Training and Development Policy in India: for Health Current gaps and Suggestions

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Abstract

After getting independence, India developed a well defined and vast public health system till now at both national and state level including private sector. But still the health outcome and goals set internationally and nationally are far behind at present. Looking at this critical situation, there is a need to re-examine the status of training and development of human resources utilized under health system.

While critically analyzing the existing policy of training and development of health department, it came to light that it is vertical in nature for all health and family welfare programmes. It gives no importance to local needs and integration.

Random nomination of trainees, short notice to attend workshop, less Per Diem and remuneration, etc influence the attendance and spirit of participation in any training program. Monitoring and evaluation of these programmes are just formality on part of the training institutions.

As suggestions, three types of training should be given to a health professional: Induction, In-service and Refresher training. Training plans should have both short and long term strategies. Training should be directly related to Job responsibilities and should be well monitored and supervised by state or nodal training officials.

Distance learning and e-learning can be promoted for participants at any remote locations.

KEYWORDS: Training, Development, Human Resource, Health Department, Training Policy

Introduction:

Since Independence, India has developed a vast public health infrastructure at national and state levels in both public and private sectors. Despite, a well developed and extensive network of public health infrastructure; including institutions for training and research, the health outcome is still behind the set goals.

At the time of independence in India, there were about 50,000 medical graduates and 25,000 nurses in the modern system of medicine to provide health care to the population[1]. During the Plan periods, various efforts were made to address the shortages of human

resources for health. In view of the shortage of medical personnel in less-developed and rural areas, the National Health Policy (2002) suggested to examine the possibility of entrusting some limited public health functions with nurses, paramedics and other personnel from the extended health sector by providing adequate training to them[2]. The changing scenario of health services and strategies, especially under National Rural Health Mission, has led to an urgent need to develop new competencies and skills among the public health personnel.

The norms for health care infrastructure and manpower were laid down for the first time by the Bhore Committee (1946) which laid the foundation for planning of health service in India. The committee emphasized the importance of providing not only integrated preventive, promotive and curative primary health care services but also tackling the causative factors for ill health. Management of deficiency diseases was a part of primary health care; the public health engineering division of health department dealt with lack of access to safe drinking water and poor environment sanitation. The norms were subsequently modified by the Mudaliar Committee (1961) followed by the Bajaj Committee (1987).

National Rural Health Mission (NRHM) launched in April, 2005 further supported the provision of affordable, equitable and quality healthcare to the population of India, especially vulnerable groups. A major strategy in NRHM was horizontal integration of vertical health and family welfare programmes as well as convergence with activities of related ministries/departments like AYUSH, Ministry of Women and Child Development (MWCD), Drinking Water and Sanitation, Panchayati Raj Institutions, etc, so that there can be provision of integrated health and family welfare, nutrition and sanitation services for the community.

Challenges and Issues to be addressed:

The existing policy on training and development of Health personnel is vertical in nature for all health and family welfare programmes. Also it mainly focuses on transfer of knowledge without ensuring local needs and integration.

The gaps identified in the existing training policy are as under:

1. Existing training programmes are vertical in nature.
2. State and district training plans are not as per need of the state.
3. Training is not synchronized with need of health facilities, supplies & referral linkages .
4. Poor monitoring of post training follow up of health workers.
5. Data bank of trained manpower is not maintained and if maintained at some places, the quality and quantity of data is not worth applicable.
6. Lack of coordination between the Health Societies, Department of Health Services and SIHFW/CTIs (Collaborating Training Institutes) in the states.

Discussion of the Challenges:

Within these ten years, there has been a exponential increase in human resources in the health sector, yet the health system in India and its goals are far from achieving the

desired status. Poor health indicators reflect the need for high level of concern, commitment towards service delivery of healthcare and competency among the health personnel, particularly at the primary care facilities. Rigorous efforts have been made to address these issues by incorporating a variety of trainings to health care providers. At this crucial point, there is a need to re-examine the status of training and strategic changes required in this context.

Most of the In-service trainings in the health departments of various states are centrally sponsored schemes or projects. More often, the trainees in these programs are nominated randomly just to fulfill orders reaching to the nominating officials at eleventh hour. Trainees have to reach to the training venue at a very short notice. Consequently trainings which are loaded with lectures with little emphasis on the theme and overall perspective of sthe program are compromised with very less number of trainees.

Provision of Per Diem for trainees and honorarium for trainers fluctuates from training to training and thus influences the attendance and spirit of participation. Profiles of the trainees nominated for training often reflect the mismatch between organization goals and the training goals. Eventually, the subjects nominated for training often do not give the signals of capacity development of the concerned health systems during their work post-training. These are well identified challenges which have remained unmet for decades[3].

Professional Development Courses (PDC)[4] of ten weeks duration for district level Medical Officers were initiated as a part of health sector reforms in the beginning of this decade. Starting from National Institute of Health and Family Welfare, these were taken down to fourteen institutions throughout the country and more than 900 medical professionals were oriented in PDCs over a period of first five years of its launch. In most of these programs, the profile of the participants nominated remained a matter of debate. Subsequent use of trained doctors and their contribution to the respective state health departments remains a matter of debate.

Trainings provided in each of the health sector project have several common components addressed to the same professional i.e. training on RTI/STI in RCH as well as NACP-3. It is also not easy to cope up with several trainings given in the same project without having a lucid PMIS (Personnel Management Information System like Himachal Pradesh health department) with the authorities nominating the trainees.

RMNCH+A[5] (which is a now a major activity within the National Rural Health Mission) has trainings on skill building for Emergency Obstetrical Care (EmOC), Life Saving Anesthesia Skills (LSAS),Skilled Birth Attendant (SBA), Medical Termination of Pregnancy (MTP), Intra Uterine Device (IUD) insertion, laparoscopy, Adolescent Friendly Health Services (AFHS), Integrated Management of Childhood Illnesses (IMNCI), Non Scalpel Vasectomy (NSV), RTI/STI (Sexually Transmitted Infection), Behavior Change Communication (BCC), Routine Immunization and Emergency Contraception. Pace with which the changes in the health systems occur after these trainings places back questions on the quality and methods of trainings. The training modules does not change with the advancement in health sector neither it reflects region wise variations to cater the area specific needs. Thus lack of coordination between need

of training and content of training defeats the very purpose for which the training is imparted.

Clinical skill development trainings envisaged in the Health System Development Projects (HSDP) had a similar fate. It took three to four years for each State to identify an institute, delegate the training and by the time trainings were initiated, it was time to wind up HSDP. Review Missions of HSDPs from World Bank have observed same phenomenon in States like Karnataka, Uttaranchal or Rajasthan[6]. Continuous turnover of personnel in project line reflected in the implementation of these activities. One of the major reasons for this weakness is poor communication between different health service system which caters to primary, secondary and tertiary care. Weak linkage between these institutions was at the core of ineffectiveness of the skill based trainings conducted.

Program based training approach over the years has also generated a culture where implementers have started demanding training for each small activities. Health systems seem to work on the premise that whether it is Auxiliary Nurse Midwife (ANM), Staff Nurse or Medical Officer, each of them need trainings even on their basic functions. If it is so then what is ANM Training School, Nursing and Midwifery School or a Medical College is doing? On the contrary, it is required to reflect light on the imparting skills in basic curricula of each of these courses.

Since Health is a state subject, thus the power of planning about Health System lies in the hands of State government. They have also yet to evolve a proper strategy for induction training similar to well established training program in other services i.e. general administration, accounts, police, forest etc. Till now, induction trainings by the health departments have neither been in consonance with induction, nor were they attempted rationally on need basis.

This is a high point when vagueness, confusion and differences in points of planning on various views of training need to be curbed. In this background, each State in the country needs a health system and state specific training policy, HR policy, personnel management information system and after all commitment to implement each policy in place in proper time.

Training provided are generally based on the duties that are to be performed in a particular post. There has been no review or classification of all posts as per job responsibilities that are to be performed and competencies required for them. Therefore, the issue of whether an individual has the necessary competencies to be able to perform the functions for a post has not been addressed.

Monitoring and Evaluation is a powerful tool to address and improve the system governments and organizations achieve ultimate goals. Previous research studies indicate that the effectiveness of training is significantly increased if the monitoring and evaluation of training programmes is systematically undertaken. In the period of limited resources and advancement, training cannot be left on individual discretion and faith. It should generate the returns on investments made.

Evaluating the effectiveness of training is a very important task. Mostly, the evaluation in training institutions is limited to pre-post test questionnaires, inviting trainees to comment on course, trainer and training material. This will only provide the short term impact of training which cannot justify the output of training against the investment of resources. Thus a system needs to be developed which evaluates the changes in the job behavior that resulted from the training programme and its impact on organizational effectiveness and improvement in the satisfaction level of patients/ clients/ citizens.

Recommendations or Suggestions or Conclusion:

a. In order to effectively discharge its HR functions, the state health directorate should have a full fledged HR department with specialized staff and dedicated budget for its activities. The activities of the department would include HR planning, streamlining personnel management and training.
b. The state should develop short and long term human resource strategies and plan by adopting the standard process of assessment of current and future demand & supply, analyzing the gap and formulating short and long term strategies, implementation of strategy and reassessment of gaps. This should be undertaken on a continuous basis.
c. The existing recruitment rules should be reviewed and modified in the light of changing job requirements and improvement in overall education level.
d. Institutions such as Public Services Commission, Subordinate Services Selection Board etc have been created for fair selection process. However delay on their part often leads large backlog of vacancies. The state government should either ensure that the recruitment process by these agencies is completed in time or explore the possibility of direct recruitment of technical staff by the department on a permanent basis.
e. Staffs working on ad-hoc basis for longer duration are denied a number of benefits which are otherwise available on regularization. This is a leading cause of dissatisfaction and de-motivation among such staff.
f. Lack of training in scientific management functions and techniques and the lack of mechanism to monitor the supervisory functions of the staff are the two important factors responsible for poor supervision. This can be overcome by proper training and effective monitoring of supervisory activities.
g. The states need a comprehensive training policy based on the actual needs as per the job requirement. There is also a need for strengthening induction training which should aim at equipping the personnel to discharge all duties independently. Besides the training policy should also have linkage with promotion and skills required for promoted position.
h. The state should undertake proper training of supervisory staff and effective monitoring of supervisory activities in order to strengthen supervision.
i. The states needs to adopt a comprehensive training policy based on the actual needs as per the job requirement
j. The partnership with Non-Governmental Organizations has been an important priority for NRHM. Investments by these organizations are critical for the success of NRHM. The partnership can be in the field of advocacy, building capacity, monitoring and evaluation of the health sector and delivery of health services.

Their participation in Training Programmes for National Diseases Control & RCH Programmes would benefit them by knowledge up gradation regarding programme components, and also information on facilities and inputs available from the Government Machinery for providing services. These facilities and supplies would enable these institutions to provide better quality service at an affordable cost which in turn will increase the demand for the utilization of such services in these hospitals.

k. Distance learning can be by e-learning/web-based training, teleconferencing etc. It can help in development of niche expertise on additional subject(s) for existing manpower, as also follow up training for specialist. It can be available as and when needed without any disturbance to the work schedule of the trainee.

Training should be seen as a part of the overall process of human development. There is a urgent need to change the current training paradigm in health sector from knowledge and competence building to organizational transformation.

Under suggested policy on training and development of Health personnel, there are three types of training given to a health professional.

1. Induction Training
2. In-Service Training
3. Refresher Training

At the time of entry into service, the induction training of at least four weeks duration must be made mandatory. This must have components of requisite skill enhancement, management and knowledge about the drugs/equipment and services offered at all levels of health care. This must be completed in a fixed time frame.

In-service Training is the major component of training. It must be provided to all categories of health care workers to upgrade their knowledge and skills in technical and management fields at least once every two years.

Refresher Training and system of continuous education for health providers needs to be institutionalized. Knowledge and skills of every health provider should be upgraded after every two years.

Thus, for any developing health system with low resources and large population to cater especially India, it is a mandate to have a well structured and rational training policy for its personnel. It is only through trained and developed human resource; India can achieve the health outcomes sooner and in a better way.

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