Management of RH Services in India and the Need for Health System Reform

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W.P.No. 2003-09-04
September 2003

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Management of RH Services in India and the Need for Health System Reform[1]

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Abstract

For the last ten to fifteen years, a comprehensive agenda of health sector reforms and health systems development has engulfed the health system in many countries in structural and organisational changes. Experience with varying degrees and types of reforms have now been reported from many countries. In our paper, we begin by describing some important issues facing the management of RH programs in India, based on our research done in a few states over the last five years. The failures in the management of RH services are complex and multi-factorial, and cannot all be addressed through health system reform. It is therefore necessary to identify which failures in service are attributable to causes, which could be removed or changed by reform in the health system. In our paper, we identify those failures and causes which could be corrected through health system reforms and propose certain concrete steps to expedite the reforms in the health system to enable the improvement of RH services in India.

1. Introduction:

Following the recommendation of the International Conference on Population and Development (ICPD) at Cairo in 1994, the Government of India undertook a major project, Reproductive and Child Health (RCH) Programme[2], to reorient the family planning programme towards reproductive health, with assistance from the World Bank and another large reform oriented project called Health and Family Welfare Sector (HFWS) Program with aid from the European Commission. The RCH program and HFWS program in India is implemented through the District Healthcare System (DHS) which consists of Primary Healthcare Centres (PHCs), Community Healthcare Centres (CHCs), and the District Hospital.

Research done in a few states in India over the last five years has given us a clear understanding of the various issues facing the management of RH services. In this paper, we discuss our research findings and argue that certain improvements in the management and delivery of RH services can only be

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[1] Paper presented at the conference "Making the Link: sexual-reproductive health and health system. Leeds, UK. 8-11th September 2003. For further correspondence contact: Dileep Mavalankar : email address: dileep@iimahd.ernet.in

[2] RCH services in India include: Prevention and management of unwanted pregnancy, Services to promote safe motherhood, Services to promote child survival, Prevention and treatment of RTI and STD, Establishment of effective referral system, Reproductive services for adolescents, and Health, sexuality, gender information, education and counselling.

realistically achieved with reforms of the health system. We support our arguments for health system reforms by drawing on experiences elsewhere which may be relevant to the Indian context.

2. Management Concerns in the delivery of RH services:

Since independence in 1947 India has expanded its DHS through a series of fine year plans and externally assisted development programs. Over the years a massive DHS with more than 150 medical college hospitals, 400 districts hospitals, 3000 rural sub-district hospitals (called Community Health Centers- CHC), 22,000 Primary Health Centers (PHC) and 130,000 sub-health centers has been developed. But inspite of such large DHS effective and efficient management of RH services is hampered by several policy and management constraints.

Of particular concern are the non-availability of staff, weak referral system, recurrent funding shortfalls, and lack of accountability for quality of care. We discuss these concerns in some detail below.

2.1 Non Availability of Staff: The DHS in India has been facing an shortage of medical and para-medical staff – especially in rural and remote areas for quite sometime. Some of the reasons are mentioned below.

Rural Postings for doctors: With a view to increase access to health services in rural areas, the number of PHCs was increased almost three folds in the mid 80s by revising the norms for PHCs from 1 PHC for 100,000 population to 1 PHC for 30,000 population. This led to establishing a larger number of PHCs in remote and small villages, which do not have basic civic amenities and/or proper infrastructure. It is therefore becoming very difficult to attract and retain doctors to work in rural PHCs. A study by the Indian Council of Medical Research (ICMR) covering 23 districts in 14 states showed that only 57% of the doctors of 473 PHCs sampled were staying at the PHC village (ICMR 1997). When a doctor does not stay at the place of his posting he is only available for about 3-4 hours per day. Similarly specialist doctors such as gynaecologists and surgeons are reluctant to take up posts in CHCs and live in rural towns.

Lack of female doctors: The earlier DHS system (1 PHC per 100,00 population) had a team of 2-3 doctors per PHC and PHCs were located in sub-district towns or large villages. Hence chance of having at least one female doctor in each PHC was good. In the new set up (1 PHC per 30,000 population), each PHC has only one doctor (or two doctors in some states) , and PHCs are located in much smaller and remote villages with poor infrastructure. Therefore it is more difficult to motivate female doctors take up positions in such PHCs and live in those villages/towns. Even in the case of PHCs, which have a female doctor, her availability cannot be ensured round the clock, if she chooses to stay away from the PHC village for want of basic amenities and security.

Multiple tasks of doctors: Over and above the clinical work, each doctor in the DHS has several other tasks to perform. On an average, each doctor could be away from the PHC on duty for 15-20 percent of the time: busy with meetings, polio eradication drives, training, school health examination, supervision and other administrative work. Hence the availability of the doctors for Clinical Reproductive Health work is limited.

Absenteeism among staff: Our observations indicate that absenteeism among the doctors, nurses and the para-medical staffs is high. When doctors are away or not residing at the PHC, the nurses and para-medical staff also absents themselves, one of the reasons being that they are not empowered to examine patients and prescribe medication independently. The ICMR study referred

to above showed that 52% of ANMs do not stay at their PHC village. The staffs who depend on public transport services to commute to their work place are more irregular and are almost never available outside office hours. Our observations show that such non-resident staff are available in their work area only for 3-4 hours per day.

In addition to the causes mentioned above for the non-availability of staff, government employees enjoy a large number of holidays (18-20 public holidays, 52 Sundays, and 26 Saturdays - as each Saturday is a half-day) and earned/casual/sick leave privileges (a total of 50-55 days). As a result, staff can be on leave of one type of another for about 42% of days in a year thus limiting availability to no more than 55-58 percent of days if there is only one doctor or specialist of one type.

Systemic Inefficiency in Human Resource Management (HRM): About 20 to 40 percent of the sanctioned posts of doctors and health workers are lying vacant at any time in remote and difficult area of many states. More than half such vacancies are due to systemic inefficiencies such as delay in appointments, improper posting. The head of PHC/CHC/DH has no powers to recruit staff even on a purely temporary basis, when the regular staffs are away on duty or on leave or when position is not filled. Neither is there any provision in the DHS to have reserve doctors or medical/para-medical staff to look after the units when the regular staffs are not available. Human resource functions in the health departments are very poorly handled leading to dissatisfaction among staff (Mavalankar 1999 a).

Lack of sanctioned posts: Financial consideration and narrow vision limit the number of sanctioned posts at various levels in DHS. As a result, there is no manager or administrator to assist the Medical Officer in charge of PHC, CHC or the DH. There are no sanctioned posts of anaesthetists at the CHC and First Referral Unit (FRU – which are designated CHC for Emergency Obstetric Care) which are 30-50 bed hospitals with Obstetrician-gynaecologist, surgeon and Operating Theatre facilities. The sanctioned strengths of nurses is also very less in many hospitals as compared to the workload. There are no posts of medical social workers in the DHS.

2.2 Weak Referral System: Many RH services require referrals to higher levels for surgical interventions, management of infertility etc. However, the referral system in the DHS is unsatisfactory, due to several reasons, major causes are highlighted below.

Systemic inefficiency: The referral system in DHS is ad-hoc and unsystematic. There are no referral forms and protocols for referral. Our study in one district showed that most case reaching higher level facilities are self-referred (Mavalankar et al 2002). There is a lack of communication between the various units participating in the referral system. Proper records of referral cases are not maintained. Referred cases do not get the attention they deserve. There is no proper feedback from the referral centres to the lower level units. Instances of refereeing the patients to the wrong referral centres are not uncommon, since many doctors at the PHC/CHC levels are not aware of the facilities available at the district/state level hospitals.

Lack of Organisational support: The existing organisational structure is not very supportive to facilitate the referral system. For example, in many states, the PHCs are under the Director in charge of Public Health Services, the CHCs and the DH are under the Director of Medical services, while the Medical College Hospitals are under the Director of Medical Education. There is very little co-ordination and co-operation between these health departments and therefore the management of the referral system remains very weak.

Poor transportation and communication facilities: Ambulance services to transport the serious patients to referral centres are very minimal. Public transportation services between the PHC/CHC to the District/State hospitals are irregular and infrequent. Private transport is expensive. And therefore, the existing DHS has become very unreliable and undependable for satisfactorily handling the serious and emergency referral cases. Many PHCs do not have telephones or wireless communications. Even when CHCs and District hospitals have telephones there are not protocols to use them for communicating referral or emergency cases.

Lack of awareness: It is true that a large number of people in rural areas are not even aware of the existence of a referral system and services. Besides, the cost of treatment in the referral centres and what to expect in the referral center is also not known to the public.

In short, the referral system as it exists in the DHS currently, is not managed either effectively or efficiently. As a result, the poor people are forced to seek medical help from the private sector where the informal referral chain is better developed due to monetary interests.

2.3 Recurrent Funding Shortfalls:

Recurrent funding shortfalls are common in government systems, and the health system is no exception. Some of the reasons for recurrent funding shortfalls are listed below.

Financial Constraints: Almost all the state governments are facing severe financial crunch. Inability to raise sufficient revenue constraints the allocation of funds to various sectors including Health. Shortage of funds applies to both recurring expenses and capital expenditure. As salaries are protected and increased based on inflation frequent shortage of funds for recurring expenses more severely constraints the funds for variable expenses such as the purchase of medicines and drugs and other supplies, purchase of fuel and repair of vehicles, repairs and maintenance of equipment, instruments and infrastructure etc. Shortage of funds for capital expenditure leads to poor investments in medical technology and enormous delays in acquiring medical equipment and communication equipment and expansion of hospital based on increase in use.

Lack of autonomy: Lack of autonomy for discretionary use of funds creates artificial funding shortfalls. The existing systems, processes, and procedures which allocate funds for each activity (instead of block grants) does not offer any power/autonomy to the heads of PHC/CHC/DH to utilise their total funds effectively and efficiently. For example, no money can be spent even for any emergency purchase of essential drugs or repair of vital equipment from the unused budget for other line items. Such inflexibilities lead to shortage of funds for some activities while funds for some other activities laps due to non-use.

Negligible Income from Patient Care: User charges are non-existent in many states and very low in other states. Even many non-poor patients get their charges waived. As a result, the total income from patient care is very negligible. The PHC/CHC/DH units which collect the user charges have no access to these funds even to meet the recurrent funding shortfalls, as all such income from patient care are deposited in the government treasuries at the end of every day. Even though citizens are willing to pay more user charges for a better quality of service, the unit heads have no powers to raise user charges. It is unfortunate that in many states the user charges are the same in all PHC/CHC/DH irrespective of the socio-economic profile of the region or clients they serve.

Bureaucratic Delays: The existing systems and processes for disbursement of funds to the various units in the DHS are very bureaucratic. Bureaucratic delays cause unnecessary and recurring

funding shortfalls. For example, payments to vendors (of drugs and medicines) are almost always delayed which in turn adversely affects the delivery schedule of drugs and medicines. Many times funds for use during the year are released in the last month or on the last day of the financial year, thus precluding their effective use.

In short, recurrent funding shortfalls which mainly affect the funding for variable expenses adversely affects the quality of patient care, making the DHS ineffective and undependable.

2.4 Lack of Accountability for quality care: Unfortunately, quality concerns are not addressed satisfactorily in the delivery of services and therefore systems of accountability for the quality of clinical care are almost non-existent in the DHS. We mention below some of the major causes.

Obsession with targets: The target- oriented approach to Family Planning evaluated the work of the units only on the number of sterilizations performed. The quality concerns in the sterilization procedures were overlooked especially when sterilizations are done in camps (Mavalankar D etal 1999 b, Townsend J etal 1999, Laxmin R etal 1999) . Even though the target oriented approach has been replaced by a target free approach in the RH range of services, the obsession with targets still continues in DHS of many states.

No clinical audit or quality control: There is practically no emphasis on clinical audit in DHS. As a result, the doctors and therefore the nurses and para-medical staff have not taken the quality aspects of medical care seriously. Many doctors in the DHS have developed a very casual approach to clinical care. There is no system of Continuing Medical Education (CME). Over a period of time, poor work culture has developed within the DHS, leading to lack of accountability for quality care. There is no system of clinical supervision. Only if there are gross problems about clinical care such as death of sterilization case or an outbreak of infection after cataract surgery camp then there is any investigation or action. In most states even maternal deaths happening in health institutions are not systematically recorded or investigated.

Inadequate understanding of range of RH services: Many doctors in the DHS have not really accepted the move away from the Family Planning approach towards an integrated set of RH services. Their understanding of RH services is poor and incomplete, mainly due to lack of training inputs. For example, not many doctors are aware of the Community Needs Assessment Approach recommended by government of India. Many doctors wrongly believe that MTP (Medical Termination of Pregnancy) is legally permissible only upto 12 weeks and not 20 weeks. Lack of knowledge by the doctors about RH services contributes towards lack of accountability for quality care for the range of RH services. The understanding of RH in nurses and health workers is even worse as their orientation to RH has been even weaker than doctors.

Lack of Interest: Many PHC/CHC doctors use their PHC/CHC experience as a stepping-stone to more lucrative and satisfying private practice or hospital work. They are therefore not eager to develop the activities of their PHC/CHC or to do innovative things to improve the PHC functioning. There is no reward or recognition by the health system for good work done by staff in rural areas. Lack of interest and/or motivation by the doctors also contributes towards lack of accountability for quality care.

Absence of legal requirements: There is no legal requirement in the existing system on accountability for quality care. There are no legally binding standards for various levels of health facilities. The majority of the rural population (and a significant population in urban areas) are not aware of their right to question the quality of clinical care. Many are even afraid to raise issues on the quality of clinical care because of the perceived consequences resulting from such actions.

Thus there are many management constrains which hamper RH services in India. We summarise below the major concerns in the management of RH services in India and the possible causes for these constraints in Table 1.

Table 1: Major Constraints in RH services and their causes.

	Major Constraints	Probable Causes
1	Non-availability of staff	Rural postings not attractive Lack of women doctors Divers tasks and absenteeism Lack of posts Systemic inefficiencies.
2	Weak referral system.	Systemic inefficiencies Lack of organizational support Poor transport and communication. Lack of awareness in the community
3	Recurrent funding shortfalls.	Financial constrains Lack of Autonomy Negligible income from patient care. Bureaucratic delays.
4	Lack of accountability for quality care:	Obsession with targets for FP No system of clinical audit or quality contr ol Inadequate understanding of RH services Lack of interest

3. The need for Health System Reform

Underlying these deficiencies rests a series of system failures attributable, not to any individual but to the inability of the health system as presently established and administered to respond effectively to increased demand and changing needs. The most feasible way to improve these shortcomings is therefore to reform the system which causes them.

A variety of health system reforms has been introduced in different countries, but they may be classified into five groups - Krasovec and Shaw (2000) refer to these as the five "reform levers":

- Financing & resource allocation
- Provider payments, incentives and motivation
- Organisational change
- Laws & regulations
- Promoting healthy behaviours

An exploration of the relevant reforms may indicate which would be most relevant for addressing the concerns set out above.

3.1 Non-availability of staff

Within the first concern, the non-availability of staff, the lack of doctors in rural areas (especially female doctors) would seem to be a consequence of service wide policies not being updated

following strategic decisions: either the allocation of staff to units has not been amended following the expansion in provision of units (a human resource policy), or the nature and function of the new units has not been clearly defined in contradistinction to the old (a health planning policy); or the recruitment of staff has not been accelerated to fill posts. This would argue for an *organisational change* towards a stronger management culture, in which swift but systematic response to changing circumstances and the needs of the RH services was highly valued and rewarded.

Another factor contributing to non-availability of staff is the absence of nursing and paramedical staff when doctors are away. Their present role is so circumscribed by professional boundaries that in the absence of a doctor they can do very little. If by *change in regulation* their roles were extended to authorise examining, prescribing and treatment for specific conditions the availability of care from RH services – and the job satisfaction of the staff – both would be greatly enhanced. Organisational and professional job satisfaction among nurses is a strong predictor of process measures of quality of care (Leveck and Jones, 1996)

A third factor quoted relates to the financial constraints which limit the number of sanctioned posts. This requires action through *financing or resource re-allocation.* There may be a need for management to re-assess priorities in resource allocation, or if there is an absolute shortfall it may call for alternative financing strategies.

Or, fourthly, the way in which posts are sanctioned and allocated may be the consequence of decisions made at too remote a level in the bureaucracy (at state level) with insufficient awareness of local circumstances, and with no powers delegated to local service managers (district and PHC medical officers). This systemic inefficiency can only be addressed by some form of *organisational change* usually decentralisation of authority (Mills *et al,* 1990).

3.2 Weak referral system

The causes of the weakness in referral system outlined above lie partly in the lack of functional integration between the component parts of the DHS, evinced in their separate management arrangements but also in the separation of staff and the failure of communication between units. The definition of integration varies between countries, but ranges from a single provider for all needs to a teamwork approach (Lush *et al*, 1999). The establishment, through *organisational change* of a strong district management responsible for the whole system, with delegated responsibility for deploying staff and other resources and with accountability to the community for the quality of RH services provided, would increase the probability of establishing a strong referral system. Decentralised decision-making gives local managers the authority to coordinate the use of resources, and facilitates intersectoral coordination (Collins 1994)

The lack of awareness among users of RH services of the existence of a referral system underlines the value of the fifth "reform lever" – *behavioural change.* Provision of information to users on the expectation of a referral system can be combined with encouragement to use the first level of service when appropriate (if necessary by differential fee rates).

3.3 Recurrent Funding Shortfalls

The two significant causes for this area of concern are the absolute shortfall, which would require consideration of *alternative financing* mechanisms, and the systemic inefficiencies in distortion of staff/non-staff spending, rigidity of line-item budgets and centralisation of fee payments and

payment delays which require *organisational change*. Alternate financing mechanisms include cost recovery, social health insurance, donations, cross subsidy, public-private partnerships.

3.4 Accountability for Quality of Care

The obsession with targets outlined earlier in this paper displays two characteristic of a vertical programme – the focus on a limited area of service and pursuit of numerical achievements to the exclusion of other areas and disregard for quality – which is not helpful to integration of RH services. Again through *organisational change* the integrated services can offer a more holistic approach to the delivery of patient care.

The lack of interest in audit in wider RH services and in innovation betrays a failure in staff motivation which can be addressed by modifying the *incentive structure* so that staff interests match more closely with aims for the quality of service. "The ideal mechanism would be one that offered incentives for producing effective, efficient and equitable treatment with no perverse incentives and with minimal transaction cost. In practice, many of the systems fail on one or more of these counts" (McKee and Healy, 2000). The absence of any accountability to the community or the individual client could be addressed both by *organisational change* – by inducting community members in a governing board, or a statutory users' council – and by *laws and regulations* which facilitate the pursuit of legal redress, and even lay a statutory duty of care on the provider or the health system, as in UK.

These possible strategies to address the earlier concerns are summarised in Table 2

TABLE 2: Areas of concern, causes and possible remedies

Area of Concern	Causes amenable to reforms	Relevant reform levers
Non-availability of staff	Outdated policies & incentive structure Paramedical' role limited Financial constraints Remote decision-making	Organisational change Regulation change Financing/resource alloc'n Organisational change
Weak referral system	Lack of integration Ignorance of referral system	Organisational change Behavioural change
Funding shortfalls	Absolute shortfall Systemic inefficiencies	Alternative financing Organisational change
Lack of accountability for quality of care	Vertical programme approach Low staff motivation	Organisational change Organisational change Laws and regulations

4. Reforms in practice

In practice, the application of health system reforms takes a wide variety of shapes by combining different components into different configurations. Thus some countries (Mongolia, Nicaragua)

encourage private sector providers to compete for government contracts for service provision, while others (Ghana, Zambia) have decentralised services to local government (Lubben *et al,* 2002). Egypt is piloting social health insurance, Bolivia works with not-for-profit private health providers, and the Philippines supports private-for-profit providers including health maintenance organisations (Krasovec and Shaw 2000). But reforms may have unforeseen effects. Lubben *et al* argue that it is important to analyse the relationships between the reform components and the key reproductive health policies, and to question the impact of each reform on each policy – for example the impact of increasing the role of the private sector, on the integration of RH services.

5. Reform in India

The implementation of large-scale health system reform demands political sensitivity, strategic thinking and management capacity of a high order. "In many countries the Ministry of Health lacks the capacity to take a strategic lead in policy-making" (Collins and Green, (1999). The Indian public health system has so far remained largely unaffected by the appetite for large-scale reform affecting so many other countries, and thereby has avoided many of the pitfalls, which early reformers experienced. India is well placed now to profit from others' experience and to develop a uniquely Indian set of reforms to enable the health system better to meet the increasing expectations of its users and staff. The second advantage India has are the highly competent professionals and reputed management institutes that can provide technical support to the reform efforts by rigorously analysing the experiences and ongoing efforts. The third advantage India has in health reforms is that the economic reforms started in 1991 have yielded good results thus creating a positive political and social environment for public system reforms in general.

6. Experience of Reform Efforts in India:

In some states and at national level there have been some initial and pilot efforts made to reform various aspects of the health care system. Here we list these efforts.

6.1 Non-availability of staff: This is a critical bottleneck for Rh services such as Emergency obstetric services (EmOC). Following efforts have been made:

- Chhatisgharh state has trained some doctors with MBBS qualification to give anaesthesia for EmOC.
- Tamil Nadu state has trained doctors with MBBS qualification do surgical procedures such as Caesarean section for EmOC.
- Some NGOs working in very remote areas have been training nurses to give anaesthesia.
- Himachal Pradesh, which has both difficult (hilly) and relatively better-off (plains) areas have developed policies of posting doctors and staff alternatively in difficult and better-off areas to ensure staffing equity.

6.2 Weak Referral System: Some small pilot projects have been done in this area and government has tried some interventions. For example:

- A project has tried to improve the referral system in Bombay Municipal Corporation health centers through colour coded referral cards - eg: red card for emergency referrals.
- There have been efforts to systematize the referral system by giving a book of printed referral slips to health workers and doctors at the PHC and CHC in Sanand sub-district of Ahmedabad district.
- Government of India, through its RCH program has given money to village councils (called "Panchayats") for referral transport cost for emergency obstetric cases.

6.3 Funding shortfalls: Recognising the seriousness of this problem, governments have tried to institute cost recovery mechanisms, social health insurance, private public partnerships etc. For example:

- Madhya Pradesh state government has set up a government owned NGO (GONGO) called "Rogi Kalyan Samiti" or patient welfare committee. Rajasthan state government has set up a similar GONGO called "Medicare Relief Society". Both these entities have set up charges for various services and use the money generated for procuring various supplies and services needed for the hospital. They are locally managed but governed by rules set up by state government.
- Of late government has been starting subsidised health insurance for poor people. In the last two national budgets the finance minister has announced such health insurance schemes.
- Public Private Partnerships (PPP) has been set up for speciality hospitals in Gujarat - eg: Gujarat Cancer Research Institute and Institute of Kidney diseases in Ahmedabad. There are many more examples of this.

6.4 Lack of accountability for quality: Following ICPD, the government of India has been de-emphasizing targets in FP and started talking about quality of services. Following initiatives have been started by the government:

- "Target Free Approach" (TFA) was started in 1996 on pilot basis to help move away from family planning target oriented monitoring.
- Community Need Assessment Approach (CNAA) was introduced after TFA to orient the program to bottom up planning. These were reform efforts which helped reduce the pressure on targets and succeeded to some extent in improving quality.
- There has been some training in the RCH program, which may have contributed to marginally improving the quality of care.

There is no major initiative to improve accountability for quality of services.

The experience of these pilot reform efforts listed above has been mixed. Unfortunately there has not been any rigorous evaluation to see who benefits and who suffers as result of such reforms. The European Commission supported Health and Family Welfare Sector program has produced a series of working papers, some of which review various reform issues.

7 Conclusions and Future Directions:

There is a clear need for India to launch a major reform effort in health system if the objectives of reproductive health programs are to be achieved. There has been sizable international experience and many pilot projects in India in various states which address the various constraints listed above. To move the reform agenda forward more rapidly and systematically, we suggest the following four steps:

1. **Reform Cells:** Each state and the central government should form a reform cell. It should include the participation of government officers, NGOs, academics, researchers and development partners. They will collect experiences of reforms, analyse them and advise the government and other partners on reform agenda. The reform cell will also review the on going reform efforts and provide guidance on implementation.

2. **Reform Strategy:** Each state, local and national governments should develop a long-term reform strategy. This should cover next 10-15 years. All reform efforts should follow the priorities identified in the strategy document.
3. **Reform Program:** Based on the strategic direction each unit of the government will prepare a short term rolling reform program which will cover 1-2 year concrete plan for reforms. This could include both small reforms and larger reforms, which will be implemented, monitored and reported on.
4. **Reform Conference:** Annually the national government should organize a conference where various experience of reform efforts could be shared and discussed by policy-makers and health managers. This would give further impetus to more reform and encourage managers to try increasingly complex reforms.

Reforms for reproductive health have to be continuous and based on analysis of experiences. Review of reform efforts is essential as some reform efforts may have unintended negative impact on equity, access and utilization of care with severe consequences for the poor.

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