several factors also limited the potential impact of the intervention. These include serious human resource constraints, frequent transfers of district heads, procedural hurdles in funds flow from state to districts and quality of governance.

Despite these constraints, leadership development and organizational effectiveness intervention is an effective instrument for strengthening rural health system. The paper presents recommendations on how its impact can be further increased.

Keywords : Rural Health, Services, Leadership, Management, Access

Introduction

Providing health services to rural population is a major challenge in India. It is more challenging in underdeveloped and poorer states where there are serious shortfalls in service delivery marked by weak infrastructure¹, lack of trained personnel, and lack of teamwork as well as low social development including hard to reach areas. The total literacy of Jharkhand is 54%; male – 67.9% and female – 39.1%². These factors are exacerbated by weak political will³. For long, it was assumed that provision of services would ensure its utilisation, which proved untrue with high morbidity and urban-rural gap. To fill this gap and to provide better health care services to its rural population, Government of India launched National Rural Health Mission⁴ (NRHM) programme (2005-2012) to carry out necessary architectural correction in the basic health care delivery system through communitization, improved management, flexible financing, innovations in human resource management and strengthened monitoring against standards. The programme focuses on decentralization of health care delivery and management at district level to strengthen infrastructure, enhance capacity, expand service delivery to meet the goals of availability, accessibility, and quality health care. To achieve these, one of the main approaches⁵ embodied by the NRHM is capacity strengthening.

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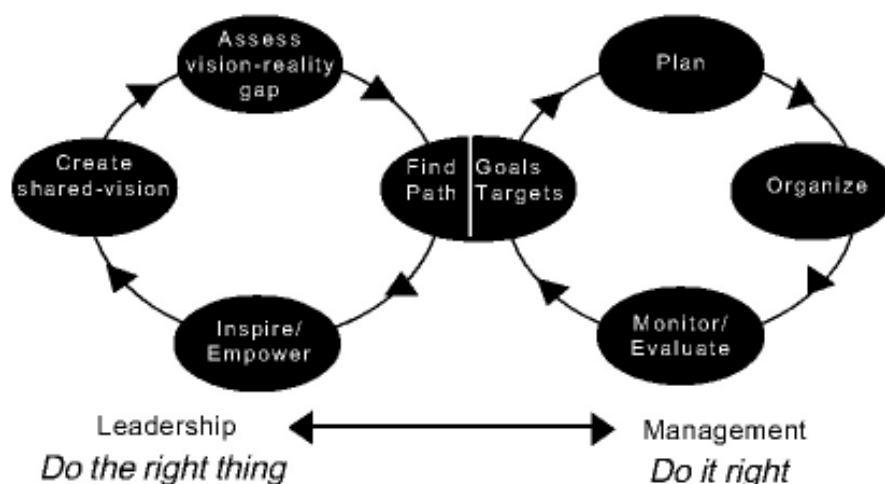
Realising the important role of leadership development and organisational effectiveness (for sustained impact) in strengthening capacity for achieving NRHM goals, the Leadership Development and Organizational Effectiveness (LDOE) programme was designed to strengthen personal, programmatic, and organisational skills and competencies of district health teams involved in programme management in the selected districts (Deoghar, Koderma and Palamu*) of Jharkhand state of India**, with particular emphasis on maternal health and family planning. The LDOE programme is a collaborative effort by the International Council on Management of Population Programmes (ICOMP), Malaysia and Xavier Institute of Social Service (XISS), Ranchi, funded by the David and Lucile Packard Foundation.

Framework

The basic goal of LDOE programme is to improve health status through enhanced systemic impact by an LDOE process that has a mix of leadership and management functions. The LDOE process uses the following framework for strategic program leadership (see figure 1) development based upon a review of contemporary leadership literature (Bennis⁶, Kouzes and Posner⁷, Stephen Covey⁸, and Management Sciences for Health⁹).

Figure 1

A Framework for Strategic Program Leadership



The framework suggests that when the team carries out leadership tasks, a shared vision is created which allows the health system efforts to be pulled in a single direction. Assessing vision-reality gap allows everyone to be aware of the gap and challenges involved. A participatory process of identifying the path/strategy brings together everyone's experience and skills to identify the actions needed to bridge the gap, which is the most critical strategic leadership challenge. Inspiring/empowering stakeholders (including health managers and staff) is necessary to implement the path/strategy and achieve the goals. In addition, the team needs to prepare and implement action plans to achieve goals. For this, they have to work effectively with sectoral, multi-sectoral settings, and other line departments, partners, and stakeholders such as NGOs and local self-government, as well as mobilise resources. Finally, they need to monitor to ensure that targets are achieved.

Methods

A blended training and learning methodology was used comprising of self and organisational assessments, customised training, mentoring, and exposure to best practices. A series of four round tables, each of two-days duration, over a period of two years, followed by an advanced 5-day training course, and subsequent follow-up activities and initiatives such as networking, exposure visit (of Malaysian health system), mentoring and exchange programmes were organised. Under this programme, the district health teams comprising 24 government officials were trained to enhance their personal leadership competencies, skills in leading for effective health system and use of tools for performance improvement (Table 1).

Table 1

Topics for Training and Learning		
Personal Leadership Competencies	Leading for Effective Health System	Tools for Performance Improvements
- Creating and sharing a vision	- Introduction to effective health system	- Situation analysis, root-cause and SWOT analysis
- Building consensus and aligning values	- Empowering households and communities	- Performance gap analysis
- Leading programme development	- Improving functioning of health systems for service delivery	- Action plan and implementation
- Leading organisational change and development	- Coordinating practices among households, communities and health service delivery, follow up visits, mentoring.	- Monitoring and evaluation
- Personal leadership skills development	- Building linkages with NGOs and private sector	
- Making friends and influencing people	- Strengthening strategic alliances among sectors	
- Gender sensitivity	- Mobilising resources within and outside the health system	
	- Securing support from district and state administration	
	- Strategic planning	
	- District planning for NRHM	

Figure 2 shows the LDOE process relating activities, outputs and outcomes.

Figure 2

LDOE Process from Activities to Outputs and Outcomes

Activities	Outputs	Outcomes
Self <ul style="list-style-type: none"> ◆ Self-assessment and action ◆ Training, Mentoring, coaching, and networking ◆ Periodic follow-through programme 	<ul style="list-style-type: none"> ◆ Shared vision ◆ Role performance plan for improvement ◆ Inter-personal communication ◆ Focus on performance ◆ Programme improvement ◆ Public-private partnership ◆ Enhanced community participation 	<ul style="list-style-type: none"> ◆ Increased performance in maternal health and family planning ◆ Improved quality of care
Organisation <ul style="list-style-type: none"> ◆ Assessment and action plan for improvement ◆ Exposure to best practices ◆ Round tables/ workshops on leadership and organizational effectiveness ◆ Build goal-oriented teams to address specific issues ◆ Periodic follow-through programme 		

Results

The programme will be evaluated upon its completion. The discussion below is based on quantitative and qualitative assessment through periodic field visits; personal interviews; group discussions at the round tables on change at personal, organisational and at programme level; and selected case studies.

Koderma district, which was judged as the worst performing district initially, was judged 'better' in maternal health (top 20%) and 'good' in family planning (top 50%) among all 24 districts in the state in the year 2009-10. Palamu district retained its rank as top performer in overall programme performance as well as in fund utilization. Although it is difficult to quantify program output improvements because of inconsistent and weak monitoring mechanisms¹⁰, one can also observe the change through increase in patient load in government health centres.

Discussion

The changes were observed at personal level, particularly, in 'modelling the role' and 'encouraging the heart'^{***}. The team members reported that with participation in LDOE process, they not only focusing on the programme but also on 'self'. The Civil surgeon, Palamu mentioned that 'I have started coming office on time, and other staff also started coming on time', 'I started providing services in the hospital when the concerned health personnel were not available to provide the service which inspired the other health personnel and colleagues to be on time'.

Improved service delivery has become the focus. Medical officer-in-Charge, Madhupur reported that his 'outpatient department (OPD) has become well functional. Emergency duty roster has been restructured; required staff including guard, fourth grade staff and male doctor have been added; one incubator has been provided, some changes were made in operation theatre and management of operations and autoclaving systems were improved'. Focusing more on emergency services, Hariharganj, a Primary Health Centre (PHC) of Palamu has made available 24x7 emergency services ensuring availability of doctors, para-medics, and essential drugs.

Public-private partnership is another important step to provide better health care considering the poor infrastructure and other challenges. For example, all three districts have signed memorandum of understanding with private hospitals and nursing homes for institutional delivery and family planning services. Because of these initiatives, Palamu district stands first rank in the state in terms of tubectomy. The Palamu district has set up Quality Assurance Committees and Quality Assurance Groups in the district with help of Engender Health (an international NGO).

Because of shared vision and leadership, there is more coordination among district team members. In one of follow up visits, it was found that through force-field analysis exercise and SWOT analysis, many problems could be solved through the discussions among the team members. For instance, one problem discussed was location of a PHC far away from the centre. From discussion among team members, it emerged that location disadvantage can be solved partially by strengthening an existing Additional Public Health Centre, which is closer to the centre, and an additional ambulance that can improve referral.

The three case studies below demonstrate all-round programme improvement activities undertaken by some of the district health teams.

Case Study 1 – Koderma District

Koderma is small district having poor services and had lowest rank in terms of overall health care delivery in 2007. Despite various obstacles and challenges such as inadequate doctors and paramedic staff and lack of infrastructure, presently there are significant improvements in health indicators such as increased number of institutional deliveries both at government facilities as well as through public-private partnership with private hospital and clinics such as Holy Family Hospital, and sterilizations. Civil surgeon reports that because of his team effort, there is increase in number of patients visiting district hospital and primary health centres in spite of inadequate basic infrastructure and hospital beds at that level.

Case Study 2 – Chainpur PHC

Chainpur PHC is situated in Palamu district of Jharkhand. Dr. S K P Yadav took charge of the PHC as medical officer in-charge (MOiC) in January 2008. When he joined, the PHC was providing only the outpatient services with limited facilities and services to patients. The situation was disappointing. After attending the LDOE programme, he decided to improve the facilities and functioning of the PHC. Presently, because of efforts by him and his colleague Dr. Ajay Kumar, and other staff, Chainpur PHC has become the model PHC of the state. At present, the PHC is functioning 24X7, serving around 150 patients daily with focus on quality, accessibility, and client focused services. The PHC facilities has been improved with 24X7 emergency services, increased institutional delivery, improved quality of care, better waiting room, water and sitting facilities for patients, cable TV network (with community contribution), etc, which are still a dream in many PHCs of the state. The PHC has developed an emergency and resource mobilisation plan using NRHM funds, community resources,

and other support. It has formed quality assurance team to continuously review and improve the services. Dr. Yadav and his team believe that 'ensuring the quality of services is prime, so if one wants to use the services, he/she is willing to use it'. He reports that 'nurses are taking interest in delivery; in the beginning there were no deliveries being conducted at the PHC but this has increased to around 80 deliveries per month'. He also shared the waste management initiative, which was clearly visible with availability of dustbin, disposal bin, and underground waste disposal. The PHC has implanted solar system for its cold chain. They have also started mobilising resources through community and patients contributions and other sources (donation from local entrepreneurs) for PHC development.

In Palamu district, Chainpur PHC has become the model for others. They have started monthly meetings at PHCs on a rotational basis for experience sharing and learning from each others' experience and innovations. Most of the PHCs are focusing more on institutional delivery and family planning services. They have fixed the days for sterilizations/operations with improvement in facilities, which has built the trust in the services provided.

Case Study – Behradih Sub-Centre

Behradih Sub Centre is situated in remote area of Jainagar block of Koderma district. Earlier this Sub-Centre was providing only limited services. After the LDOE training, Medical Officer in Charge, Dr. S P Singh, focused to develop this sub-centre as one of model functioning Sub-Centre. The Sub-Centre services, functioning, and infrastructure (from the fund for Hospital Management Society) have improved significantly leading to provision of delivery services.

Constraints

Several factors limited the potential impact of the intervention. These include serious human resource constraints, frequent transfers of district civil surgeons¹¹, procedural hurdles in funds flow from state to districts and quality of governance. For instance, only 46 per cent of the sanctioned positions of medical officers in the Jharkhand state had been filled by the end of December 2008¹². One of the district civil surgeon was transferred soon after the LDOE process began. For some time the funds did not flow smoothly from the state to districts, particularly for cash transfers for institutional delivery. Finally, much can be done to improve quality of governance.

Conclusion

Several recommendations can be made for more efficacious LDOE process based upon lessons learnt. One, LDOE requires intensive efforts as norms of behaviour and habits set over a long period cannot be changed easily. Therefore, this process needs to be institutionalized. Two, there is a need for stability of and commitment from state level program leaders to internalize LDOE process. Three, the whole state health system needs to be covered through this process because of frequent transfers at district health levels.

The Millennium Development Goals emphasise need to improve the health status of the populations – through better coverage and access to priority health services. The LDOE programme is an input, which can synergize with other NRHM actions but has not been paid adequate attention to for building leadership competencies and strong management with a focus on long-term systemic change. Whilst 'poor management' is often cited as a constraint to expanding effective healthcare, the experience of LDOE programme shows that, despite challenges, it is possible to catalyse systemic change and efforts to improve healthcare in rural areas.

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Notes

- * The districts were identified based on considerations of their performance in the National Rural Health Mission as well as convenience of project implementation.
- ** Each district health team is made up of the following officers: Civil surgeon, District programme manager, Additional chief medical officer, District RCH officer, and four Block Medical officer-in-charge.
- *** These are two leadership competencies mentioned by Kouzes and Posner. The other three competencies are inspire a shared vision, challenge the process, and enable others to act.

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