Government of India

Managing Human Resources for Health in India

A case study of Madhya Pradesh & Gujarat

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In collaboration with WHO - India Country Office

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FOREWORD

Availability of appropriately prepared, deployed and supported health workforce is critical in achieving our national health goals. While adding numbers to the existing workforce is important, it is imperative that the workforce is properly managed and motivated to enhance their productivity and attain optimum level of utilization.

This report on "Managing Human Resources for Health in India – A case study of Madhya Pradesh & Gujarat" provides an opportunity to better understand the existing policies and practices of human resource management for health personnel in the two study states. The report also highlights the key concerns of the health personnel that have bearing on their motivation and supports steps to strengthen the health human resource management practices.

It is hoped that the report will help in formulating policies and systems related to human resource management and may guide in undertaking such studies on a larger scale in order to facilitate achieving objectives of NRHM and national Health Policy in our country.

(Dr R K Srivastava)

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PREFACE

WHO declared "Working Together for Health" as the theme for the World Health Day 2006. The core message of the theme signifies the importance and requirement for appropriately prepared, deployed and supported health workforce. The government of India has accorded a high priority to augmenting its health workforce through various strategies under the National Rural Health Mission (NRHM).

In order to provide a better understanding of the health workforce in the country, Central Bureau of Health Intelligence (CBHI) in collaboration with WHO - India Country Office decided to undertake a study on Human Resource Requirement for Health in India. The aim of the study was to understand the existing health workforce in the country and the future requirement to achieve various national health goals. Advent Healthcare Private Limited, a New Delhi based consulting organization was invited to undertake the study.

Though a number of such studies/estimation has already been attempted and documented however no study had been carried out on human resource management policies and practices which is equally important in enhancing the productivity, coverage and outreach of health services. This necessitated to undertake the present case study in the states of Madhya Pradesh and Gujarat. In order to provide the technical guidance to the study, CBHI constituted a technical group of relevant experts. The study was conducted during April – October 2007 using primary data collection techniques covering all categories of health personnel.

This report on "Managing Human Resources for Health in India – A case study of Madhya Pradesh & Gujarat" provides an understanding and insight into the existing policies and practices of human resource management for health personnel in the two study states. The report also attempts to arrive at a standard methodology to conduct such studies in future, as may be required under NRHM or otherwise. The report will be useful for planners, administrators, academicians, researchers and all others concerned with health development in India to understand the human resource management practices.

The valuable suggestions regarding this publication will be highly appreciated, which may kindly be shared with CBHI/Dte. GHS, GOI.

14/12/07
(Dr Ashok Kumar)

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Our sincere thanks are due to the following members of the technical group who provided valuable guidance during the study:

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The research, analysis and documentation for the report on Managing Human Resources for Health in India was meticulously undertaken by Advent Healthcare Group, New Delhi and its team consisting of Dilip Jha, I C Tiwari, Prabir Chetia & Tarun Sahni.

We would like to thank all the health officials and functionaries of Madhya Pradesh and Gujarat for their valuable data, comments and insight into the human resource management practices in the respective states.

Acronyms

AYUSH	Ayurvedic, Yoga, Unani, Siddha and Homeopathy
ACR	Annual Confidential Report
ANM	Auxiliary Nurse Midwife
BEE	Block Extension Educator
BHO	Block Health Officer
BMO	Block Medical officer
BPL	Below Poverty Line
CBHI	Central Bureau of Health Intelligence
CHC	Community Health Centre
CMHO	Chief Medical & Health Officer
DPC	Departmental Promotion Committee
DPH	Diploma in Public Health
DPHNO	District Public Health Nursing Officer
GAD	General Administration Department
GOI	Government of India
GoMP	Government of Madhya Pradesh
GPSC	Gujarat Public Services Commission
HRA	House Rent Allowance
IEC	Information, Education & Communication
IPHS	Indian Public Health Standard
ISM&H	Indian System of Medicine & Homeopathy
LHV	Lady Health Visitor
MCI	Medical Council of India
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MO	Medical Officer
MPHW	Multi-purpose Health Worker
NPA	Non Practicing Allowance
NRHM	National Rural Health Mission
OBC	Other Backward Classes
PGMO	Post Graduate Medical Officer
PHC	Primary Health Centre
PHN	Public Health Nurse
RCH	Reproductive & Child Health
RNTCP	Revised National Tuberculosis Control Programme
SC	Schedule Caste
SIHCM	State Institute of Health Communication & management
SIHFW	State Institute of Health & Family Welfare
ST	Schedule Tribe
WHO	World Health Organisation

Executive Summary

India's existing disease burden and the changing demographic and disease profile reflect a critical need for adding more health workers in order to achieve even modest coverage for essential health interventions. The need for more health workers have been envisaged under the NRHM which has made the estimates of such requirement. However, it is equally important to properly manage and motivate the staff to enhance their productivity. In this context, the study on "Managing Human Resources for Health in India" has been undertaken by Central Bureau of Health Intelligence (CBHI) in collaboration with WHO India - Country Office.

The study is aimed at understanding the existing policies and practices related to human resource management in select states in India. The Scope of the study is as follows:

- Review the current human resource policies and organizational structures and the capacity to develop and manage health manpower.
- Assess the actual practices with regard to planning, recruitment, induction, management and retention of workforce "on the ground".
- Identify innovative strategies and good practices with regard to development and management of health workforce within states.
- Provide options and solutions to further improve the manpower planning, development, recruitment, deployment, sustenance and retention.

The study was conducted in two states – Madhya Pradesh & Gujarat. Madhya Pradesh was selected as a poor performing state and Gujarat as a better performing state based on health human resource indicators. The approach was to study the government records – rules, regulations and policies regarding management of health manpower in the states. The implementation mechanism and actual practices of human resource management was studied through interview and discussion with the entire spectrum of officials and functionaries at state, district and field levels. In each of the state two districts were visited – One with better and the other having poor manpower availability.

Findings & analysis

The states of Madhya Pradesh and Gujarat do not have a formal mechanism in place to undertake manpower planning on a continuous basis. Planning exercise in the department of health is primarily focused on creation of new infrastructure. In spite of having such a large staffing the directorate does not have a specialized HR department nor do they have HR specialist to guide them on various HR functions.

The recruitment and other service conditions for staff in health services of the state government are regulated by the respective Civil Services recruitment rules. Although the rules and its interpretation have undergone modifications from time to time based on amendments and court ruling, there has not been any concerted efforts to analyse and modify the existing criteria in the light of changing job requirements.

There exist large vacancies in certain categories of staff. The delay on the part of institutions such as Public services commission, subordinate services selection board etc has been sited as the reason for large backlog of vacancies. However the requirement is even larger as the number of sanctioned post of staff have not been revised over the years where as the load of patients and utilization of health facilities have gone up significantly. A majority of recruitment in the recent past has been on ad-hoc basis. Staff working on ad-hoc basis for longer duration are deprived of a number of benefits which are otherwise available on regularization which is a leading cause of dissatisfaction and demotivation among such staff. The policy of appointing staff on

contractual basis is seen as a short term and ad-hoc solution to the actual requirement. Moreover, attrition of contractual staff is quite high.

Many a times the state government in its bid to reduce administrative expenses, announce cuts in staff and freeze on recruitment as in case of Gujarat since 1998. These orders adversely affect the normal process of recruitment leading to large vacancies. It also affects services in hospital and health centres.

The salary structure of health personnel is based on the standards followed for the entire state i.e. all state government departments. Usually prevailing salary of the central government employees is seen as the benchmark for the states. The compensation in the government sector is mostly seen in the context of the accompanying job security and stability. Satisfaction with the existing salary structure is specific to different staff category and the state.

There is no financial incentive for Working in rural, remote and tribal areas. Although the government is finding it increasingly difficult to motivate people to serve in the rural areas, they are yet to devise any incentive for rural posting.

Both the study states provide a contrast as Non Practicing Allowance (NPA) is paid in Gujarat where as private practice during off duty hours is allowed in Madhya Pradesh. Private practice is more lucrative in urban areas due to higher paying capacity of people. This is also one of the reasons for preference of urban posting.

Reservation of seats in government medical colleges in Madhya Pradesh for in-service doctors is an incentive for medical officers working in rural areas. It also helps the state in improving the availability of post graduate doctors.

Promotion act as an important motivating factor even when it is not accompanied by substantial financial benefits. Promotions in both the states are dependent on the availability of vacancy in the promotional post. There is no system of time bound promotions. In actual practice promotions are often delayed due to lack of regularity in constituting DPCs. Non-availability of ACRs at the time of promotion is one of the important reasons for delay in promotions.

Government of Madhya Pradesh has a transfer policy issued by the department of general administration which applies to all categories of staff in the state. The current practices of transfers and posting in Madhya Pradesh are seen as non-systematic. Where as in Gujarat although transfers are mostly on individual's request, the practice is seen as fair and reasonable.

There is no systematic supervision in either state. Supervisory styles of officers, their frequency and content is as varied as the number of supervisors. This is because of the fact that the staff at different levels has not been adequately trained in scientific management functions and techniques. Also there is no mechanism in place to monitor the supervisory functions of the staff.

Although both the states have some system of induction training, its content and duration is grossly inadequate. As a result these new appointees face difficulty in discharging duty during initial period. In-service training for doctors is mostly programme driven. Attempts have been made by both states to impart management training to the managerial staff. However these practices have not been institutionalized due to lack of clear cut policy and the mechanism to ensure the implementation of the training policy.

Recommendations

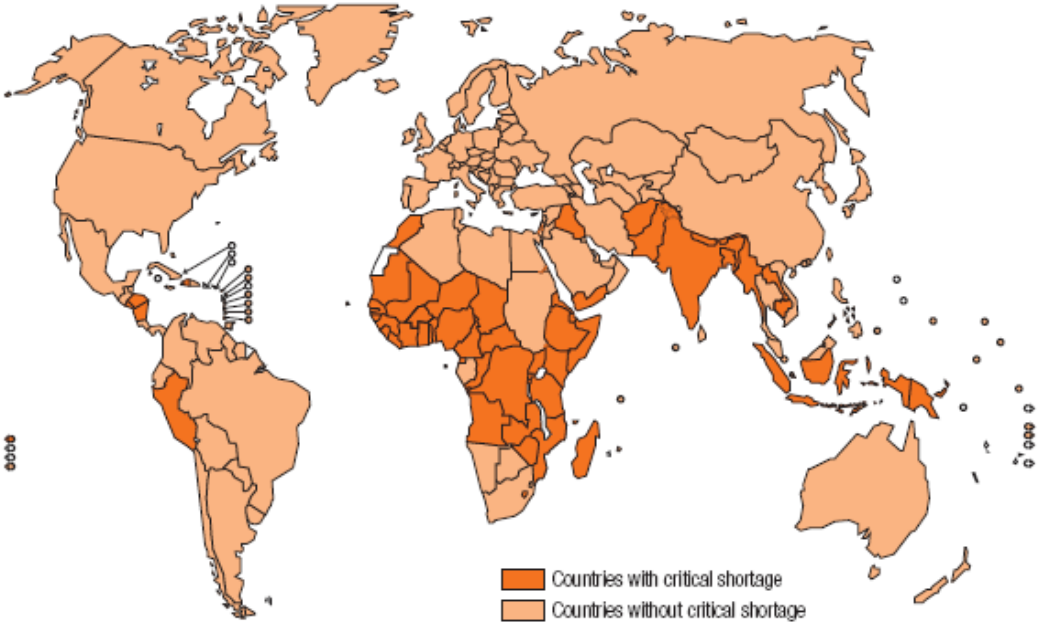
Some of the recommendations emerging out of the study are as follows:

- The state health directorate should have a full fledged HR department with specialized staff and dedicated budget.
- The states should develop short and long term human resource strategies and plan by adopting the standard process of manpower planning.
- The existing recruitment rules should be reviewed and modified in the light of changing job requirements and improvement in overall education level.
- Recruitment of programme staff should be undertaken with a view at long term utilization.
- The states should review the sanctioned post as per the existing workload and create additional posts wherever required.
- The government should either ensure that the recruitment process is completed in time by the recruiting agency or explore the possibility direct recruitment of technical staff by the department.
- The state government should avoid ad-hoc appointments and regularize the existing ad-hoc staff at the earliest.
- There is a need for flexibility in fixing compensation for health personnel in order to make the government services more attractive.
- The state governments should devise policy for providing financial incentives along with better housing and education facility for children to make rural posting more attractive.
- The state government should consider time bound promotion for all category of staff. Further promotions should be linked to training and attainment of higher knowledge and skills relevant to service delivery.
- The state should adopt a time bound transfer policy where a person has to serve in the rural and remote areas only for a fixed duration after which they get a chance to gradually move to cities over a defined time period.
- The state should undertake proper training of supervisory staff and effective monitoring of supervisory activities in order to strengthen supervision.
- The states needs to adopt a comprehensive training policy based on the actual needs as per the job requirement.

1 Introduction

1.1 Context

WHO has declared "Working Together for Health" as the theme for the World Health Day 2006. The core messages of the theme signifies the importance and requirement for appropriately prepared; deployed and supported health workforce, governance of health workforce through sustainable human resource for health development and increased strategic investment in health workforce for achieving equity oriented national health goals. WHO has identified a threshold in workforce density below which high coverage of essential interventions, including those necessary to meet the health-related Millennium Development Goals (MDGs), is very unlikely. Based on these estimates, there are currently 57 countries with critical shortages (including India) equivalent to a global deficit of 2.4 million doctors, nurses and midwives.1 Countries with critical shortage of health service providers (doctors, nurses and midwifes)



Data source: World Health Organization. *Global Atlas of the Health Workforce* (http://www.who.int/globalatlas/default.asp).

Almost all countries suffer from maldistribution characterized by urban concentration and rural deficits, but these imbalances are perhaps most disturbing from a regional perspective. The WHO Region of the Americas, with 10% of the global burden of disease, has 37% of the world's health workers spending more than 50% of the world's health financing, whereas the African Region has 24% of the burden but only 3% of health workers commanding less than 1% of world health expenditure. The exodus of skilled professionals in the midst of so much unmet health need has lead to health workforce crisis.

India's disease profile is expected to follow the same pattern as in developed economies. Based on demographic trends and disease profiles, lifestyle diseases - cardiovascular, asthma and cancer have become the most important segments, and in-patient spending is expected to represent nearly 50 per cent of total healthcare expenditure. In the inpatient market, the share of infectious diseases is expected to decline from 19 per cent in 2004 to 16 percent in 2008.

[1] World Health Organisation, World Health Report-2006, April 2006

These estimates highlight the critical need for more health workers in order to achieve even modest coverage for essential health interventions in the countries most in need such as India.

While increasing the number of health workers is linked with increasing training centres which serve as a long term solution, there is an urgent need to manage the existing Human Resources in Health with intent of enhancing their productivity and being able to achieve greater coverage through proper deployment.

In the above context the Central Bureau of Health Intelligence (CBHI) in association with WHO-India has undertaken the "Study on Managing Human Resources for Health in India".

1.2 About the study

The study on "Managing Human Resources for Health in India" is aimed at understanding the existing policies and practices related to human resource management in select states in India.

Scope of the study:

- Review the current human resource policies and organizational structures and the capacity to develop and manage health manpower.
- Assess the actual practices with regard to planning, recruitment, induction, management and retention of workforce "on the ground".
- Identify innovative strategies and good practices with regard to development and management of health workforce within states.
- Recommend options and solutions to further improve the manpower planning, development, recruitment, deployment, sustenance and retention.

Approach & Methodology

Human resource development and management is a vast domain. Taking into account the allocated time and resources for the study, the technical committee (formed by CBHI to provide technical guidance for the study) discussed all components of the study and decided to focus on the broad areas of manpower planning, recruitment, compensation & benefits, promotion, transfer & posting, supervision and training. The study attempted to cover all cadres of health staff. It include medical education, AYUSH, administrative staff in health department and all medical nursing and paramedical staff.

On the recommendation of the technical group, the study was conducted in two states – Madhya Pradesh & Gujarat. Madhya Pradesh was selected as a poor performing state and Gujarat as a better performing state based on health and human resource indicators. In each of the state two districts were visited – one with better and the other having poor manpower availability. The details are as follows:

State	District
Madhya Pradesh	Hoshangabad
	Betul
Gujarat	Vadodara
	Narmada

Betul in Madhya Pradesh and Narmada in Gujarat are tribal dominated districts with poor accessibility. These districts have higher staff vacancy and poor performance as compared to Hoshangabad and Vadodara districts in

respective states. In each district a block level PHC and CHC were visited to cover all categories of functionaries.

The approach was to understand the existing human resource management policies and practices through studying government records/orders and discussion with policy makers managers and functionaries. It was initially planned that all key officials at state, district and field level shall be interviewed using a interview checklist (a detailed data collection matrix showing data type, categories of respondents, tools used is given in Appendix A).

However during the initial discussion with state officials, it was realized that different officials have been assigned responsibility of one or more components of HR management for a particular staff category. For example there are separate officials looking after paramedical staff at district/taluka hospital and CHC/PHC. Thus the study required interaction with all such officials who were responsible HR management for one or more category of staff. Interaction with these officials focused on specific components from the interview checklist.

The officials and functionaries contacted during the study include commissioner (secretary), directors (additional/joint/deputy director), administrative staff at the directorate, Principal/dean and faculty at medical colleges, regional director, chief district medical and health officer, programme officers at district level, civil surgeon, specialists and doctors at hospitals and CHCs, nursing & paramedical personnel at all levels, medical officer at PHC, health workers, supervisors, BEE and clerical staff. Besides director and medical officers of AYUSH department were also interviewed during the study.

At the district level interviews were held with officials at the office of the Chief Medical/Health Officer. This included CMHO, programme officers (national programmes), district public health nurse, media officer, statistical officer and administrative officer. Attempt was made to interview at least one official from each cadre of staff to understand specific issues faced by the cadre. In each of the four districts interview with the superintendent and group discussion with doctors, nurse and paramedical staff were conducted.

At CHCs, group discussion with all categories staff were conducted where as interviews with Block Health Officer, BEE, supervisors and multipurpose health workers were conducted at Block PHC.

The interaction with functionaries at district, CHC and block levels focused on understanding the actual implementation of HR management policies, advantage/disadvantage of the policies/practices and seeking solutions for better HR management.

Secondary data obtained during the study include recruitment rules and government orders for various categories of staff, government orders regarding salary, compensation and promotion, current staff position and result of various recruitment drives. Besides annual reports and other statistical reports of the directorate in both the states were obtained.

The analysis focused on comparison of practices in both the states as well as with the standard practices in the corporate sector.

2 Human Resource Management Practices

2.1 Case study Madhya Pradesh

2.1.1 Background

Madhya Pradesh is located in the central part of India covering an area of 308,245 square kilometers with the population of 60.4 million, it has a large proportion of scheduled castes and tribes (15.17% and 20.27% respectively) with 73% of the population living in rural areas. The State is typically characterized by difficult terrain, high rainfall variability, uneven and limited irrigation, deforestation and land degradation.

Despite significant progress in socio-economic development over the last decade, the state continues to be afflicted with some of the worst indicators in India. These include low literacy rates, high levels of morbidity and mortality and 37% of the population living below the poverty line. 89% of the population in rural areas is dependent on agriculture.

Table 1: Socio-demographic profile of Madhya Pradesh

S. No.	Indicator	Madhya Pradesh	India
1	Area (In sq. km) [1]	3,08,245 (9.38% of India's total area)	32,87,240
2	Population[1]	6,03,48,023 (5.87% of India's population)	1,028,737,436
3	Population growth rate (1991-2001) [2]	24.34	21.34
4	Population density [1]	196	325
5	Literacy Rate[2]	64.11	65.38
6	Sex ratio (Females per 1000 Males) [2]	920	933
7	Urban population[1]	26.5%	27.8%
8	Scheduled Castes[1]	91, 55,177 (15.17%)	16,66,35,700 (16.20%)
9	Scheduled Tribes[1]	1,22,33,474 (20.27%)	8,43,26,240 (8.20%)

Source: 1- Census, 2001, RGI, Govt of India
2 - NRHM Project Implementation Plan 2006-12, Deptt. Of Health & Family Welfare, Govt. of Madhya Pradesh

Although the population density in Madhya Pradesh remains low relative to most other large states, the rising density indicates an increasing pressure on land and other resources.

According to the 2001 Census, literacy rate for Madhya Pradesh was 64.08 percent compared with 65.38 percent for India as a whole. The proportion of illiterates is almost twice as high for rural females (63 percent) as for urban females (33 percent), and nearly thrice as high for rural males (34 percent) as for urban males (13 percent).

According to the Third Madhya Pradesh Human Development Report (2002), population Below Poverty Line (BPL) in 1999-2000 has been estimated at 37.43% (37.06% for rural and 38.44% for urban). This figure is higher than the national average of 26.10%. The Per Capita Income (calculated at constant prices, 1993-1994) for Madhya Pradesh was Rs.7876/- in 1999-2000, being much lower than the National figure of Rs.9739/- (Source: Dept. of Finance, GoMP).

Health indicators:

Table 2: Status of Key Health Indicators

Health Indicator	Referral Year	M.P.	India
Birth Rate	2005	29.4	23.8
Death Rate	2005	9.0	7.6
Infant Mortality Rate	2005	76	58
Maternal Mortality Rate	2003	379	301
Total Fertility Rate	2004	3.7	2.9

Source: National Health Profile 2006, CBHI, Govt of India

During the last two decade, IMR has reduced to a level of 79 in 2004 from a level of 142 in 1981. A large number of infant deaths occurred during the neo-natal period. The maternal mortality rate continues to be high. One of the reasons being poor access and availability to health facilities, more than 75 percent deliveries are conducted at home and most of them are being conducted by unskilled persons in unhygienic conditions, there by contributing to the increased rate of MMR.

2.1.2 Health institutions in Madhya Pradesh

Primary health care including preventive, curative and promotive care is provided through a network of Sub Centres, Primary Health Centres and Community Health Centres to cater the health needs of the community in rural areas. While secondary care is provided through district hospitals & civil hospital and tertiary care through medical college hospitals. The number of health institutions in the state are as follows:

Table 3: Health institutions in Madhya Pradesh (as in February 2007)

S. No.	Category	Number
1	Medical College	5
2	District Hospital	48
3	Civil Hospital	54
4	CHC	270
5	PHC	1149
6	Subcentre	8834
7	Ayurvedic Hospital	28
8	Ayurvedic Dispensary	1427
9	Homeopathic Hospital	3
10	Homeopathic Dispensary	146
11	Yunani Dispensary	50

2.1.3 Organisation Structure

The department of health and family welfare in Madhya Pradesh is headed by the Minister of Health & Family Welfare, a cabinet minister. The minister is responsible for policies and administrative decisions at the highest level.

Principal Secretary Health & Family Welfare is the administrative head of the department and responsible for implementing the policies. Principal Secretary is assisted by a secretariat consisting of secretary and deputy secretary.

There are various directorates under the principal secretary which are directly involved in implementation of various programmes and activities. The directorate is responsible for technical as well as administrative support to the activities under them. A detailed organization structure is given in appendix C.

There are a total of 10 directors under the principal secretary out of which director medical education, ISM&H, state AIDS control Society and Controller Food & Drugs report directly to the principal secretary. The remaining six directors report to the commissioner health who in turn reports to the principal secretary. Director public health, medical services, communicable diseases, family welfare, IEC Bureau and State Institute of Health Communication & Management (SIHCM) report to the commissioner health.

The earlier directorate of Public Health & family welfare and medical services is now headed by four directors tentatively called as director Public Health, medical services, communicable diseases and family welfare. However, a clear cut and logical distribution of job responsibility among them is lacking. Also the responsibilities are frequently changed. At the level of joint directors and deputy directors, often they have to report to more than one director as the allocation of tasks are not discreet and logical.

The directorate of medical education and ISM&H is usually headed by principal secretary medical education but it is currently under the principal secretary health and family welfare.

In a bid to decentralize the administration, regional joint directors have been appointed for decision making and supervision of districts under them. At the district level, Chief Medical & Health officers along with programme officers for various disease control programme, heads CHCs, PHCs and subcentres within the district. Where as district hospital and civil hospitals within district are looked after by the civil surgeon of the district hospital.

The government of Madhya Pradesh has also created a position of Block Medical Officer (BMO) to supervise the activities within the block. However, there is no separate cadre/post of BMO. One of the medical officers within the block is designated as BMO.

Personnel management functions are carried out by the department of establishment headed by a joint director (currently headed by additional director). This position is usually filled by officers on deputation from the general administration department.

2.1.4 Classification of Staff

As per the MP Civil Services Rule 1961 all staff in the government has been categorised into four classes i.e. class I to IV. Class I & II are gazetted posts which are mainly occupied by doctors. Only in few cases any class III staff are promoted to class II (gazetted) posts.

As per the recruitment rules all staff has been grouped under Group A – medical staff, Group B – Non medical staff and Group C – Nursing staff.

Currently all doctors are recruited as assistant surgeons in grade II. Those holding PG degree are designated as Post Graduate Medical Officer (PGMO)

without any additional compensation i.e treated at par with MBBS. These PGMOs have a chance to be promoted to grade I whenever there is a vacancy of specialist against a regular post.

All specialist and senior positions such as programme officers, deputy director & equivalent posts and higher posts are Class I posts. All medical Officers and district level officials from group B & C such as Statistical Officer, Extension & Media officer etc. fall under Class II.

Class III consist of bulk of the staff including nursing personnel and paramedical staff. While class IV staff include ward boy, sweeper etc. (For details see Appendix E)

2.1.5 Manpower Planning

There is no formal mechanism for health workforce planning. All decisions regarding creation of new posts & filling up vacant posts are taken on an ad-hoc basis as per the need which arises from time to time or programme driven. The mandate of equipping health facilities with adequate staff as per the IPHS norms under the NRHM has led to the assessment of gaps in the availability of relevant categories of staff. This has also prompted an analysis of supply and demand scenario leading to certain policy decisions. For example requirement of a large number posts of nursing personnel has led to the “swablamban yojna” where financial support has been provided to needy candidates to study in private nursing colleges in lieu of a bond of 7 years of service. However, these initiatives are prompted by the mandate of the programme and the financial allocation for recruiting the staff. The state government has not yet sanctioned additional posts to bring the staffing at par with IPHS norms. Most of the additional posts are treated as contractual.

Factors such as population growth, demographic changes, disease burden, patient load and health seeking behaviour are not taken into consideration while planning. In the past, a large number of posts e.g. Director Public Health, District Family Welfare Officers, additional posts of medical officers at PHC, staff of Post Partum Program, ANMs for Sub Health Centres, etc. were created on the basis of recommendations of Government of India which also provided budgetary support for the purpose.

The directorate has a separate planning & development department headed by a joint director. The planning department undertakes the planning of new institutions which include creation of posts for the new institutions as per the Govt of India norms.

For existing institutions, there is no provision for increasing the number of sanctioned staff. However an institution may be provided additional contractual staff from the provisions of the programmes mainly RCH. Demand for filling up of vacant posts are raised by the Chief Medical & Health Officer (CMHO) of each district.

2.1.6 HR Information

State has the statutory requirement of preparing and maintaining gradation list based on the seniority of staff in each category/subcategory. Gradation list for doctors is available in computerized format. The data contained in the list include age, sex, PG qualification & year, date of joining, home district, current posting etc. It is only used for determining seniority. However this vital data is not used for planning. Systematic data on other categories of

personnel are not available. Whenever there is any requirement, data on personnel is sought from the districts.

2.1.7 Recruitment & vacancies

The recruitment and other service conditions for staff in health services of the state government is regulated by the Madhya Pradesh Civil Services (general condition of services) Rules 1961. The rules and its interpretation have undergone modifications from time to time based on amendments and court ruling. Based on the Madhya Pradesh Civil Services (general condition of services) Rules 1961, separate recruitment rules for each category of personnel have been notified in the official gazette. The recruitment rules specify the number of positions, classification, method of recruitment/ promotion including constitution of departmental promotion committee, salary etc. (for detail see Appendix E)

Recruitment of Medical Officers

For recruitment of Medical Officer (called assistant surgeon as per the recruitment rules), district wise vacancies are obtained from CMHO of each district. This is then aggregated at regional level. The region-wise vacancies are advertised. The candidates are interviewed at the regional headquarters and a merit list of successful candidates is sent to the directorate. Appointment order is issued by the commissioner health. There is no satisfactory system for tracking by the Directorate as to how many of the medical officers issued posting orders have actually joined the posts and/ or how many have left after a brief period. The Directorate depends on the Chief Medical & Health Officer/ Civil Surgeon for this information. (Source: Interview with the Regional Joint Directors and CMHOs)

Table 4: Medical Officer Vacancy Madhya Pradesh

S. No.	Category	Sanctioned	Posted	Vacant
1	Medical Officer	3147	2044	1103
2	Lady Medical Officer	213	223	-10
3	Post Graduate Medical Officer	1348	740	608
Total		**4708**	**3007**	**1701**

Note: The number of vacancies given in different tables vary due to method of compilation and difference in reference period.

The above table shows that more than 35% posts of medical officers are lying vacant. However this gap has comedown to 22.3% due to recent recruitment efforts. In addition to the current vacancy 8% seats are filled on a contractual basis which has to be eventually filled on a permanent basis. There is no separate cadre of PGMO. However, 1348 posts of medical officers have been designated as Post Graduate Medical Officer (PGMO). These posts have to be filled with candidates having PG degree/diploma. In geographical terms, the vacancies are more in tribal and remote areas. Tribal dominated districts like Mandla, Dhindori, Balaghat, Umaria etc have more than 50% vacancies. The following table shows the district wise vacancy of medical officers:

Table 5: District wise vacancy of Medical Officer, Madhya Pradesh (as on 1-5-2007)

S. No.	Districts Name	Sanctioned	Posted	Vacant
1	Sheopur	56	21	35
2	Morena	94	87	7
3	Bhind	75	76	-1
4	Gwalior	107	112	-5
5	Shivpuri	87	57	30
6	Guna	77	52	25
7	Ashok nagar	65	33	32
8	Datia	52	38	14
9	Dewas	103	56	47
10	Ratlam	19	53	66
11	Shajapur	74	40	34
12	Mandsaur	125	52	73
13	Neemuch	57	29	28
14	Ujjain	145	94	51
15	Indore	181	121	60
16	Dhar	149	93	56
17	Jhabua	119	61	58
18	Khargone	148	80	68
19	Barwani	88	57	31
20	Khandwa	107	43	64
21	Burhanpur	56	25	31
22	Bhopal	189	189	0
23	Sehore	81	64	17
24	Raisen	71	56	15
25	Rajgarh	87	55	32
26	Vidisha	105	79	26
27	Betul	95	40	55
28	Hoshangabad	78	57	21
29	Harda	44	27	17
30	Sagar	139	108	31
31	Damoh	82	32	50
32	Panna	66	46	20
33	Chhatarpur	123	112	11
34	Tikamgrah	53	46	7
35	Jabalpur	122	94	28
36	Katni	99	14	53
37	Narsinghpur	87	44	43
38	Chhindwara	202	125	77
39	Seoni	98	57	41
40	Mandla	86	42	44
41	Dhindori	77	32	45
42	Balaghat	116	47	69
43	Umaria	45	15	30
44	Rewa	101	68	33
45	Shahdol	90	48	42
46	Sidhi	99	54	45
47	Satna	115	100	15
48	Anuppur	74	34	40
Total		**4708**	**2997**	**1711**

Note: The number of vacancies given in different tables vary due to method of compilation and difference in reference period.

While in some of the regions adequate number of candidates apply against the vacancies, others do not get the required numbers especially in tribal areas.

Thus the backlog remains. Besides, a number people joining in remote areas wait for vacancies in the preferred area and leave for the same within a short span of time. A significant number of candidates appointed by the department, do not join at the place of posting which in most cases are in rural areas. Such candidates keep appearing for interviews in the hope of getting the posting of their choice. Even candidates belonging to the remote and tribal areas give their preference for major cities and surrounding places.

Rules related to reservation apply on the recruitment process. The vacancy is much higher for Schedule Tribe and OBC categories which is 75.6 and 54.3 percent respectively. For ST category approx 700 posts are vacant (See table below)

Table 6: Medical Officer Vacancy as per reservation category Madhya Pradesh

S. No.	Category	Sanctioned	Posted			Vacant
			Regular	Contractual	Total	
1	Unreserved	2827	2471	200	2671	156
2	SC	753	589	85	673	80
3	ST	942	187	43	230	712
4	OBC	186	35	50	85	101
Total		**4708**	**3282**	**379***	**3659**	**1049**

** include 1 MO whose caste status is not known*

Note: The number of vacancies given in different tables vary due to method of compilation and difference in reference period.

There is a provision that a ST candidate can walk in for interview on any working day. However in spite of its best efforts the state government is unable to attract any significant number of schedule tribe candidates. One of the reasons is that level of education among schedule tribes in the state is poor as a result very few candidates are able to join medical colleges.

In order to partially overcome the shortage of doctors due to non–availability of the ST candidates, government has created additional 300 contractual positions. Besides, doctors are being recruited on contractual basis against regular vacancies and RCH programme which is as follows:

Table 7: Availability of Contractual Doctors in Madhya Pradesh

S. No.	Category	General	OBC	SC	ST	Caste not known	Total
1	Regular	200	50	85	43	3	379
2	300 Post	48	7	23	15	0	93
3	RCH	187	55	70	27	3	342
Total		**433**	**112**	**178**	**85**	**6**	**814**

Doctors are currently recruited on a contractual basis. Among the newly recruited doctors, many of them do not join the service and a high number leave the job within short span of time. The percentage of such doctors vary from district to district. Most of the new recruits are posted in rural areas. The terms of contract specify that the posts are non-transferable. Most doctors apply for the vacancies in the hope of getting their choicest place of posting. However, place of posting is allotted based on the merit list. Those who are unable get their preferred place of posting do not join or leave the service in a short span of time. While in urban districts like Bhopal, Indore, Gwalior most

positions are filled, inaccessible, remote and tribal districts like Dindori, Sidhi, Betul etc have higher vacancy.

Recruitment of Specialists

As per the recruitment rules, 75% of the post of specialist has to be filled by promotion of assistant surgeon having PG degree with 5 years experience or PG diploma with seven years experience. The remaining 25% seats have to be filled directly with candidates having postgraduate degree in the concerned specialty with 3 years or 5 years experience after PG Diploma in the given specialty. In practice specialists are recruited through promotion only. Currently a total of 791 posts of specialists are sanctioned for 48 district hospitals, 54 civil hospitals and 270 CHCs. The number of sanctioned posts of specialists is grossly inadequate. As per the recent IPHS standard, a CHC should have at least 4 specialists while a 31-50 bedded civil hospital and 101-200 bedded district hospital should have 10 and 23 specialists respectively. Thus a total of 2724 specialists are required against which 791 posts (less than one third) are sanctioned.

Table 8: Availability of Specialists at District Hospital & CHCs

S. No.	Specialty	Sanctioned*		Posted	Vacant
		District Hospital	CHC		
1	Medicine	60	60	332**	459**
2	Surgery	59	65		
3	Paediatrics	59	68		
4	Obstetrics & Gynaecology	57	63		
5	Anaesthesiologist	28	5		
6	Ophthalmologist	43	-		
7	Radiologist	29	-		
8	Pathologist	29	-		
9	ENT Specialist	29	-		
10	Orthopaedic Surgeon	29	-		
11	Psychiatrist	13	-		
12	Dental	8	-		
13	Skin & VD Specialist	16	-		
Total (in the year 2000)		**459**	**261**		
Currently sanctioned post		**791**			

** Data pertains to the year 2000. Currently there are 791 sanctioned post of specialist which include 13 TB specialists in TB hospitals*

*** Against the sanctioned post 791*

The Govt of Madhya Pradesh has recently taken a decision to convert 1181 posts of PGMO into specialist. Hence the total sanctioned post has gone up to 1972. Further in terms of availability against the sanctioned post, the above table shows that only 42% of the total posts are filled. While PGMOs are available against approximately 55% of the sanctioned posts. Assuming that all PGMOs will be eventually promoted to fill up the newly created positions, the state has the potential to fill up 54% (i.e 1072 of 1972) of the sanctioned posts. However process of recruitment is yet to start for filling up the newly created 1181 posts.

Nursing Staff

The availability of nursing personnel in the state is quite good. Most of the sanctioned positions of staff nurse are filled. However some vacancies exist in the senior positions which are filled through promotion. The detailed availability of nursing personnel is as follows:

Table 9: Staff position – Nursing

S. No.	Designation of post	Sanctioned	Filled	Vacant
1	Deputy Director (Nursing)	1	-	1
2	Principal, Regional Public Health Nurse Training Centre, Ujjain	1	-	1
3	Principal, Grade I, Public Health Orientation Training Centre, Gwalior, Grade II, Senior Post	1	-	1
4	Nursing Superintendent	13	5	8
5	District Public Health Nurse	43	32	11
6	Senior Sister Tutor/ Principal	27	12	15
7	Matron	60	39	21
8	Nursing Sister/ House Keeper	496	234	262
9	Sister Tutor / Public Health Tutor	207	172	35
10	Staff Nurse / Warden	3565	3549	16
Total		**4414**	**4043**	**371**

The Regional Joint Director issues appointment orders for nursing staff, which is based on the vacancy position provided by the CMHO and the sanction for new posts received from the Directorate. The Regional Joint Director does not have up to date information regarding how many of these nurses have joined duty and what is the current vacancy till such time that information is received from the CMHO.

As per the existing practices, staff nurse are recruited from those having passed out of Govt nursing college and the nursing schools. Although the existing posts are adequately filled, there is a demand for additional positions under NRHM. Besides govt in order to meet the requirement of Medical Council of India, has sanctioned 500 additional posts of nurse for each of the five medical colleges which the current supply is unable to fulfill.

The existing number of sanctioned post has not been revised for a long time. Further, new requirements have come up after the launch of NRHM. Last year the govt took a policy decision that in order to meet the additional requirement of approximately 1000 staff nurse, the government would provide financial support to candidates joining private nursing colleges under the *Swablamban Yojna*. In lieu these candidates will have to serve in the govt hospitals for 7 years. Since last year a provision for 500 seats in private colleges have been made. Under the policy, the government would bear the fee of the candidates which amounts to approximately Rs 1.5 lacs. The funding has been arranged under NRHM. However most of the officials are skeptical regarding the sustainability of the policy. According to them the government will not be able to employ all nurses in the health department. Hence the bond of 7 years of service will become invalid. Further, legally government may not be able to enforce the compulsory service. Recruiting nurses passing out of the private nursing colleges is against the govt's policy as they are expected to give preference to those passing out of government's nursing school and college.

Paramedical staff

Paramedical staff such as lab technician, radiographer etc have more stability in job i.e. attrition is very low. They are recruited at district level by the CMHO with posting limited within the district. The following table shows the availability of paramedical staff:

Table 10: Vacancy position of Paramedical Staff

S. No.	Category	Sanctioned	Posted	Vacant
1	Pharmacist	1719	1033	686
2	Lab Technician	1245	1030	215
3	Radiographer	535	383	152
4	BEE	284	123	161
5	LHV	326	288	38
6	NMA	603	137	466
7	Malaria Inspector	283	179	104
8	Eye Assistant	476	414	62
9	MPHW Male	6716	5613	1103
10	MPHW Female	9503	8878	625

The vacancy is high among pharmacists and block extension educators. Radiographers are not in position against 26% posts. One of the reasons for the same is non availability of x-ray facility in many CHCs. While there is adequate number of MPHW female posted against the sanctioned posts, approximately 18% vacancy exist among the MPHW male. The sanctioned posts of MPHW male is less than the norm of one per subcentre.

Staff under the Directorate of Indian System of Medicine & Homeopathy (ISM&H)

The directorate of ISM&H falls under the department of medical education which is separate from department of health & family welfare. This department is usually headed by principal secretary medical education. However currently the department is under the principal secretary health & family welfare. There are 1623 dispensaries and 31 hospitals under the department out of which 1427 dispensaries and 28 hospital belong to Ayurvedic stream and rest are homeopathic & Unani. Besides there are 7 Ayurvedic college and 1 each for Unani and Homeopathy. The combined staff strength under the directorate of ISM&H is as follows:

Table 11: Staff under the Directorate of ISM&H

S. No.	Class	Sanctioned	Posted	Vacant
1	Class I	145	50	95
2	Class II	1544	1296	248
3	Class III	2647	2183	464
4	Class IV	3578	2947	631
Total		**8014**	**6476**	**1438**

Medical Education

There has been large vacancies in the 5 state medical colleges due to delays on the part of the government to appoint/promote faculty. The medical colleges had to face difficulty during annual MCI inspection. However recently the government has made all medical colleges autonomous societies with the authority to create adequate number of posts as per the MCI norms, appoint and promote staff. The decision has come in the wake of warning by the MCI to derecognize the colleges if it did not take appropriate steps to provide staff as per norm. During the last year the directorate of medical education has undertaken regular recruitment i.e. every four months. The largest vacancy existed in the cadre of professor. During the last year the government has promoted 28 associate professor to professor and 8 assistant professor to associate professor. The current vancancy position of teaching staff are as follows:

Table 12: Teaching staff in medical colleges

S. No.	Class	Sanctioned	Posted	Vacant
1	Professor	145	116	29
2	Associate Professor	319	168	151
3	Assistant Professor	518	428*	90
Total		**982**	**712**	**270**

** include 48 contractual appointments*

The MCI's intervention has also led to sanction of five hundred additional posts of nursing staff in each medical college to meet the norms. However filling up of 2500 additional posts is an up hill task as the supply is not geared up for the same.

Bonded Doctors: The state government has made it compulsory for all students joining govt medical colleges in Madhya Pradesh to sign a bond (of Rs 70000) to serve in the rural area for a period of three years. However the officials pointed out that the bond could not be fully implemented due to legal hassles.

2.1.8 Salary, compensation & benefits

The salary structure is revised periodically based on the prevailing norms in the central government. However due to delays in the revision there is always a gap of 10-12% as compared to those in the central government. The salary structure of health personnel is based on the standards followed for the entire state i.e. all state government departments. Therefore any change in the structure has wider implication.

The compensation is adequate if not attractive in the context of the state. As compared to the private sector which is not well developed in the state, government's compensation is attractive when regularized. However there remains uncertainty over the chances of getting regularized as all new appointments are contractual.

In spite of comparatively better compensation, the attrition is very high as doctors do not want to serve in rural areas for longer duration. There is no clear cut policy regarding duration of service in rural areas. Most people feel that they will not be able to get good schooling facilities for their kids.

Private practice

The government of Madhya Pradesh does not provide any Non Practicing Allowance (NPA) to the doctors posted in the hospitals, PHCs, CHCs etc. In lieu the government has allowed private practice during off duty hours. Private practice is more lucrative in urban areas due to higher paying capacity of people. This is also one of the reasons for preference of urban posting. Private practice is more paying if a person stays longer in one location. As a result in many cases doctors do not accept promotion if they are transferred to other locations. Doctors posted in administrative capacity e.g. Directors, Joint Directors, Deputy Directors, CMHOs, etc. receive non practicing allowance

Reservation of seats in government medical colleges for undertaking higher studies

The government has reserved 20% PG & Diploma seats in the govt medical colleges i.e. 33 PG and 29 Diploma seats reserved for in service doctors. Eligibility is 5 years of continuous service in rural areas and passing PG entrance examination. For lady doctors working in rural area, criteria is only 3 years. Any in-service doctor fulfilling the criteria has to appear in the PG entrance exam and a merit list is prepared which gives weightage to number of years served in rural areas. Option for college and specialty are provided as per the merit list and availability of seat in a given discipline. Doctors are provided leave without pay during the period of training and are given additional increments after rejoining the services. Most staff continue in service on completion of PG courses.

Age at retirement

Age at retirement for doctors in Madhya Pradesh is 62 years. The age of retirement has been extended from 60 to 62 years to ensure higher availability of doctors.

2.1.9 Promotion

For any promotion, a departmental promotion committee (DPC) as per the recruitment rules has to be constituted every year which will recommend the same. Besides the promotion rules 2002 lays down the details as to how the promotions will take place. The promotion rules 2002 specify that the promotion of Class I officials into higher grades shall be done on the basis of merit-cum-seniority where as all others shall be on seniority-cum-merit. Most of the Class I positions are managerial where importance has been given on merit. Rules also specify that 16% of each category of promotional post shall be reserved for schedule caste and 20% for schedule tribe candidates. All seniority-cum-merit promotion will be based on the gradation list of the cadre which has to be updated regularly by the department.

One of the important documents required at the time of promotion is the Annual Confidential Report (ACR) of each employee. A typical ACR consist of three parts. Part one (personnel information) and part two (self assessment) are to be filled by the staff themselves while part three (supervisor's assessment) has to be filled by the supervising officer. The self assessment section consist of a description of job responsibilities, targets & achievements, constraints in achieving targets, assistance in important task achievement and a description of non-movable property. The supervisor's section consists of comments on the achievements listed by the staff, quality of work, knowledge level, attitude towards work, ability to take decisions, meet contingencies & take initiatives; clarity of instructions, ability to motivate, teamwork and public relation. Besides planning, management and supervision skills are also assessed. Finally the supervising authority has to comment on the commitment and grade overall performance. Usually these grades are counted at the time of promotion especially when merit is given importance.

The CMHO and Civil Surgeon at the district level are responsible for writing the ACRs of all the staff within the district. These ACRs are stored at the district level. Higher officials at the state level are responsible for writing the ACRs of district head, regional and directorate level officials. However in practice the ACRs are not written regularly and at times not written objectively. Non-availability of ACRs at the time of promotion is one of the important reasons for delay in promotions.

There is no direct entry into Class - I i.e. specialist cadre. All doctors MBBS or Post Graduate have to join the services in Class - II as Assistant Surgeon. After 5 years of service, those having PG degree are designated as PGMO and are entitled to additional salary increments. The PGMOs are usually posted at CHCs and civil hospitals where posts of specialists are lying vacant. Hence they are expected to perform the task of specialist without equivalent compensation. This is a leading cause of demotivation among the PGMOs. PGMOs become eligible for promotion Class–I /specialist cadre. However the actual promotion to Class - I depends on availability of vacant posts in the given specialty. For this purpose a seniority list of PGMO in different specialty is prepared and promotion to specialist cadre is given on the basis of seniority. Due to the policy of promoting doctors as specialists depending on the availability of specialist post in a given discipline, quite often some doctors get their promotion earlier than the others even though they may have joined service on the same day or are even senior to the doctor promoted. This is an important cause of dissatisfaction among the doctors. Those who do not get any promotion until 15 years of service, they become eligible for selection grade – revised pay scale equivalent to the specialists.

During the field study, most of the doctors viewed the current practices of promotions as non-transparent. They quoted several instances where doctors did not get any promotion even after 20 years of service while some managed regular promotions. There was a general dissatisfaction with the existing system of promotion. The delay in promotion is also evident from the fact that a majority of posts of CMHO and civil surgeons (to be filled by promotion) are not filled (a senior doctor is given the charge).

2.1.10 Transfer & posting

Government of Madhya Pradesh has a transfer policy issued by the department of general administration which applies to all categories of staff. The rules prescribe minimum tenure of posting in one location. The transfer policy does not strictly apply to the health department as many exceptions are made for health staff. In practice most of the transfers are made on individual's request while transfer by the department to reallocate the staff is also made from time to time. In general there is a great degree of dissatisfaction with the existing practices of transfer and posting among the staff. The current practices are seen as non systematic and non transparent.

In case of a transfer, a person can leave for the new location only when they are relieved by the authorities. There is a common perception that a person once posted in rural and remote area is likely to remain there as no one else will be available to take charge. In many cases in the absence of somebody to take charge, the transferred staff is not relieved and the transfer order is reverted. Use of influence in getting posting of choice or to revert transfer orders are perceived to be quite common.

Most staff believe that there should be time bound transfer from rural to semi-urban to urban area and cities. Many link this to the progression in their personal life. Most staff believe that when their children start going to school,

they should get a posting in urban area in order to avail better education facilities. Similary higher education facilities are available in cities where one should get posted say after 20 years of service. The Directorate of Health Services had developed in the past a policy of transfer of doctors from rural to urban areas after completing certain number of years of service. But this policy was never implemented with sincerity and has been forgotten.

2.1.11 Supervision

Supervision, particularly supportive supervision of staff is considered an important element for efficient running of health services. An overview of the supervisory functions of personnel shows that some sort of supervision is provided by the senior level staff to lower level staff at different levels. But supervisory styles of officers, their frequency and content is as varied as the number of supervisors. This is because of the fact that the staff at different levels has never been exposed to scientific management functions and techniques.

A number of supervisory posts are lying vacant and are looked after on ad-hoc basis by a designate official. In such cases the officer in charge do not have the motivation to discharge their supervisory functions effectively.

2.1.12 Training

Training of medical and paramedical personnel constitutes an important element of health manpower management as it not only influences the output and hence the availability of personnel but also the competency of the workers in carrying out the job responsibility assigned to them.

Two types of training programs are conducted for medical and paramedical personnel : pre-service training and in service training. The government sector plays important and major role in conducting the training programs. In recent years the private sector has got increasingly involved in training of medical and paramedical personnel. But its contribution has remained confined to pre-service training only, the in-service training n falling almost exclusively in the domain of public sector. A brief account of training of medical and paramedical personnel in Madhya Pradesh is given below:

Training of medical personnel

There are eight medical colleges in Madhya Pradesh including three colleges in private sector. The total annual intake of medical students in these colleges is a little less than 1000. This is one among several important reasons of shortage of doctors in the state, particularly in the public sector. In the absence of any personnel planning on the part of the government the shortage of doctors has persisted over the years. Post-graduate training program is conducted only within the public sector as the private sector colleges are as yet new and are not ready for this responsibility. The government has a policy of providing leave without pay to its in-service doctors for pursuing postgraduate training programs and about 10 per cent seats are filled up by this method. But the government does not decide the disciplines in which its doctors should undergo post graduate training. Thus the shortage of doctors with post-graduate qualifications in some disciplines like anaesthesia, obstetrics and gynaecology and paediatrics, which are vital for implementing the RCH program, remains un-addressed.

In-service training program for serving doctors is conducted exclusively by the government. These programs are specific program driven and their content and duration is determined by the Government of India, which funds these programs. Training programs under RCH, HIV/AIDS control, RNTCP, National Leprosy Eradication program, family planning, etc are conducted from time to time for both medical and paramedical staff. These training programs are conducted at medical colleges and other training institutions, which include State Institute of Health Management and Communication at Gwalior, and Regional Health and Family Planning Centres are at Gwalior, Indore and Jabalpur. Madhya Pradesh had also undertaken a five- day management training of its senior level officers e.g. Joint Directors, Deputy Directors, CMHOs and Civil Surgeons at Indian Institute of Management, Ahmedabad. The State also receives from time to time fellowships for training / orientation of its officers outside India. But these opportunities are almost invariably grabbed by “creamy layers” who, in any case, have only short term stay and hence low stake in the department.

The State had developed in 2004 a Training Policy for health personnel but its recommendations have not been implemented

Training of paramedical personnel

– Training of paramedical health personnel
  The State has established a training school for Public Health Nurse at Ujjain, two LHV Promotional Training Centres at Jabalpur and Ujjain and 27 ANM Training Centres in different districts. In addition, it has one Training Centre for male Multi Purpose Health Worker at Gwalior. All these centers provide pre-service training to paramedical health persons. In-service training of these personnel (ANM, LHV, PHN, Male MPW) are imparted at Regional Health and Training Centres and District Training Centres which have been established under the World Bank project.

– Training of Nursing staff
  For the training of nursing personnel the state runs a Nursing College at Indore and Nursing Schools attached to District Hospitals. These training programs are for general nursing. There is no post-graduate training program for nurses. As such there is a chronic and serious shortage of Nursing Tutors in the state. Of late private sector has come up in a big way in establishing nursing schools in the state and over 50 colleges are running in private sector. The State government has started in 2006 an innovative scheme of payment of tuition fee (Rs. 50,000 per year) to nursing students enrolled in private nursing schools. With a few exceptions, no in-service training of nursing personnel is conducted in the state with the result that the knowledge and skill of nursing personnel is not updated.

– Training of other paramedical staff
  Training of other paramedical personnel e.g. laboratory technicians, X-Ray technicians, Pharmacists, Physiotherapist, etc is conducted in designated government hospitals but the existing training capacity is not adequate. However, the private sector is catering to the needs of training of these personnel to a large extent and is meeting the personnel needs of both public and private sector institutions.

2.2 Case Study Gujarat

2.2.1 Background

The state of Gujarat came into existence on 1st May 1960 and is the seventh largest state in India with an area of around 196,024 sq. km. Located on the Western coast of India, It has the longest coastline in the country of about 1600 km. The geographical areas in Gujarat comprise desert areas of Kutch, arid /semi arid regions of North Gujarat, Saurashtra and Kutch, tribal/ hilly and forested areas of South Gujarat, plain and irrigated areas of Central Gujarat and coastal areas right from South Gujarat to North western part. Administratively, it is made up of 25 districts subdivided into 225 talukas. Gujarat has been in the forefront of industrial and economic activity in the country and has made rapid progress on all fronts be it economic growth, human resource development, or diversifying its industrial base.

At the time of its creation, it was largely an agrarian economy with little industrial base. Animal Husbandry and Dairying have played a vital role in the rural economy of Gujarat. Today Gujarat accounts for nearly 19% of the total industrial investments in India and has emerged as a leading industrial State in the country. It is also one of the most urbanized States in India with 37% of the population living in urban areas. Most urban and rural settlements contain a mix of communities, with varying socio-economic levels. Growing industrialisation of the State, increasing needs of the people for better quality of life and the need to cater to the burgeoning trade has put tremendous pressure on the existing infrastructure in the State.

Table 13: Socio-demographic profile of Gujarat

S. No.	Indicator	Gujarat	India
1	Area (In sq. km)	196,024	3,287,263
2	Population (Census 2001)	50,671,017	1,027,015,247
3	Population growth rate (1991-2001)	22.63	21.34
4	Population density	258	324
5	Literacy Rate	69.14	65.38
6	Sex ratio (Females per 1000 Males)	920	933
7	Urban population	37.36%	27.78%
8	Scheduled Castes	3,592,715 (7.04%)	16,65,76,000 (16.20%)
9	Scheduled Tribes	7,481,160 (14.76%)	8,31,88,235 (8.10%)

Although the population growth rate has decreased during the last four decades, it is still higher than the all India average. The population density has shown consistent increase during the last four decades indicating an increasing pressure on the resources in the state.

Health indicators:

Table 14: Status of Key Health Indicators

Health Indicator	Referral Year	Gujarat	India
Birth Rate	2005	23.7	23.8
Death Rate	2005	7.1	7.6
Infant Mortality Rate	2005	54	58
Total Fertility Rate	2005	2.8	2.9

Source: National Health Profile 2006, CBHI, Govt of India

During the last five years, birth rate and death rates have shown progressive decline. While the TFR has remained constant.

2.2.2 Health institutions in Gujarat

Primary health care including preventive, curative and promotive care is provided through a network of Sub Centres, Primary Health Centres and Community Health Centres to cater the health needs of the community in rural areas. While secondary care is provided through district hospitals & taluka hospital and tertiary care through medical college hospitals. The number of health institutions in the state are as follows:

Table 15: Health institutions in Gujarat

S. No.	Category	Number
1	Medical College	6
2	District Hospital	26
3	Taluka Hospital	30
4	CHC	273
5	PHC	1073
6	Subcentre	7274
7	Ayurvedic Hospital	48
8	Ayurvedic Dispensary	780
9	Homeopathic Hospital	12
10	Homeopathic Dispensary	216

2.2.3 Organisation Structure

The department of health and family welfare in Gujarat is headed by the Minister of Health & Family Welfare, a cabinet minister. The minister is responsible for policies and administrative decisions at the highest level.

Principal Secretary health & family welfare (currently Additional Chief Secretary) is the administrative head of the department and responsible for implementing the policies. Principal Secretary is assisted by a secretariat consisting of secretary, joint secretary and deputy secretary.

There are various directorate under the principal secretary which are directly involved in implementation of various programmes and activities. The directorate is responsible for technical as well as administrative support to the activities under them. A detailed organization structure is given in appendix D.

The director Indian System of medicine and ESIS report directly to the principal secretary. The directorate of health, medical services and medical education are headed by Additional directors reporting to the Commissioner Health, Medical & medical education who in turn reports to the principal secretary.

The directorate of health has four additional directors looking after health, family welfare, Vital statistics and SIHFW. Besides, Chief Personnel Officer also fall under the directorate of health. Currently the post of additional director is held by a senior professor from medical college which is seen as a positive step to bring in officials on the basis of merit. Most of the programmes and activities are looked after by the deputy directors as there are only four posts of joint directors

In a bid to decentralize the administration, regional deputy directors have been appointed for decision making and supervision of districts under them. At the district level, Chief District Health Officer along with programme officers for various disease control programme, heads PHCs and subcentres within the district where as district hospital, taluka hospitals and CHCs within district are headed by the Chief District Medical Officer of the district hospital.

The government of Gujarat has recently created a position (not sanctioned) of Block Health Officer (BHO) to supervise the activities within the block. One of the medical officers from within the block is designated as BHO.

The state of Gujarat has the position of chief personnel officer who looks after the personnel management functions. The chief personnel officer heads the establishment department and reports directly to the commissioner health. The individuals holding the position are deputed from Gujarat Administrative Services holding the position equivalent to deputy collector.

2.2.4 Classification of Staff

As per the Gujarat Civil Services Classification and Recruitment (General) Rules 1967 all staff in the government has been categorised into four classes i.e. class I to IV. Class I & II are gazetted posts which are mainly occupied by doctors. Currently all doctors are recruited as Medical Officer in Class II. Those holding PG degree are recruited as Specialist Class I. All paramedical and administrative staff are recruited in Class III while rest of the support staff fall under Class IV

All specialist and senior positions such as programme officers, deputy director & equivalent posts and higher posts are Class I posts. All medical Officers and other district level officials such as health education officer, DPHNO etc. fall under Class II.

Class III consist of bulk of the staff including nursing personnel and paramedical staff. While class IV staff include ward boy, sweeper etc. (For details see Appendix F)

2.2.5 Manpower Planning

Workforce planning involves assessment of current and future demand & supply and analysing the gap and formulating short and long term strategies for ensuring availability of sustainable levels of staff. The state of Gujarat does not have a formal mechanism/system in place to undertake manpower planning on a continuous basis. There have been initiatives in the recent past to analyse the gap in the availability of different categories of personnel in the state. The

impetus to look at the existing vacancies and the supply factors came from court order to fill up existing vacancies in hospitals and the mandate of NRHM to augment the staff in medical and health institutions.

The state has recently taken initiative to develop the personnel management information system. The system has the potential to provide vital information regarding availability of different categories personnel in different regions, personnel information, recruitment, promotion transfer posting etc., training, performance appraisal. This task when fully implemented will be of great use in planning and personnel management.

2.2.6 HR Information

The personal information of Class I & Class II officers serving under the office of the Commissionerate of Health, Medical Services and Medical Education (H.S.), Gandhinagar is being computerized in two different formats as under.

E.I.S (Employees Information System) as per the format prescribed by the G.A.D of the State Government. There are total 122 Class-I officers serving in the cadres of Addl. Director, Dy.Director, Asst. Director, Chief District Health Officer, Addl. District Health Officer, District T.B. Officer, District Leprosy Officer. Total 118 officers have submitted their E.I.S. information in the prescribed format. The remaining information shall be collected and submitted to the Government within a short time. There are total 104 Class-I specialists serving in the cadres of Superintendent, Gynecologist, Pediatrician, and Ophthalmic surgeon etc. Out of these 97 officers have already submitted their information. This information has been sent to the Government.

E.P.I.S (Employee Personnel Information System) is a computerized programme developed by the Commissionerate of Health, Medical Services & Medical education. At present there are total 2321 officers serving as Medical Officer Class-II. Information of 2238 Medical Officers Class-II has been computerized.

2.2.7 Recruitment & vacancies

The recruitment and other service conditions for staff in health services of the state government is regulated by the Gujarat Civil Services Classification and Recruitment (General) Rules 1967. The rules and its interpretation have undergone modifications from time to time based on amendments and court ruling. Based on the civil services rules, the department of Medical, Health & Medical Education has issued notification for each category of personnel. One of the significant notification issued by the GAD (Govt of Gujarat resolution no.PRC/102003-672(1)/G-2, dated 13-1-2005) makes it compulsory for all candidates to produce the proof of basic computer knowledge for recruitment & promotion for class I-III. As per the government's recruitment policy for all categories of personnel except at the entry level, there is a provision for recruiting personnel through promotions as well as direct recruitment of meritorious candidate in a specified ratio. For example Chief District Health Officers are appointed through promotion as well as direct recruitment in 5:1 ratio. Rules related to reservation apply on the recruitment process.

Recruitment of doctors

Medical officers (Class II) and Specialists (Class I) are gazetted posts and the recruitment is done by Gujarat Public Services Commission (GPSC). On receipt of vacancies from the Department of Medical, Health and Medical education, GPSC starts the process of recruitment which involves vacancy announcement/advertisement screening/ shortlisting, interview and preparation of merit list. The merit list is handed over to the department which in turn issues appointment letter to the candidates.

In recent years, there has been large number of vacancies of doctors. One of the reasons for the backlog was the slow process of recruitment by the Gujarat Public Services Commission since GPSC looks after recruitment of gazetted posts for all government departments.

Since 1998, there had been a freeze on recruitment of staff under the Gujarat government's policy of downsizing the staff strength of all govt departments by 30%. This led to acute shortage of doctors in health facilities. Therefore the government allowed ad-hoc recruitment of doctors on a case to case basis. However the vacancy could not be filled through ad-hoc appointment. In 2006 the Gujarat High Court asked the government and GPSC to fill up all vacant posts in medical colleges and hospitals in the state. As a result, 1500 posts of doctors were advertised in 2006 out of which approximately 600 were selected. Fresh recruitment drive is under process.

Some of the doctors are working on ad-hoc basis for more than 8 years. A medical Officer appointed on ad-hoc basis is expected to appear for GPSC interview in order to get regularized. However in the absence of regular GPSC recruitment, they were allowed to continue. A candidate can appear for GPSC interview only till 35 years of age. Services of those who are unable to clear GPSC, within 35 years age have to be terminated. Some of the doctors in the remote areas could not apply for the advertised positions as they did not get the information regarding the same in time. A large number of doctors who have already served for more than 5 years and are now ineligible for regular appointment have gone to the court for regularization. These doctors are continuing on ad-hoc basis due to court stay. Another disadvantage with the ad-hoc doctors was that there is a long gap of more than 5 years after passing out of medical colleges as a result they did not fare well on knowledge front in the interview.

Lack of recruitment on a routine basis or recruitment of doctors in large numbers at any given point of time also leads a situation in coming years where all such staff retire at the same time leaving a large vacancy of senior experienced people. It was learnt that during 1960-65, a large number of doctors were recruited who retired during recent years leading to a large number of vacancies.

Unlike Madhya Pradesh, the reserved category seats are adequately filled in Gujarat. 7% seats are reserved for each of Schedule Caste and Schedule Tribe categories. The basic educational level and representation in medical & other institution is quite good leading to their better availability.

Bonded Doctors: The state government has made it compulsory for all students joining govt medical colleges in Gujarat to sign a bond (of Rs 75000) to serve in the department for a period of three years. However the officials pointed out that the bond could not be fully implemented due to legal hassles. Further most of the students prefer to pay the bond money, while other simply ignore it. The reason for such preference is that most of the students aspire for doing PG courses and do not want a break in studies. During 2005 and 2006, less than 10% of the pass outs joined the govt services.

Similarly, about a little less than 50% of the medical officer appointed on ad-hoc basis do not join as they do not get their preferred place of posting which is invariably big cities.

Table 16: Appointment of Medical Officer Class-II during 2004-05 & 2005-06

Sr. No.	Candidate	2004-05		2005-06	
		Appointed	Joined	Appointed	Joined
1	Bonded	889	66	1456	145
2	Adhoc	96	49	100	51

Source: Annual Administrative Report 2005-06, SBHI, Commissionerate of Health, Medical services & medical Education

Shortage of specialists

There is an acute shortage of specialists in the state. Out of 363 sanctioned posts of specialists at district and taluka hospitals, only 143 (43%) are filled. Another 63 posts have been filled on ad-hoc basis leaving a deficit of 39%. The deficiency of regular specialist is much higher for orthopaedic surgeon, radiologists and paediatrician.

Table 17: Availability of specialists in Gujarat

S. No.	Category	No. Sanctioned	No. Filled			vacant
			GPSC	Ad-hoc	Total	
1	Superintendent	4	4		4	0
2	Gen Surgeon	35	15	8	23	12
3	Orthopaedics Surgeon	26	6	11	17	9
4	Physician	37	16	4	20	17
5	Eye Surgeon	32	22	10	32	0
6	Radiologist	24	3	1	4	20
7	Pathologist	24	15	4	19	5
8	E.N.T	13	7	6	13	0
9	Psychiatrist	11	5	0	5	6
10	Cardiologist	1	0	0	0	1
11	Paediatrics	46	8	3	11	35
12	Gynaecologist	48	20	13	33	15
13	Anesthesiologist	53	30	2	32	21
14	Dermotologist	9	6	1	7	2
Total		**363**	**157**	**63**	**220**	**143**

At CHC level only 329 posts of specialists are sanctioned for 273 CHCs against the requirement of 4 specialists per CHC i.e. 1102. The existing number of sanctioned post is less than one third of the requirement as per norms. Further out of the 329 position only 81 are filled which is less than one fourth of the requirement.

Table 18: Availability of specialist at CHC Level (June 2007)

S No.	Category Name	No. Sanctioned	No. Filled	No. Deficit
1	Superintendent Class-1	251	65	186
2	Gynaecologist Class-1	34	4	30
3	Paediatrics Class-1	34	6	28
4	Orthopaedics Surgeon Class-1	3	1	2
5	Ophthalmologist Surgeon Class-1	3	3	0
6	Resident Medical Officer Class-1	4	2	2
Total		**329**	**81**	**248**

For entry into the cadre of specialist, a candidate should have MBBS degree & Post Graduate degree of any statutory university in India in the respective subject; the candidate should not be more than 35 years of age. The age limit for the post of Medical officer remains the same whereas the educational qualification is MBBS from recognized university.

A total of 2893 posts of Medical Officer are sanctioned for 1073 Primary Health Centre, 273 CHCs, 30 Taluka Hospital and 26 District Hospitals. Out of this, 2637 posts are filled while 256 are vacant. The post filled also include a large number of MO appointed on ad-hoc basis.

Table 19: Availability of Medical Officer Class-II

Sr. No.	Cadre	Sanction Post	Filled Post	Vacant Post
1.	Under Jilla Panchayat	1254	1111	143
2.	Under CHC	625	512	113
3.	Under Hospital/Municipal Corp.	668	592	76
4.	Under TB/Leprosy/Sub Centre	137	117	20
5.	Under Block Health Officer	171	158	13
6.	S.S.P.A., Vadodara	21	20	1
Total		**2876**	**2510**	**366**

Recruitment of Nursing and paramedical staff

Nursing and paramedical staff are recruited by Staff Selection Board (Seva Pasandgi Mandal). For all new class III appointment, a candidate has to serve for 5 years on a fixed salary of Rs.3500/- per month which is much lower then those of regular staff. On completion of the 5 year tenure, the person will be regularized based on the performance. This is seen as one of the moves to reduce expenditure on staff. While some point out that those under the 5 year contract do a better work as compared to regular staff.

Nursing Staff

Nursing personnel are recruited by Staff Selection Board (Seva Pasandgi Mandal). The minimum qualification for staff nurse is 3 years General Nursing and Midwifery course from a government recognized nursing school/college. The vacancy of staff nurse is not very high (only 362) as 5909 are posted against the sanctioned strength of 6271. The vacancies are more at CHC and Taluka Hospital level as compared to district hospitals. The current sanctioned strength is lower than those recommended under the IPHS. The state is already facing difficulty in recruiting staff nurses for providing 24X7 services at PHCs. Currently the PHCs do not have sanctioned post of staff nurse. In total the nursing cadre have 7419 sanctioned posts out of which 6750 are posted (669 vacant). This includes staff at nursing schools and nursing college under the government of Gujarat.

Paramedical staff

Paramedical staff such as lab technician, X-ray technician, junior pharmacists etc are recruited by Staff Selection Board. The maximum age for joining services is 28 years.

At district & taluka hospital, 28% vacancy exists among pharmacists. The vacancy among lab technician and x-ray technician is 27% and 25% respectively.

Table 20: Availability of Paramedical staff

Sr. No.	Cadre	Sanctioned	Filled	Vacant
District & Taluka Hospital				
1	Chief Pharmacist	16	12	4
2	Senior Pharmacist	45	29	16
3	Junior Pharmacist	273	199	74
4	Laboratory Technician	108	79	29
5	Laboratory Assistant	38	34	4
6	X-ray Technician	63	47	16
7	X-ray Assistant	35	19	16
8	E.C.G Technician	3	2	1
9	E.E.G Technician	4	0	4
10	Dental Mechanic	12	8	4
11	Physiotherapist Grade A	17	0	17
12	Physiotherapist	12	5	3
CHC				
1	Junior Pharmacist	282	169	113
2	Laboratory Technician	255	212	43
3	X-ray Technician	251	123	128
PHC				
1	Junior Pharmacist	1073	618	455
2	Laboratory Technician	1073	694	379

2.2.8 Salary, compensation & benefits

The basic salary structure of medical officer and specialists is at par with those existing in the central government. However there is a difference in terms of dearness allowance which is lower in Gujarat. In the year 1994 the Govt of Gujarat constituted a committee called Tikoo Committee to look into various salary and promotion related issues for doctors and bring them at par with the practices in the central government. The committee recommended time bound promotion of medical officer to senior medical officer in 6 years, then to chief medical officer in 7 years, then to chief medical officer selection grade in 6 years with accompanying increase in salary. Similarly for specialist appointed as specialist grade 2 then to in 6 years specialist senior scale. The raise in salary scale (selection grade commonly called Tikoo grade) is currently given at an interval of 9 years i.e. first at 9 years, second on completion of 18 years of service and the third after 27 years. There is a plan to raise the time period for selection grade to 12 years.

The existing compensation is adequate if not attractive for medical officers and Class III & IV staff. However, it is not perceived to be adequate for specialists. Specialists are reluctant to join the government service as they see better opportunity for earning in private sector. It is widely perceived that many specialists join the government services for a short duration of one or two years to gain experience after which they join private sector.

House Rent Allowance (HRA): The HRA of 15% of basic salary for big cities and 5% for small towns is paid to the regular staff. This is seen by many as an added incentive for posting in big cities or a disadvantage for staff posted in smaller places. There is no additional incentive for serving in the remote and difficult area.

Non-practicing Allowance (NPA): The doctors are given non-practicing allowance as the private practice is not allowed for those in the government service. However a recent government order provides option of private practice in non working hours for the doctors who have served for 15 years while the new recruits are allowed private practice and will not get the NPA. The implementation of this policy is on hold due to litigation against allowing private practice by the government doctors. The policy is seen as a cost cutting measure by the government.

In yet another cost cutting measure, the government has made it compulsory for all Class III & IV category staff to serve for initial 5 years on a contract basis on the assurance that they will be regularized on completion of the 5 years period. During this period they will be paid a fixed salary (without annual increment) which is approximately half of the gross salary drawn on regularization.

In spite of large vacancy of specialists, the state govt does not have a policy for supporting in-service doctors to undertake post graduate courses in the deficient specialty. There is no seat reserved in govt medical colleges for in service doctors. It was argued that there is no guarantee that the sponsored candidate will continue working in the department after completion of the PG course. Therefore the govt does not support such policy. In case a person wants to undertake a post graduate course, he/she will have to resign from the service and seek fresh employment on return. However doctors serving in the rural areas are given a chance to undertake Diploma in Public Health (DPH). DPH is essential for promotion of medical officer to Class I positions such as district programme officer. A medical officer gets a chance for undertaking DPH after serving in the rural area for at least six years.

Age at retirement

Age at retirement for all category of staff is 58 which is among the lowest as compared to other states. However, they may apply for contractual position in the department until the age of 62. In practice only a few doctors and some of the nursing personnel join as contractual staff after retirement. Doctors feel that their age at retirement should be higher as they get less number of years of service due to longer duration of medical education.

2.2.9 Promotion

For any promotion, a departmental promotion committee has to be constituted every year which recommends promotions. Administrative officers under each of the department i.e. health, medical & medical education are responsible for looking after various cadre of staff under the department. These administrative officers undertake all necessary documentation to initiate the process of promotion. It was reported that setting up the DPC and processing

the cases of promotion is now undertaken on a regular basis however it was not the case in the past.

Promotions are guided by the recruitment rule which specify the eligibility criteria for filling up a position through promotion. The rules also defines the ratio of person to be promoted from various feeder cadre. (Detailed recruitment rules given in Appendix D). However, promotions depend on the promotion avenues in a given cadre and vacancy.

A person joining as specialist will have the opportunity to be promoted to Superintendent – Chief District Medical Officer – Deputy Director – Joint Director - Additional Director. However most specialist prefer clinical responsibilities as compared to administrative ones. As a result in many cases they do not accept the promotion. The other reason for non acceptance is that promotion often lead to transfer of a person to the place where vacancy exist. After having lived in a place for long duration, a person is reluctant to move out.

For medical officers working in CHCs and district/taluka hospital, promotional avenues are limited. First of all the MO has to be promoted to Resident Medical Officer (Class I) and then to Chief District Medical Officer – Deputy Director – Joint Director - Additional Director. The post of Resident Medical Officer are limited as a result only a few of MOs are able to get promotion and that too towards the end of the service.

Medical officers working in PHCs have a better chance of getting promoted in the public health cadre. They are given a chance based on seniority to undertake Diploma in Public Health. After completing DPH they have the opportunity to be promoted to District Programme Officers - Chief District Health Officer – Deputy Director – Joint Director - Additional Director.

Doctors who were initially recruited on an ad-hoc basis are at a disadvantage as the number of years served on ad-hoc basis is not counted while preparing the seniority list. As a result they end up getting lesser salary, benefits and promotions. During our field visit we came across doctors who had served for more than 15 years on ad-hoc basis. In one such case, the person who was posted in a remote location did not get the information regarding GPSC recruitment and missed the opportunity to get rgularised.

Nursing cadre have a number of promotional posts. For a person joining as staff nurse has the opportunity to be promoted as Staff Nurse – Head Nurse – Matron Class III – Matron Class II – Chief Matron Class II. They have the opportunity to get into the cadre of nursing education by undergoing tutor training after completing 3 years of service as staff nurse. Tutor gets the opportunity to become principal class II. The third stream for staff nurse is to join public health nurse cadre by undergoing 10 month PHN training at PHN training school. The PHN can become District Public Health Nursing Officer Class II.

There are limited opportunity for promotion of pharmacists. While pharmacists working at PHC and CHC do not have any avenue for promotion, those posted in district and taluka hospital can be promoted as senior pharmacists and chief pharmacist. No promotional avenue exist for other paramedical staff such as lab technician, X-ray technician etc.

2.2.10 Transfer & posting

The government of Gujarat does not have a specific transfer policy for the department of Medical, Health & Medical Education. Currently transfers are made on four count:

1. On request of the staff
2. Transfer by the department to deficient areas
3. Complaint against the staff
4. On promotion

Most of the transfers fall under the first category. All decisions regarding transfers are taken by the Commissioner. Transfers are not made in a routine manner. Usually people are not transferred unless they opt for the same or have complaints against them or promoted to higher position for which vacancies are not available at that location. Many a times promotions are not accepted by the staff in order to avoid transfers. In general, people are satisfied with the way transfers are handled by the department. However they desired a proper policy where a person has to serve in the rural and remote areas only for a fixed duration after which they get a chance to gradually move to cities over a defined time period. Education for the children of staff was reported to be most important factor for preference of urban location. Most of the staff member desired that as their children grow, they should get a posting in cities where better education facilities exist.

2.2.11 Supervision

Supervision, at the primary level in Gujarat is focused on achieving the programme related targets. Block health officer along with supervisors undertake regular field visits to monitor the progress and provide support to the health workers. Supervisor male & female at the PHC level are perceived to be the weakest link in the supervision. Supervisors are recruited through promotion from the cadre of multi-purpose health workers. As a result their skill and capabilities are similar to those of MPHWs. They lack in orientation and skills for effective supervision.

The Medical officers at the PHCs are more focused on providing outpatient services. By training, they lack in skills and orientation towards programme management and supervision. This is true for most of the doctors who have more inclination towards clinical work as compared to programme management, administrative duties and functions.

2.2.12 Training

The state of Gujarat does not have a training policy. Lately the government has taken the initiative to draft a training policy which is under review. Some of the highlights of the policy are as follows:

- Objective criteria has been developed for selection of trainers from among the personnel serving in the state. The criteria focuses on knowledge, skills, experience and training aptitude and capabilities. The identified trainers has to undertake a test and interview in order to qualify as a trainer.
- Selected trainers would be trained in training technology
- Planning exercise and development of annual training calendar
- Trainees should be objectively evaluated and the certificate should be given to only those who obtain minimum marks
- Fee should be charged from trainees to bring about seriousness in the entire exercise

A 12-day induction training is provided to newly recruited doctors at the Regional Institute of Health and Family Welfare. It includes 6 days orientation on health programmes and 6 days on understanding duties and responsibilities.

In-service training for doctors is programme driven. Their content and duration is determined by GOI, which funds these programs. Training programs under RCH, HIV/AIDS control, RNTCP, National Leprosy Eradication program, family planning, etc are conducted from time to time for both medical and paramedical staff. These training programs are conducted at SIHFW and Regional Health and Family Planning Centres.

The government of Gujarat has also developed management training programme in collaboration with IIM Ahmedabad. Currently all BHOs are being given management training.

3 Analysis and Insights

The study of human resource management practices in the states of Madhya Pradesh and Gujarat has raised several issues that are important to most of the states in India.

Manpower Planning

Manpower planning involves assessment of current and future demand & supply and analysing the gap and formulating short and long term strategies for ensuring availability of sustainable levels of staff. The states of Madhya Pradesh and Gujarat do not have a formal mechanism in place to undertake manpower planning on a continuous basis. Planning exercise in the department of health is primarily focused on creation of new infrastructure/institutions. After the launch of NRHM both the states took steps to assess the vacancy and supply factors. These steps mainly focused on increasing the supply of nursing personnel through increasing the seats in existing institutions and establishing new institutions. However the states have not assessed whether the existing terms and conditions are attractive enough and what needs to be done to attract and retain staff at various positions.

Lack of comprehensive and dynamic database on existing workforce is lacking in both the states hampering any planning process. During the study in Madhya Pradesh it was learned that the state did not have any information on the number of doctors who joined the services after issue of appointment letter. The state of Gujarat has recently taken initiative to develop the personnel management information system. The system has the potential to provide vital information regarding availability of different categories personnel in different regions, personnel information, recruitment, promotion transfer posting etc., training, performance appraisal. This task when fully implemented will be of great use in planning and personnel management. However the use of such tools needs to be institutionalized. In the past such systems have remained unutilized.

The state health department despite having such a large workforce, does not have a specialized HR department nor do they have HR specialist to guide them on various HR functions. Under the NRHM HR consultant has been hired by both the states to streamline its HR functions. However their role and involvement till date has been only limited. Moreover such consultants are mainly drawn from retired bureaucrats rather than professional HR fields.

Recruitment & vacancies

The recruitment and other service conditions for staff in health services of the state government are regulated by the respective Civil Services recruitment rules. These rules are elaborate and provide clear cut guidelines for recruitment, promotions etc. Although the rules and its interpretation have undergone modifications from time to time based on amendments and court ruling, there has not been any concerted efforts to analyse and modify the recruitment criteria in the light of changing job requirements. A comparison of minimum qualification of lab technician shows that in Madhya Pradesh it is higher secondary where as the same is graduation in Gujarat.

Most of the positions sanctioned by the states earlier were programme related with programme specific responsibilities. However, there has been integration of the existing functions in recent years and addition of new responsibilities. Further, technological advancement on one hand has made some of the

functions easier, on the other hand it has necessitated additional skills and orientation to effectively utilize the technology. The paradigm of programme implementation itself has undergone a sea of change. All these factors requires a comprehensive review of existing recruitment rules in order to align it to current and future needs.

There is also a need to look at the utility of a variety of posts that has been created and maintained over the years. For example a number of posts were created under the National Leprosy Eradication Programme. The activities under the programme are now significantly reduced making several posts redundant.

The number of sanctioned post of staff have not been revised over the years where as the load of patients and utilization of health facilities have gone up significantly. In many cases the number of functional beds in hospitals have also gone up without corresponding increase in staff. After the launch of NRHM, states have started looking at the staffing gap as per IPHS. However getting approval of the finance department for the additional staff is always difficult. Most of the new positions created during recent years are contractual and programme funded.

A majority of recruitment in the recent past both in Gujarat and Madhya Pradesh have been on ad-hoc basis. Staff 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 demotivation among such staff.

In spite of well laid out rules and procedures of recruitment, large vacancies exist. The delay on the part of institutions such as Public Services Commission, subordinate services selection board etc has been cited as the reason for large backlog of vacancies. This is true to a great extent as these organizations are burdened with recruitment for all departments of the state. One of the solutions could be direct recruitment of technical staff by the department.

Lack of recruitment on a routine basis or recruitment of any category of staff in large numbers at any given point of time also leads to a situation in future where all such staff retire at the same time leaving a large vacancy of senior experienced people.

Many a times the state governments in its bid to reduce administrative expenses, announce cuts in staff and freeze on recruitment. These orders adversely affect the normal process of recruitment leading to large vacancies. It also affects services in hospital and health centres. Health services can not be treated at par with other departments and hence should be kept out of the purview of such policies. In fact with increasing population and load on the existing facilities, the effort should be to increase the staff strength to match the need.

The policy of appointing staff on contractual basis is seen as a short term and ad-hoc solution to the actual requirement. Many higher officials view this as a parallel system imposed by the programmes. Moreover, attrition of contractual staff is quite high.

In both the study states, it is compulsory for all students joining govt medical colleges to sign a bond of specified amount to serve in the department for a period of three years. However the officials pointed out that the bond could not be fully implemented due to legal hassles. Less than 10% student join the government services under the bond obligation in Gujarat.

Vacancy of posts for reserved category especially for Scheduled Tribe is much higher in Madhya Pradesh. In fact more than 700 posts of medical officer for ST category are lying vacant. It was argued that due to poor education status of ST students only a few are able to enter medical colleges. Hence the backlog remains. In contrast educational status of Scand ST students are higher hence there is better availability of candidates for reserved category posts.

Salary, compensation & benefits

The salary structure of health personnel is based on the standards followed for the entire state i.e. all state government departments. Therefore any change in the structure has wider implication for the state. Usually prevailing salary of the central government employees is taken as the benchmark for the states. However, salary expectations are state specific. While in Madhya Pradesh a post graduate doctor is ready to join the government services as a medical officer in the hope of eventually getting promoted to specialist, salary of specialists in the govt of Gujarat is seen as much lower as compared to their counterpart in private sector. As a result very few specialist join the govt service and the attrition is high. Where Madhya Pradesh has post graduate doctors working as medical officers in the hope of getting promoted to specialist. The compensation in government service in Madhya Pradesh although lower than Gujarat is perceived to be better than those in the private sector. The compensation in the government sector is mostly seen in the context of the accompanying job security and stability. Besides, doctors generally argued that working in the private sector would require them to indulge in unethical practices to extract more money from the patient.

It was observed in both the study states that most of the state health personnel were concerned with parity in salary within their cadre and other comparable cadre in the state. This implies that delay in increments and disparity due to late regularization etc is causes of concern and demotivation.

There is no financial incentive for working in rural, remote and tribal areas. Although the government is finding it increasingly difficult to motivate people to serve in the rural areas, they are yet to devise any incentive for rural posting. In fact people posted in urban areas are entitled to a higher HRA which is seen as a disincentive for rural posting.

Children's education is one of the most important concerns of the staff. It was argued by many staff members in Madhya Pradesh that the government should provide good educational facility as given by many public sector undertakings for the children of staff.

Non Practicing Allowance (NPA) Vs Private practice by doctors

Both the study states provide a contrast as Non Practicing Allowance (NPA) is paid in Gujarat where as private practice during off duty hours is allowed in Madhya Pradesh in lieu of NPA. A mixed response was received regarding NPA and private practice from doctors across the two states. Private practice is more lucrative in urban areas due to higher paying capacity of people. This is also one of the reasons for preference of urban posting. Private practice is more paying if a person stays longer in one location. As a result in many cases doctors do not accept promotion if they are expected to be transferred to other locations. Certain specialists are more in demand and hence they prefer private practice instead of NPA. Preference for NPA was shown by the doctors posted in rural areas.

Officials in Gujarat argued that in spite of general ban on private practice by the government doctor, many indulge in that. It is difficult for the state to stop

that. Hence they have come out with the policy giving the option of private practice for existing doctors and no NPA for new recruits. However this order has been challenged in the court on the ground that it will lead to deterioration of services in government hospital and implementation is pending.

Reservation of seats in government medical colleges in Madhya Pradesh for in-service doctors is an incentive for medical officers working in rural areas. It also helps the state in improving the availability of post graduate doctors. However, there is no policy of encouraging doctors to go for postgraduate training program in those specialties (Paediatrics, Anaesthesia, Obs & Gynaec., etc) where the shortage is large and which are also critical for successful implementation of national programs e.g. RCH.

In Gujarat where the vacancy of specialist is much higher, there is no such policy of reservation of Post Graduate seats for in-service medical officers. Any doctor who wishes to pursue post graduate courses will have to resign from service and seek fresh employment on return. It was argued by the officials that the chances of a doctor rejoining the services after completion of PG course are very low. However, in Gujarat doctors serving in rural areas (public health cadre) are given a chance based on seniority to undertake Diploma in Public Health. After completing DPH they have the opportunity to be promoted to District Programme Officers and higher positions. As compared to their rural counterparts, medical officers posted in district and taluka hospitals in Gujarat are demotivated due to lack of career advancement opportunities.

Promotion

Promotion acts as an important motivational factor even when it is not accompanied by substantial monetary benefits. As per the recruitment rules, a departmental promotion committee (DPC) has to be constituted every year for each cadre of staff where vacancy of promotional post exist. The promotion rules specifies the eligibility criteria however it does not guarantee promotion. Promotions in both the states are dependent on the availability of vacancy in the promotional post. Time bound promotions are not given to any category of staff. Rules related to reservation for SC & St categories apply in promotion also. All seniority-cum-merit promotions are based on the gradation list of the cadre which has to be updated regularly by the department. Interview with officials and functionaries in both the states revealed that the DPCs were not constituted regularly in the past. This resulted in delay in promotion inspite of availability of posts. In Madhya Pradesh a majority of posts CMHO and civil surgeon are lying vacant and the DPC for filling up these posts have not been constituted in the recent past.

One of the important documents required at the time of promotion is the Annual Confidential Report (ACR) of each employee. However in practice the ACRs are not written regularly and at times not written objectively. At times the ACRs are difficult to locate as it is maintained at the district headquarters. Non-availability of ACRs at the time of promotion is one of the important reasons for delay in promotions.

Promotions are also dependant on the promotional avenues for a given category of staff. In Gujarat, lab technician and x-ray technicians do not have any promotion avenue while nursing personnel have a number of promotional posts such as Head Nurse – Matron Class III – Matron Class II – Chief Matron Class II. Besides they can get into the nursing education or public health nurse cadre.

Most of the specialists prefer clinical responsibilities as compared to administrative ones. As a result in many cases they do not accept the

promotion. The other reason for non acceptance is that promotion often lead to transfer of a person to the place where such place where there is vacancy. After having lived in a place for long duration, a person is reluctant to move out.

For doctors who do not get any promotion for long duration of 15-20 years, both the states have made provision for higher salary grade called selection grade at a defined interval which is 15 years for Madhya Pradesh and 12 years for Gujarat. The provision has been made in order to bring parity in salary for doctors who otherwise do not get any promotion for long duration.

Transfer & posting

Government of Madhya Pradesh has a transfer policy issued by the department of general administration which applies to all categories of staff. The rules prescribe minimum tenure of 3 years of posting in one location. The policy makes exception of the health personnel and suggests that minimum tenure should be of longer duration. In practice most of the transfers are made on individual's request. In general there is a great degree of dissatisfaction with the existing practices of transfer and posting among the staff in Madhya Pradesh. The current practices are seen as non systematic and non transparent. In Gujarat although transfers are mostly on individual's request, the practice is seen as fair and reasonable. The satisfaction with the existing practices is more on account of the approach of individual officials rather than the system.

However in both the states, most of the staff member desired a proper transfer policy where a person has to serve in the rural and remote areas only for a fixed duration after which they get a chance to gradually move to cities over a defined time period. Most of the staff member desired that as their children grow, they should get a posting in cities where better education facilities exist.

Supervision

Supervisor male & female at the PHC level are perceived to be the weakest link in the supervision. Supervisors are recruited through promotion from the cadre of multi-purpose health workers. As a result their skill and capabilities are similar to those of MPHWs. They lack in orientation and skills for effective supervision.

The Medical officers at the PHCs are more focused on providing outpatient services. By training, they lack in skills and orientation towards programme management and supervision. This is true for most of the doctors who have more inclination towards clinical practices as compared to programme management, administrative duties and functions.

There is no systematic supervision in either state. Supervisory styles of officers, their frequency and content is as varied as the number of supervisors. This is because of the fact that the staff at different levels has not been adequately trained in scientific management functions and techniques. Also there is no mechanism in place to monitor the supervisory functions of the staff. In addition a number of supervisory posts are lying vacant and are looked after on ad-hoc basis by a designated official. In such cases the officer in charge do not have the motivation to discharge their supervisory functions effectively.

Training

Induction training is one of the crucial events that create a long lasting impression regarding the department. In corporate world, induction training is organized as an important activity where all top officials participate and welcome the incumbent. During the training participants are given orientation towards the organization vision, mission, goals and importance of working in the organization. Besides thorough orientation regarding job responsibilities, departmental rules and procedures are given at the time of induction.

Although both the states have some system of induction training, its content and duration is grossly inadequate. As a result the new appointees face difficulty in discharging their duty during initial period.

In-service training for doctors is programme driven. Their content and duration is determined by GOI, which funds these programs. Training programs under RCH, HIV/AIDS control, RNTCP, National Leprosy Eradication program, family planning, etc are conducted from time to time for both medical and paramedical staff.

Attempts have been made by both states to impart management training to the managerial staff. However these practices have not been institutionalized due to lack of clear cut policy and the mechanism to ensure the implementation of the training policy.

4 Recommendations

Adopting good practices in human resource management will go a long way in ensuring the availability of adequately prepared and motivated personnel in health facilities across the country. Some of the recommendations emerging out of the study are as follows:

- 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.
- 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, analysing the gap and formulating short and long term strategies, implementation of strategy and reassessment of gaps. This should be undertaken on a continuous basis.
- The criteria for recruitment depends on the job requirement. Although there has been considerable change in job requirement over the period, the corresponding eligibility criteria has not been modified. Further overall education level and standards have also improved leading to availability of better qualified people. In this context the existing recruitment rules should be reviewed and modified in the light of changing job requirements.
- Recruitment of programme staff should be undertaken with a focus on long term utilization of such personnel. Therefore the recruitment criteria should include not only programme specific functions but also other responsibilities within the health department. In this regard the government of India should issue the guidelines for recruitment.
- The number of sanctioned post of staff specially in the hospitals have not been revised over the years where as the load of patients and utilization of health facilities have gone up significantly. There is an urgent need to review the sanctioned post as per the existing workload and create additional posts wherever required. The staffing norm for hospitals can be derived from the IPHS.
- 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.
- Staff 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 demotivation among such staff as in case of both the states. The state government should avoid such appointments and regularize the existing ad-hoc staff at the earliest.
- The general policy of cuts in staff and freeze on recruitment (in the state of Gujarat) can not be implemented on the health department as it leads to large vacancies which affects services in hospital and health centres. Health services should be kept out of the purview of such policies. In fact with increasing population and load on the existing facilities, the effort should be to increase the staff strength to match the need.

- There is a need for flexibility in fixing compensation for health personnel in order to make the government services more attractive. In the state of Gujarat, lower compensation for specialist is a major issue in non availability of such staff.
- Children's education is one of the important concerns of the staff. It will be worthwhile to explore the possibility of providing incentives for children's education. Any such initiative will go a long way in making the government services more attractive and ensuring retention of staff especially in rural areas.
- There is no financial incentive for working in rural, remote and tribal areas. Although the state governments are finding it increasingly difficult to motivate the staff to serve in the rural areas, they are yet to devise any incentive for rural posting. Financial incentives along with better housing and education facility would make rural posting more attractive. The states need to formulate policies in this regard.
- Reservation of seats for post graduate courses in government medical colleges for in-service doctors is an incentive for medical officers working in rural areas. It also helps the state in improving the availability of post graduate doctors. The state of Gujarat which does not have such policy also has large vacancy of specialists. A policy in this regard will help the state in motivating its doctors and augmenting its workforce.
- Promotion act as an important motivating factor even when it is not accompanied by substantial financial benefits. The state government should consider time bound promotion for all categories of health staff. Such policy already exist in central government health services where a medical officer is promoted to senior medical officer then to chief medical officer.
- Promotions should also be linked to training and attainment of higher knowledge and skills relevant to service delivery. Thus state's promotion policy should have strong linkage with the training policy.
- The states should adopt a time bound transfer policy where a person has to serve in the rural and remote areas for a fixed duration after which they get a chance to gradually move to cities over a defined time period. Most of the staff members who were interviewed, desired that as their children grow, they should get a posting in cities where better education facilities exist.
- 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.
- 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.

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6 Appendices

Appendix A: Approach & Methodology

S. No.	Major Areas	Specific Issues	Data required	Source	Methodology
1	Assessment of existing human resources in the selected states	▪ Total number of personnel ▪ Composition – categories, ratio ▪ Distribution – geographical & levels of institutions ▪ Requirement as per population and infrastructure norms ▪ Gaps	– Number of different categories of personnel – Number of personnel in each district – Number of personnel at different levels of institution – Number of personnel required as per population norms – Number of personnel required as per infrastructure norms	Statistics & planning section within DGHS in the states and from office of CMO in selected district	Secondary data collection and analysis
2	**Assessment of human resource management practices**				
a	Manpower Planning	▪ Is there an effective planning mechanism to take care of long and short term manpower requirement?	– Existing mechanism for workforce planning including workforce analysis (supply, demand & gap analysis) – norms standards followed – long & short term planning	Relevant annual / 5 year plan documents, GOs & documents related to recent vacancy announcement, officials of personnel & Admin sections in department of health &FW	Document review, interview with officer in charge for planning, personnel/admin using interview checklist & Comparative analysis with the corporate planning process
		▪ Is the existing HR & Personnel information useful for planning?	– Existing mechanism for managing HR/personnel information – status of maintenance /updation – uses of data for planning – level computerisation	Relevant documents, personnel records, officials of planning/personnel & Admin sections in department of health &FW	Interview with officer in charge for planning, personnel/admin using interview checklist & document review Comparative analysis with the corporate PMIS & other states
b	Recruitment & vacancies	▪ Is the existing recruitment policy effective in filling up vacancies? ▪ Does it lead to greater stability and ownership	– Existing policies for recruitment of different categories of staff – Changes over the time – strength & weakness of the policy (stakeholder's perspective) – Mechanism to ensure implementation – Status of implementation	Relevant policy documents, GOs & documents related to recent vacancy announcement, officials of personnel & Admin sections in department of health & FW	Document review Interview with officer in charge for personnel/admin (director/ addl. Dir/ Jt. Director), interview with Chief medical officer of district & group discussion with different categories of staff at field level Comparative analysis with the corporate recruitment process & practices

S. No.	Major Areas	Specific Issues	Data required	Source	Methodology
c	Job classification	▪ Is the existing rules/ regulations regarding employee classification /grading suited for the job requirement ▪ Does it have impact on motivation & retention?	– Employee grading/classification (such as grade A, B etc or technical, clinical, managerial, support staff etc and associated qualification) system and related rules and policies – Job description of staff – Strength & weakness of the system – have impact on motivation & retention	Documents regarding job classification/job description, Officials of Admin/finance sections in department of health & FW, all categories of staff	Review of documents, Interview with officer in charge for personnel/admin (director/ addl. Dir/ Jt. Director), interview with Chief medical officer of district & group discussion with different categories of staff at field level Comparative analysis with the best practices in other states where cadre system is implemented
d	Compensation and benefit	▪ Is the compensation adequate to attract and retain staff especially in rural & remote areas? ▪ Is there performance linked benefits and incentives?	– Existing policies and rules regarding compensation and benefit to various categories of staff (salary, increment, merit awards etc.) – Changes over the time – strength & weakness of the policy (stakeholder's perspective) and in comparison with the existing compensation package in the private sector – Incentives for serving in remote inaccessible areas? – Mechanism to ensure implementation – Status of implementation	Documents/GOs regarding salary structure, Officials of Admin/finance sections in department of health & FW, all categories of staff	Review of documents, Interview with officer in charge for personnel/admin & finance (director/ addl. Dir/ Jt. Director), interview with Chief medical officer of district & group discussion with different categories of staff at field level Comparative analysis with the corporate best practices & private sector compensation packages
		▪ Benefits of policy on reserving seats in post graduate courses for serving employees?	– Existing policies on reserving seats in post graduate courses for serving employees – Number of doctors who availed the benefit, number retained/attrition – Benefits and drawbacks of the policy	Officials of Department of medical education, personnel section in department of health & FW, doctors in district and periphery.	Interview with Director medical education, officer in charge for personnel/admin (director/ addl. Dir/ Jt. Director), interview/ group discussion doctors at district and periphery.
		▪ Positive & negative impact of private practice by the doctors.	– Existing policies on allowing private practice by the doctors – Mechanism to ensure fair practice – Status of implementation of the policy – Benefits and drawbacks of the policy	Officials of Director health & FW, doctors in district and periphery, all categories of staff	Interview with Director health & FW, interview with Chief medical officer of district &), interview/ group discussion doctors at district and periphery. and different categories of staff at field level
e	Promotion	▪ Does promotion act as a motivational tool?	– Existing policies and rules regarding promotion of various categories of staff – Existing promotional avenue for each cadre – Mechanism and actual practices	Documents/GOs regarding promotions, Officials of personnel section, all categories of staff	Review of documents, Interview with officer in charge for personnel/admin (director/ addl. Dir/ Jt. Director) & group discussion with different categories of staff at field level

S. No.	Major Areas	Specific Issues	Data required	Source	Methodology
			related to promotions – Acceptance and satisfaction with promotion rules and practices		
f	Transfer & posting	▪ Are transfer & posting need based? ▪ Are employees satisfied with the policy and its implementation	– Existing policies and rules regarding posting in terms of area of posting – urban/ rural/remote, initial/mid-career, towards retirement, long & short term posting – Changes in policy over the time – strength & weakness of the policy – Mechanism to ensure implementation – Status of implementation	Policy document for transfer and posting, Service manual, Officials of Personnel/Admin section in department of health & FW, all categories of staff	Review of documents, Interview with officer in charge for personnel/admin (director/ addl. Dir/ Jt. Director), interview with Chief medical officer of district & group discussion with different categories of staff at field level Comparative analysis with the corporate best practices & private sector compensation packages
g	Supervision and reporting	▪ Is the current mechanism of supervision effective in support and performance enhancement?	– Existing reporting and supervision structure & mechanism – Changes in structure over the time/ innovations over the period – Mechanism to ensure that supervisors undertake supervision regularly – Current reporting and supervision practices - Nature of supervision- (onsite training and support) – Training and skill upgradation of supervisor – Benefits and drawbacks of the existing mechanism – Changes required	Service manual, Officials of planning/monitoring & personnel section in department of health & FW, programme officers & all categories of staff	Review of documents, Interview with officer in charge for planning/ monitoring & personnel (director/ addl. Dir/ Jt. Director) & incharge of national programmes, interview with Chief medical officer of district & group discussion with different categories of staff at field level Comparative analysis with best practices in other states
h	Training – induction, skill development	▪ Does the state have effective training policy for human resource development?	– Existing policies for o Induction training o in-service training o Skill upgradation training – strength & weakness of the policy – Mechanism for ensuring implementation of the policy – Status of implementation of training policy	Policy document for training, Service manual, Officials of Personnel/Admin section in department of health & FW, director of state institute of health & family welfare and all categories of staff	Review of documents, Interview with officer in charge for personnel/admin (director/ addl. Dir/ Jt. Director), interview with director SIHFW & group discussion with different categories of staff at field level Comparative analysis with best practices in other states

Appendix B: Checklist / Guidelines for Discussion / Interview with Officials / Staff

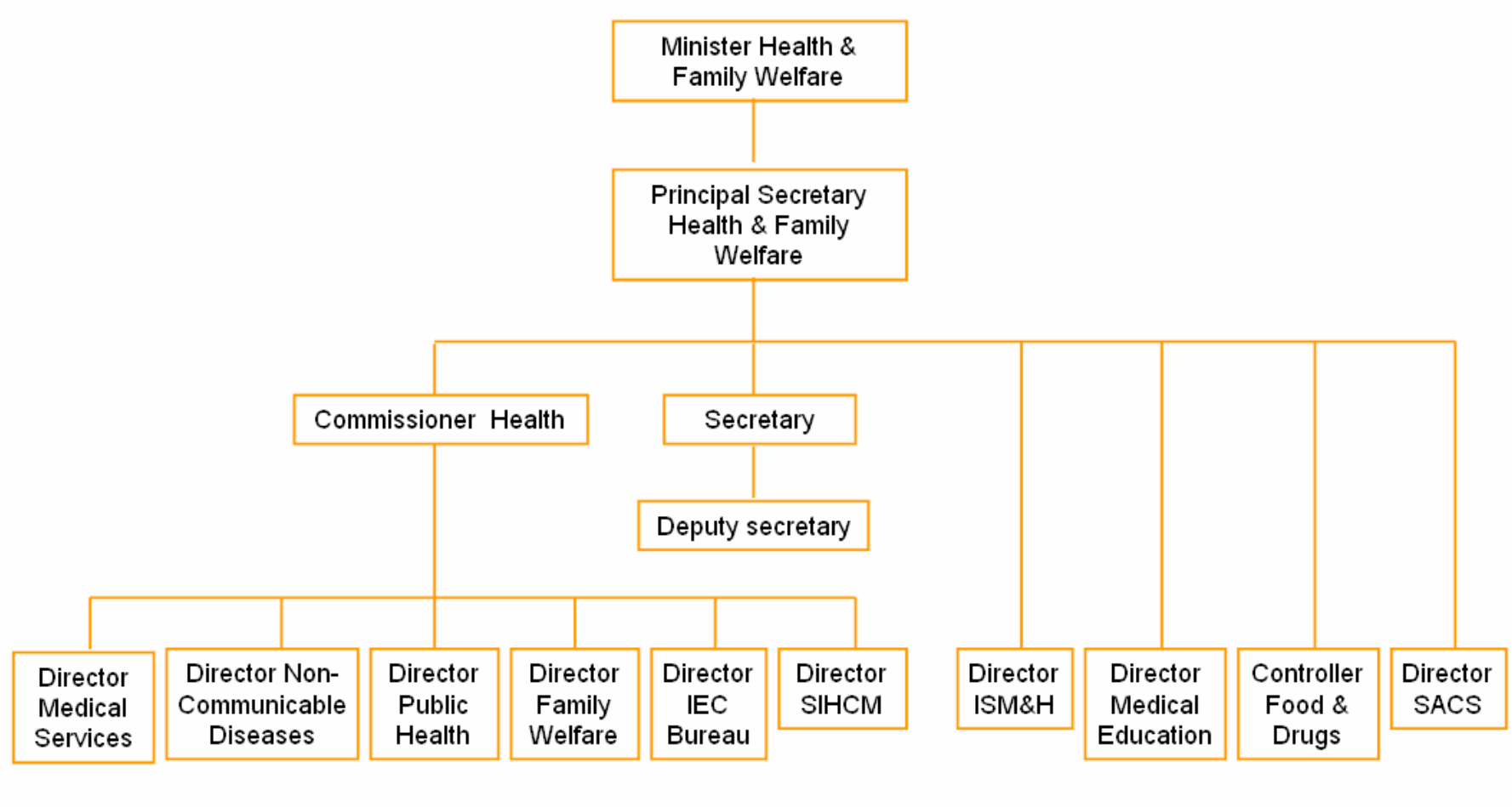
S. No.	Issues
a	**General Information**
i	Categories of staff covered under the directorate
ii	Details on posts filled/vacant
iii	Organisation Structure
b	**Manpower Planning**
i	**Is there an effective planning mechanism to take care of long and short term manpower requirement?** – What is the existing mechanism for workforce planning? Does it have long & short term planning components? – How do you assess current and future demand & supply and analyse the gap? – Also, what is the basis for arriving at the workforce requirement (including norms standards followed)? – Have there been changes in the planning mechanism/process over the period? What has been the impact of these changes? *(Obtain relevant plan documents & GOs)*
ii	**Is the existing HR & Personnel information useful for planning?** – What is the existing mechanism for managing HR/personnel information i.e. How the data is collected, recorded and stored? – What are the rules and regulations regarding maintenance, updation and use of personnel data? – What kind of employee data is available (fields such as DoB, sex, education, date of joining etc) – Status of maintenance /updation – Whether the existing data is used for planning & deployment? How? – Has the employee data been computerized? What has been the benefits of computerization? *(Review the format of existing database, documents related to rules/ GOs)*
c	**Recruitment & vacancies**
	▪ **Is the existing recruitment policy effective in filling up vacancies? Does it lead to greater stability and ownership?** – What are the existing policies for recruitment of different categories of staff? – What are the strength & weakness of the policy? – What is the existing mechanism to ensure implementation of the policy regarding recruitment of staff? – How the vacancies are notified and filled in? – Have there been changes in the policy and mechanism for implementation over the period? What has been the impact of these changes? – What is the current status of implementation and the level of effectiveness in filling up the vacant position *(Obtain relevant policy documents, GOs & documents related to recent vacancy announcements)*

S. No.	Issues
d	**Job classification & Performance review**
	▪ **Is the existing rules/ regulations regarding employee classification /grading suited for the job requirement?** ▪ **Does it have impact on motivation & retention?** – What is the basis for existing system of employee grading/classification (such as grade A, B etc or technical, clinical, managerial, support staff etc and associated qualification)? – What are the relevant rules/policies/GOs for the above? – Is the employee grading relevant to job requirement of staff? – What are the strength & weakness of the present grading system? – Does the system pose any constraint in effective performance of duties? – What impact does the grading system have on motivation of staff? – Suggestions regarding better alternative to current grading system
e	**Compensation and benefit**
i	▪ **Is the compensation adequate to attract and retain staff especially in rural & remote areas?** ▪ **Is there performance linked benefits and incentives?** – What are the existing policies and rules regarding compensation and benefit to various categories of staff (salary, increment, merit awards etc.) – Have there been changes in compensation over the time? What was the basis for such changes? – Is the compensation adequate to attract and retain the required workforce or meet the expectations (as compared to existing compensation package in the private sector)? If not, explanation for the same? – What are the incentives for serving in remote/inaccessible areas? Is it attractive for the staff in comparison to urban posting? – What is the existing mechanism to ensure implementation of policies on compensation and benefits? Is it properly implemented? *(Obtain documents/GOs regarding salary structure and incentives)*
ii	**Benefits of policy on reserving seats in post graduate courses for serving employees?** – What are the existing policies on reserving seats in post graduate courses for serving employees? – What it the response of staff to this policy – number of seats filled? – Number of doctors who availed the benefit in last 5-10 years? – Number of staff who continued their services after availing benefits? – Is the policy aligned with the requirement of specific skills/qualification? – How far has the policy been successful in filling the skill gaps?
iii	**Positive & negative impact of private practice by the doctors** – What is the existing policies on allowing private practice by the doctors? – What is the mechanism to ensure that private practice does not hamper hospital performance? – To what extent doctors are involved in private practice? – Does it support/hamper hospital functioning? How? – Does this policy serve as incentive for working in the government hospitals? Has the policy been able to attract and retain staff especially in rural areas? – Does this policy lead to a preference of posting in urban areas in anticipation of better outcome of private practice? – How far has the policy had impact on ensuring availability of manpower in the health institutions – Does the policy need any changes in the present day context? (suggestions)

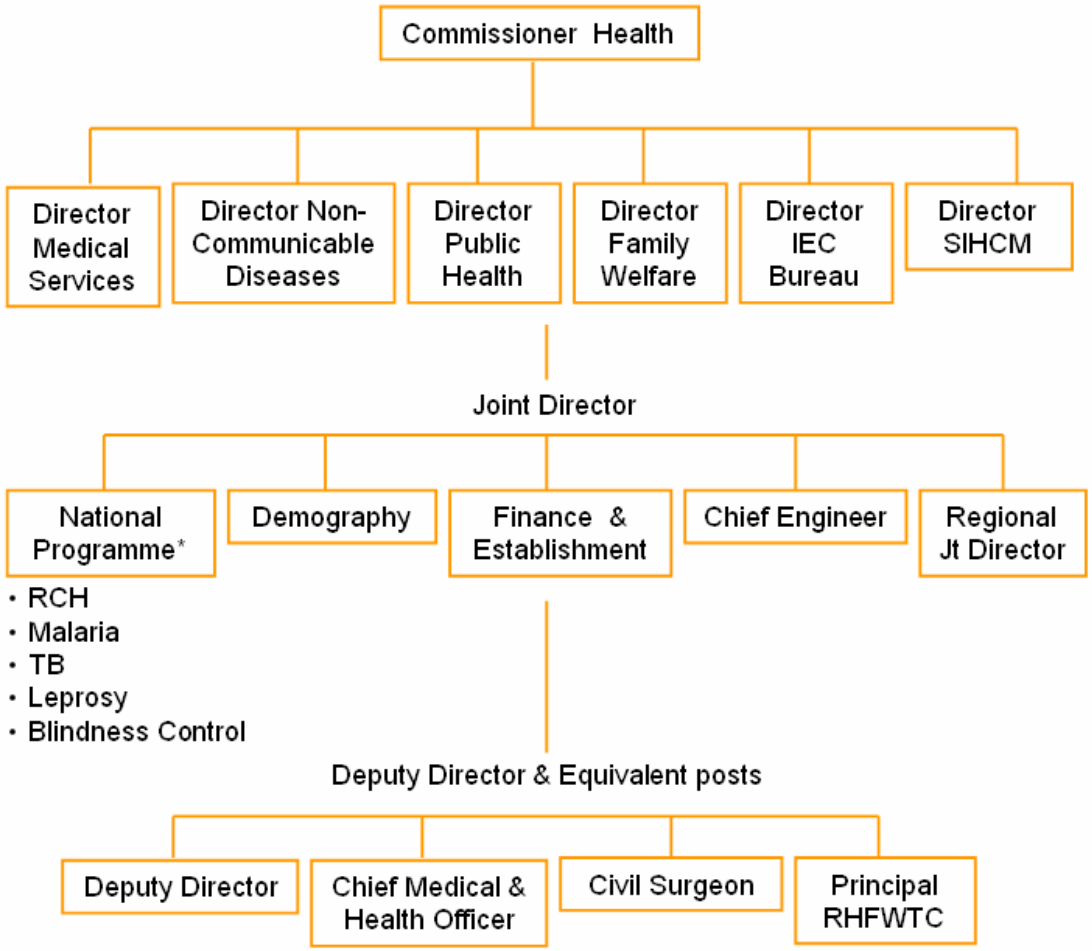
S. No.	Issues
f	**Promotion** ▪ **Does promotion act as a motivational tool?** – What are the existing policies and rules regarding promotion of various categories of staff? – What is the mechanism to ensure implementation of rules? – How are the existing policies and rules regarding promotion being implemented? – Is the existing promotional avenue adequate (for each cadre)? – Are the staff satisfied with promotion rules and practices?
g	**Transfer & posting** ▪ **Are transfer & posting need based?** ▪ **Are employees satisfied with the policy and its implementation** – What are the existing policies and rules regarding posting in terms of area of posting – urban/ rural/remote, initial/mid-career, towards retirement, long & short term posting? – What are the strength & weakness of the policy – Have there been changes in the transfer policy over the time? What was the basis for such changes? – What is the mechanism to ensure implementation of the policy and how the policy is currently implemented? – Are the employees satisfied with the policy/implementation? Reasons for satisfaction/dissatisfaction? – Does the policy/implementation mechanism need any change (explain)? *(Obtain a copy of policy document for transfer and posting and service manual)*
h	**Supervision and reporting** **Is the current mechanism of supervision effective in support and performance enhancement?** – What is the existing reporting and supervision structure & mechanism? – What are the current reporting and supervision practices - Nature of supervision-(onsite training and support) – Is there any mechanism by which supervisors are provided training and skill upgradation so as to undertake onsite training & supportive supervision? – In case of weak supervision, how does the staff solve problems requiring knowledge & skill support? – What are the changes required existing mechanism *(Obtain service manual defining supervision structure)*
i	**Training – induction, skill development** ▪ **Does the state have effective training policy for human resource development?** – What are the existing policies for o Induction training o in-service training o Skill upgradation training – What is the mechanism for ensuring implementation of the policy – Has the training policy been effective in preparing the workforce for their job requirement? – What changes are required for enhancing the capabilities of staff to improve performance?

Appendix C: Organogram: Madhya Pradesh

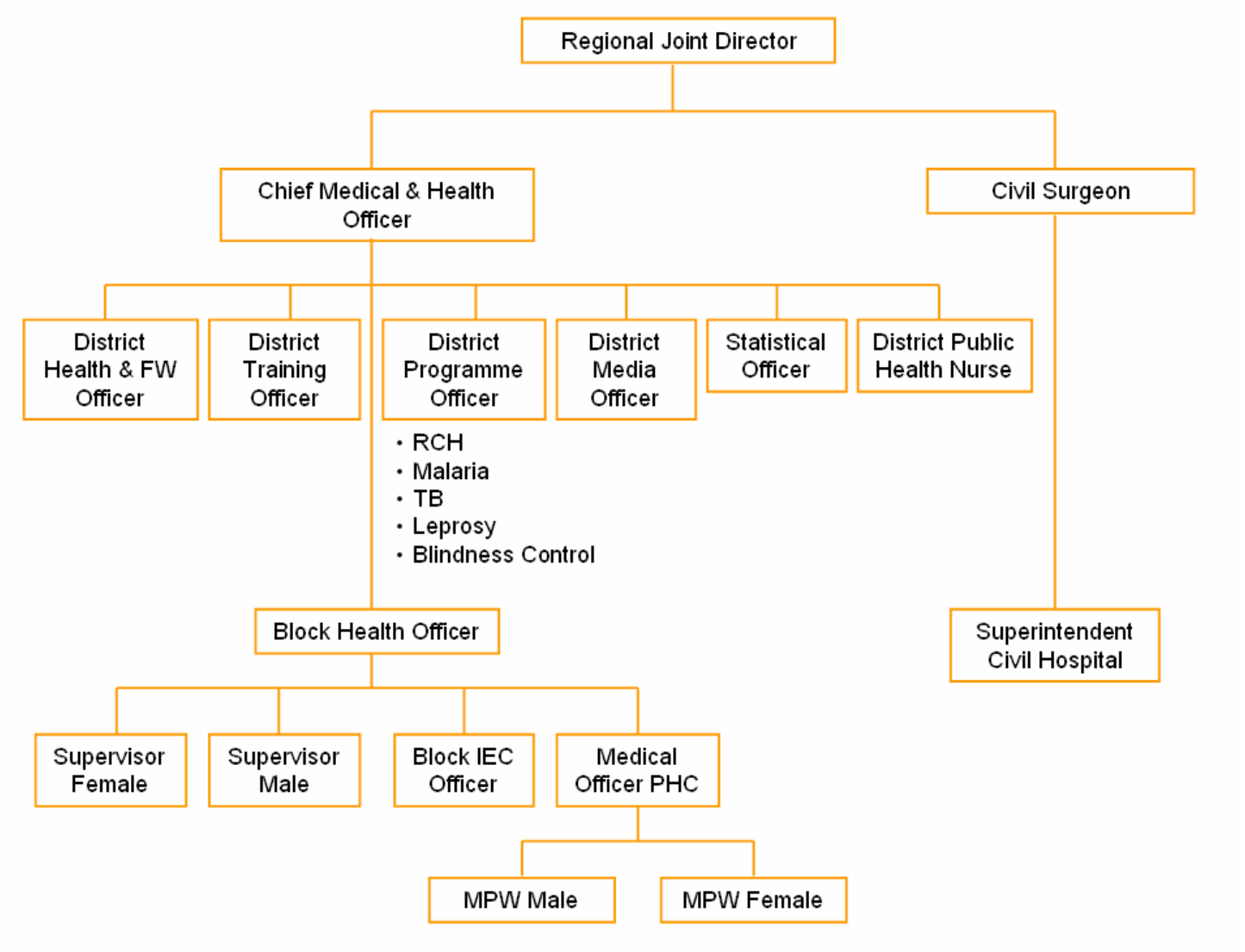
Slide 1



Slide 2

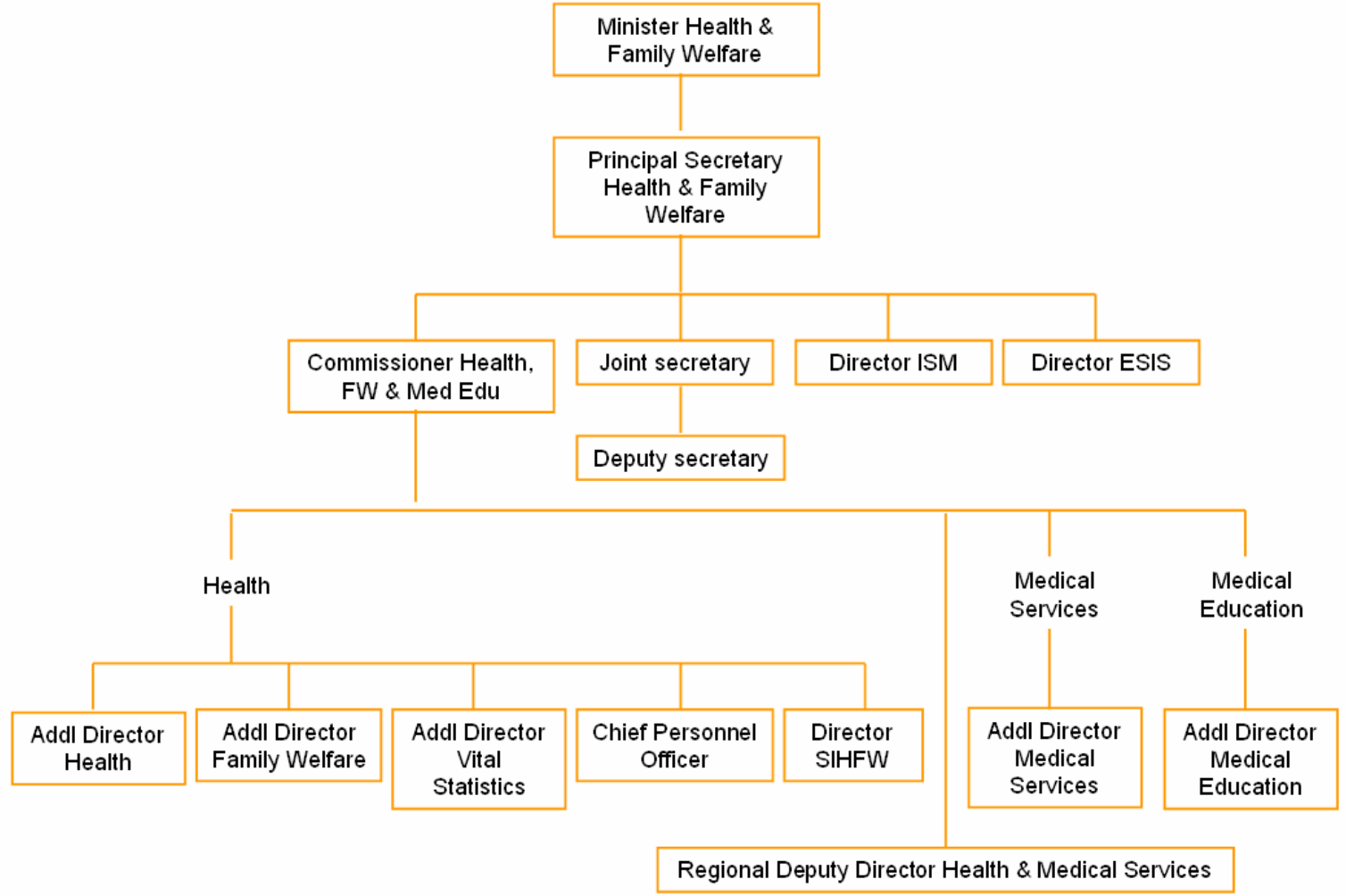

Commissioner Health
Director Medical Services
Director Non-Communicable Diseases
Director Public Health
Director Family Welfare
Director IEC Bureau
Director SIHCM
Joint Director
National Programme*
Demography
Finance & Establishment
Chief Engineer
Regional Jt Director
• RCH
• Malaria
• TB
• Leprosy
• Blindness Control
Deputy Director & Equivalent posts
Deputy Director
Chief Medical & Health Officer
Civil Surgeon
Principal RHFWTC

Slide 3

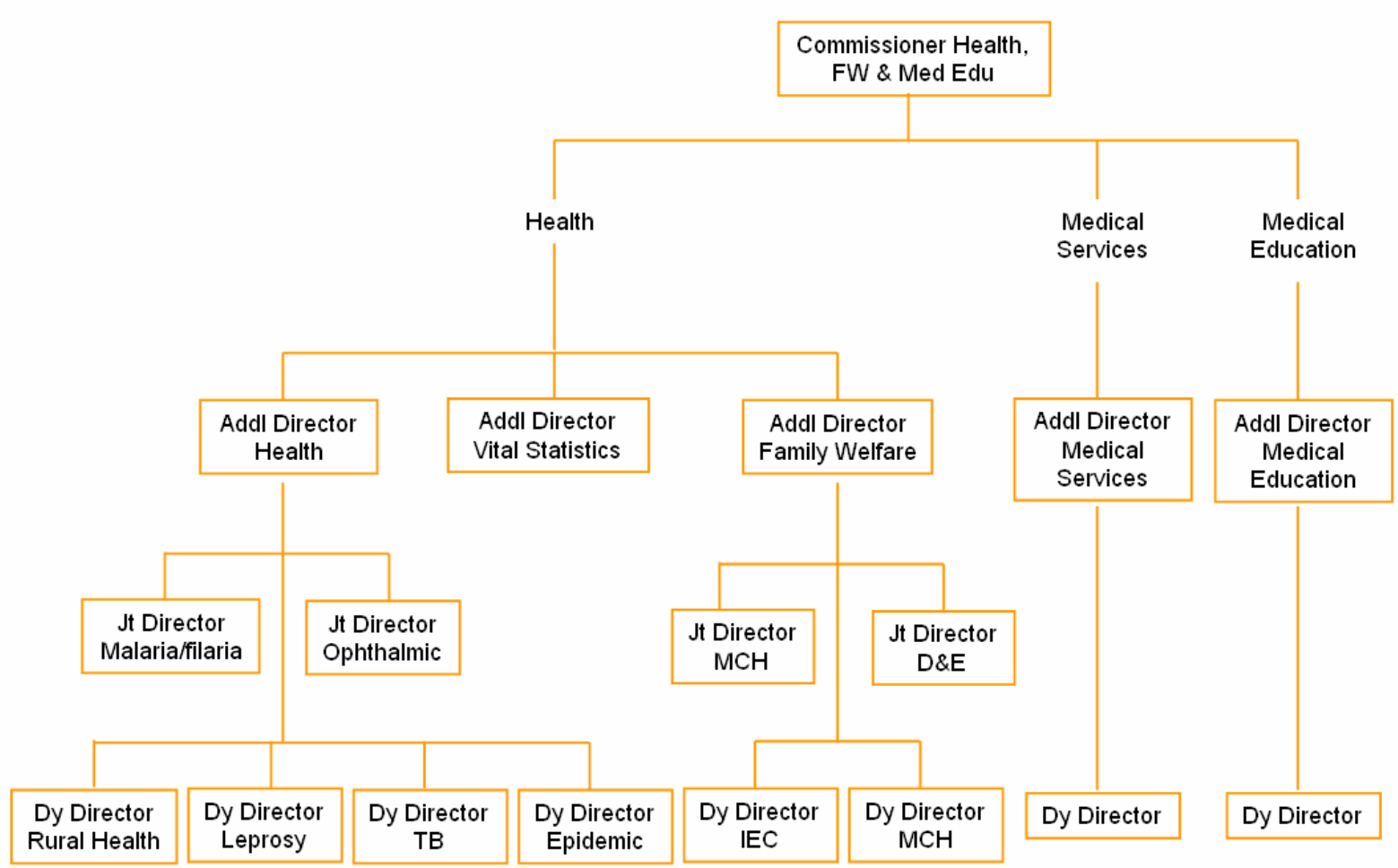

Regional Joint Director
Chief Medical & Health Officer
Civil Surgeon
District Health & FW Officer
District Training Officer
District Programme Officer
District Media Officer
Statistical Officer
District Public Health Nurse
• RCH
• Malaria
• TB
• Leprosy
• Blindness Control
Block Health Officer
Superintendent Civil Hospital
Supervisor Female
Supervisor Male
Block IEC Officer
Medical Officer PHC
MPW Male
MPW Female

Appendix D: Organogram: Gujarat

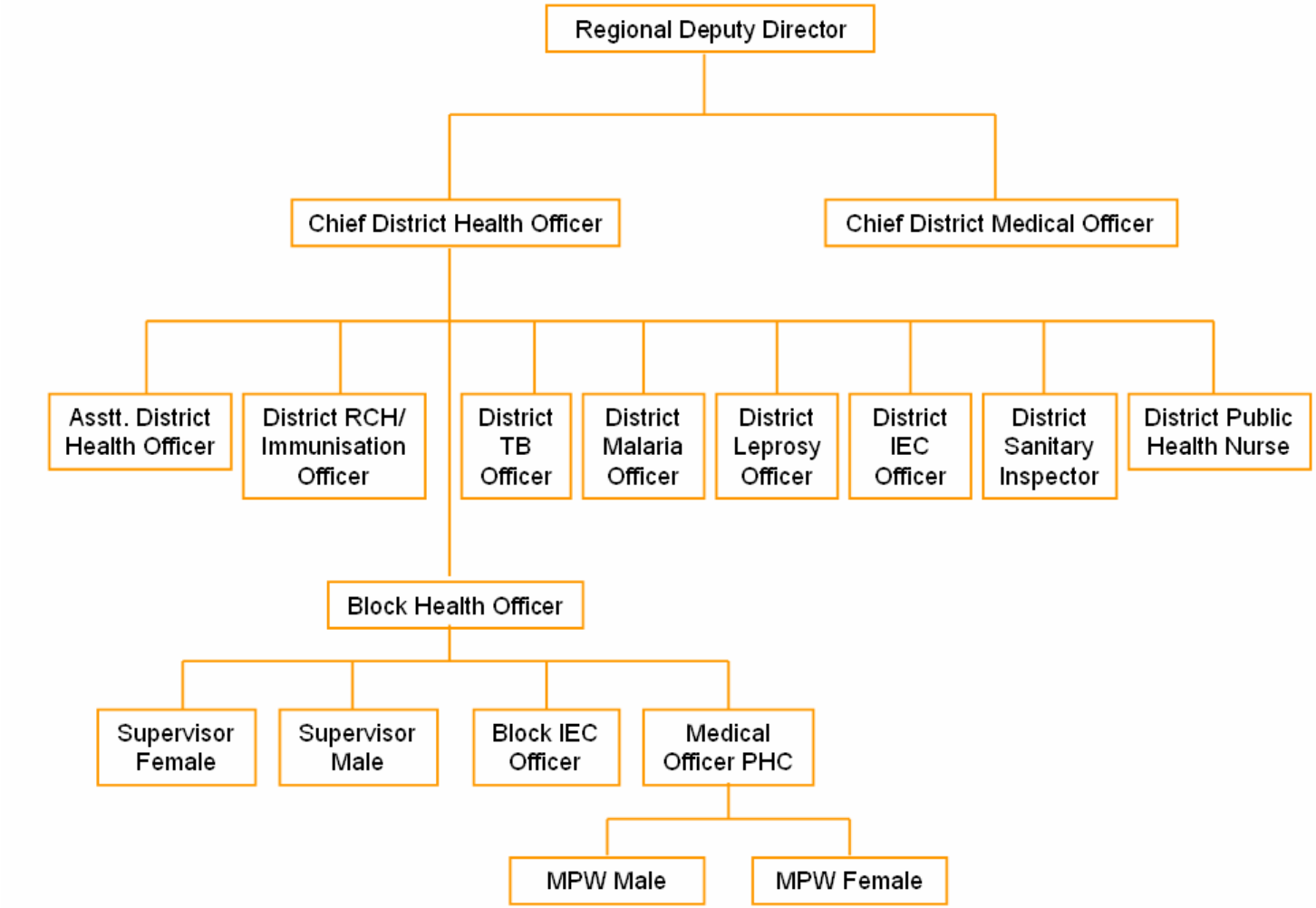
Slide 1



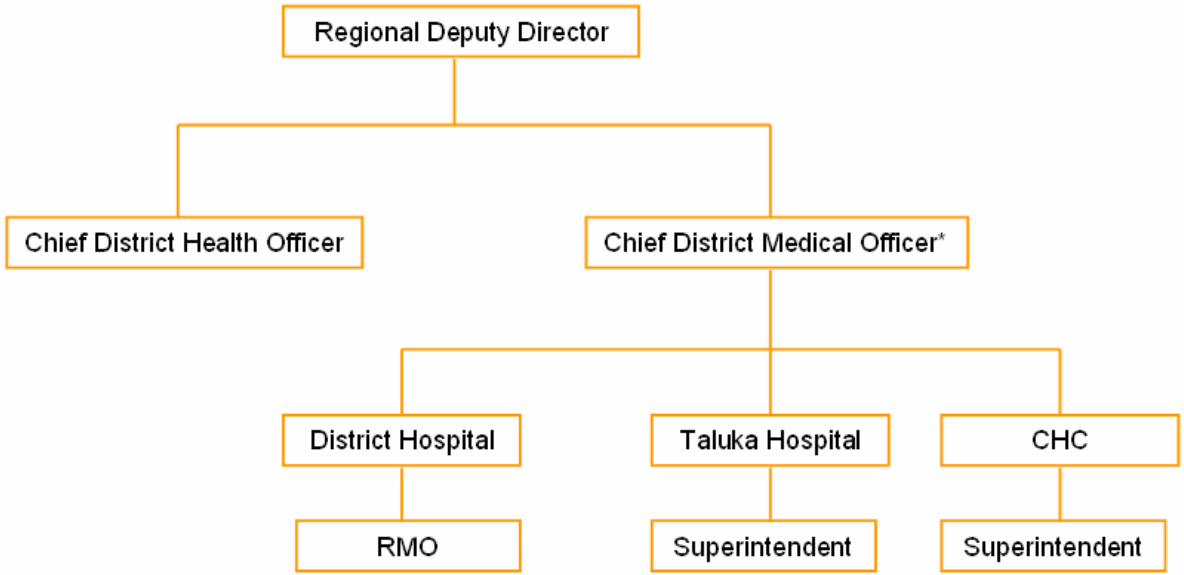
Slide 2


Commissioner Health, FW & Med Edu
Health
Medical Services
Medical Education
Addl Director Health
Addl Director Vital Statistics
Addl Director Family Welfare
Addl Director Medical Services
Addl Director Medical Education
Jt Director Malaria/filaria
Jt Director Ophthalmic
Jt Director MCH
Jt Director D&E
Dy Director Rural Health
Dy Director Leprosy
Dy Director TB
Dy Director Epidemic
Dy Director IEC
Dy Director MCH
Dy Director
Dy Director

Slide 3


Regional Deputy Director
Chief District Health Officer
Chief District Medical Officer
Asstt. District Health Officer
District RCH/ Immunisation Officer
District TB Officer
District Malaria Officer
District Leprosy Officer
District IEC Officer
District Sanitary Inspector
District Public Health Nurse
Block Health Officer
Supervisor Female
Supervisor Male
Block IEC Officer
Medical Officer PHC
MPW Male
MPW Female

Slide 4



** CDMO is also the Superintendent for District Hospital*

Appendix E: Recruitment Rules: Madhya Pradesh

S. No.	Type of Staff	Category	Recruitment	Age limit Min / Max	Qualification	Experience	Probation
1	Director, Public Health & Family Welfare/Director, Medical Services	Class – I	By Promotion			3 years as Joint Director	
2	Joint Director of Health Services	Class – I	By Promotion			3 Years as Deputy director	
3	Deputy Director, Chief Medical & Health Officer, Superintendent KNK Hospital, Lady Elgin Hospital	Class – I	By Promotion (75%)		.	3 years as District Family Welfare cum-health officer, Principal, RHFWTC, Addl Civil Surgeon/Supdt TB Hospital	
			by Direct recruitment (25 %)	28/40	Postgraduate degree in clinical subjects (Medical), PSM with 5 years professional experience after obtaining post graduation degree/experience in hospital administration will be preferred		
4	Leprosy officer Grade – I	Class – I	By Promotion			3 years as Leprosy officer (Grade – II)	
5	District Family Welfare cum-health officer, Principal, RHFWTC, Addl Civil Surgeon/Supdt TB Hospital	Class – I	By Promotion			10 years experience as Assistant Surgeon	
6	Superintendent, T.B Hospital	Class – I	By Promotion			5 years experience as Assistant Surgeon after PG in Chest Disease or 7 years experience after diploma in tuberculosis & chest disease	
7	Specialists	Class – I	By Promotion (75%)			5 years experience as Assistant Surgeon after PG or 7 years experience after PG Diploma in the given specialty	
			Direct recruitment (25 %)	28/40	Postgraduate degree in the concerned specialty with 3 years or 5 years experience after PG Diploma in the given specialty		

S. No.	Type of Staff	Category	Recruitment	Age limit Min / Max	Qualification	Experience	Probation
8	Leprosy officer Grade – II	Class – I	By Promotion (75%)			Assistant Surgeon with 3 years of experience in Leprosy work	
			Direct recruitment (25 %)	28/40	MBBS or equivalent qualification recognised by medical council of India with minimum 5 years experience in the field of leprosy, postgraduate in the leprosy field will be preferred.		
9	Psychiatrists Mental hospital	Class – I	By Promotion (50%)			5 years experience as Assistant Surgeon after PG in Psychiatry or 7 years experience after diploma in the specialty	
			Direct recruitment (50 %)	28/40	MD (Psychiatry) or equivalent from a recognised university with 3 years experience after passing M.D or D.P.M with 5 years experience after passing DPM from recognized university		
10	Assistant surgeons	Class – II	By Direct recruitment	21/32	M.B.B.S or equivalent qualification recognised by medical council of India		
11	Dental specialist	Class – I	By Promotion (75%)			5 years experience as Dental Surgeon after PG (MDS) or 10 years experience as dental surgeon	
			Direct recruitment (25 %)	28/40	Post graduate degree in specialty from a recognised university with three years experience after post graduation in specialty.		
12	Dental surgeon	Class – II	By Direct recruitment	21/32	B.D.S degree or equivalent qualification from recognised university.		
Group - B							
1	Joint Director (Mass education and media)	Class I	By Promotion			3 years as Deputy director (Health education bureau)	
2	Deputy director (Health	Class I	By Promotion			3 years as Exhibition officer	

S. No.	Type of Staff	Category	Recruitment	Age limit Min / Max	Qualification	Experience	Probation
	education bureau)						
3	Exhibition officer	Class – II	By Promotion (75%) by Direct recruitment (25 %)			3 years as Deputy district extension and media officer	
4	Publicity officer/ editor	Class – II	By Promotion			3 years as Sub editor (class III)	
5	Deputy district extension and media officer	Class – II	By Promotion			6 years as block extension educator	
6	Deputy director (Planning, Evaluation and monitoring)	Class – I	By Promotion			3 years as statistical officer	
7	Deputy director (Supplies)	Class – I	By Promotion			3 years as finance officer	
8	Statistical officer	Class – II	By Promotion (75%)			5 years as assistant statistical officer (class – III)	
			Direct recruitment (25 %)	21/30	M.A (statistics) preferably with PhD/ diploma in health statistics		
9	Social scientist	Class – II	By Promotion			5 years as medico social worker Class III	
10	Finance officer	Class – II	By Promotion			3 years as junior accounts officer	
11	Administrative officer	Class – II	By Promotion (75%) by Direct recruitment (25 %)	25/40	Graduate with 5 years supervisory experience and accounts trained. Preference will be given to S.A.S qualifies persons	3 years as store inspection officer/superintendent	
12	Management instructor	Class – II	By direct recruitment	21/30	Master degree in Public administration/business administration from recognised university. Preference will be given to candidates having teaching and supervisor experience		
13	Assistant engineer	Class – II	By Promotion			5 years as sub engineer	
14	Senior sanitary officer	Class – II	By Promotion			3 years as community health officer	
15	Deputy director (vigilance)	Class – I	By transfer of persons from other services				
16	Deputy director (Law)	Class – I	By transfer of persons from other services				
17	Executive engineer	Class – I	By transfer of persons				

S. No.	Type of Staff	Category	Recruitment	Age limit Min / Max	Qualification	Experience	Probation
	(Transport)		from other services				
18	Accounts officer	Class – II	By transfer of persons from other services				
19	Sanitary engineer	Class – II	By transfer of persons from other services				
20	District malaria officer	Class – II	By direct recruitment (25 %)	21/30	MSc Entomology	5 years as assistant malaria officer	
			By transfer of persons from other services(75 %)				
21	Entomologist	Class – I	By transfer of persons from other services			5 years as district malaria officer/Assistant Entomologist	
22	Physiotherapist	Class – II	By transfer of persons from other services			5 years as physiotherapy technician (Class – III)	
23	Cold chain officer	Class – II	By Direct recruitment	21/30	A university degree in mechanical or refrigeration engineering with one month experience or diploma in refrigeration engineering with 6 years experience in maintenance and operation of refrigeration equipments.		
			Group – C				
1	Deputy director of health services (Nursing)	Class – I	By Promotion			5 years as nursing superintendent	
2	Principal, Regional public health teacher training institute, ujjain	Class – I	By Promotion			5 years as nursing superintendent	
3	Nursing superintendent grade – I	Class – II	By Promotion			5 years as senior sister tutor	
4	Assistant nursing advisor/ Nursing superintendent grade – II	Class – II	By Promotion			3 years as district nursing supervisor	
5	Public health Nursing officer	Class – II	By direct recruitment (25 %)	28/40	B.Sc nursing or certificate in public health nursing from any recognised institution or 10 years experience in nursing service.	5 years as public health tutor	
			By transfer (75 %)				
6	Senior training officer	Class – II	By Promotion			5 years as senior tutor class	

S. No.	Type of Staff	Category	Recruitment	Age limit Min / Max	Qualification	Experience	Probation
						– III	
7	Senior sister tutor	Class – II	By Promotion			5 years as sister tutor class – III	
8	District nursing supervisor	Class – II	By Promotion			5 years as Matron Class – III	
9	Senior Lab Technician	Class III	By promotion			3 years experience of working as Lab technician	
10	Lab Technician	Class III	Direct recruitment	18-30 years	Higher secondary (10+2) pass with biology, chemistry or physics and certificate of having passed lab technician course		
			By promotion		Promotion at regional level	5 years experience of working as Lab Assistant	
11	Senior radiographer	Class III	By promotion			5 years experience of working as radiographer	
12	X ray Technician/radiographer	Class III	Direct recruitment	18-30 years	Higher secondary (10+2) pass with biology, chemistry or physics and certificate of having passed 6 month radiographer course		
13	Store Keeper	Class III	By promotion			5 years experience of working as pharmacist	
14	Pharmacist Grade II	Class III	Direct recruitment	18-30 years	Higher secondary (10+2) pass with biology, chemistry or physics and certificate of having passed diploma in pharmacy and registration with pharmacy council		
15	Ophthalmic Assistant	Class III	Direct recruitment	18-30 years	Higher secondary (10+2) pass with biology, chemistry or physics and certificate of having passed 2 years Ophthalmic assistant course		
16	Senior Non-medical Supervisor	Class III	By promotion only			5 years experience of working as Non-medical Supervisor	
17	Non-medical Supervisor	Class III	By promotion only			10 years experience of working as Non Medical	

S. No.	Type of Staff	Category	Recruitment	Age limit Min / Max	Qualification	Experience	Probation
						Assistant (Leprosy)	
18	Health Education & extension Officer	Class III	By promotion only			3 years experience of working as BEE	
19	Block Extension Educator	Class III	Direct recruitment	21-30 years	Post graduate in sociology		
			By promotion			5 years experience of working as multi-purpose supervisor	
20	Multipurpose Health Supervisor - Female	Class III	By promotion only			5 years experience of working as Female Health Worker	
21	Multipurpose Health Supervisor - Male	Class III	By promotion only			5 years experience of working as Multipurpose Health Worker	
22	Multipurpose Health Worker - Male	Class III	Direct recruitment (80%)	18-30 years	Passed senior secondary school exam or equivalent exam and passed 1 year MPHW (M) training course.		
			By promotion (20%)		Passed senior secondary school exam or equivalent exam and passed 1 year MPHW training course.	5 years experience	
23	Multipurpose Health Worker - Female	Class III	Direct recruitment	18-30 years	Passed senior secondary school exam or equivalent exam and passed 18 month MPHW (F) training course.		

Appendix F: Recruitment Rules: Gujarat

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
1	Additional Director	Class I	Direct recruitment	45 years or less	MBBS, PG in any stream	10 years or more in Class I post	2 years
			By promotion	Relaxed for person serving with the Govt of Gujarat	Same as above	Same as above and those holding Joint director or Deputy Director's post	
2	Joint Director	Class I	Direct recruitment	45 years or less	MBBS, PG in any branch of Medicine, or degree or diploma in public health, hygiene or sanitary science recognised by Gujarat Medical Council	10 years of experience in health administration under the govt, panchayat or municipal corporation	2 years
			By promotion	Relaxed for person serving with the Govt of Gujarat	Same as above	Same as above and those holding Deputy Director's post	
3	Deputy Director	Class I	Direct recruitment	45 years or less	MBBS, PG in any branch of Medicine, or degree or diploma in public health, hygiene or sanitary science or a degree in tuberculosis diseases recognised by the Govt of Gujarat	7 years of experience in health administration in Class I or equivalent post under the govt, panchayat or municipal corporation	2 years
			By promotion	Relaxed for person serving with the Govt of Gujarat	Same as above	Same as above and those holding Assistant Director's post	
4	Assistant Director	Class I	Direct recruitment	40 years or less	MBBS, PG in any branch of Medicine, or degree or diploma in public health, hygiene or sanitary science, PSM or a degree in tuberculosis diseases recognised by the Govt of Gujarat	5 years of experience in health administration in Class I or equivalent post under the health department	2 years
			By promotion	Relaxed for person serving with the Govt of Gujarat	Same as above	5 years of experience as Chief District Health Officer or ADHO/ DFWO/ DTO/ DLO/ DIO or equivalent post	

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
5	State Entomologist	Class I	Direct recruitment	35 years or less	A degree in Science (Second Class) from recognised university or Master degree	7 years experience of entomological work in connection with malaria/ filaria or 5 years experience of entomological work for master degree holders	
			By promotion	Relaxed for person serving with the Govt of Gujarat		8 years of experience as entomologist Class II	
6	Chief District Health Officer Addl District Health Officer District Immunisation Officer District RCH Officer	Class I	Direct recruitment	40 years or less	MBBS, degree or diploma in public health, hygiene or sanitary science, PSM recognised by the Govt of Gujarat	6 years of experience in health administration in Class II or equivalent post under the health department	2 years. The candidate shall have to serve the government for a period of 5 years under a bond
			By promotion Ratio promotion to direct recruitment – 5:1	Relaxed for person serving with the Govt of Gujarat	Same as above	8 years of experience as medical officer in the Gujarat health services or if the above is not available, 6 yrs exp may be considered	
			By transfer from Gujarat health services Class I services having qualification for direct recruitment	Same as above	Same as above	6 years of experience in health administration in Class II or equivalent post under the health department	
7	District TB Officers	Class I	Direct recruitment	40 years or less	MBBS, diploma in tuberculosis diseases or public health recognised by the Govt of Gujarat	5 years of experience in tuberculosis work in field or clinic	2 years.
			By promotion Ratio promotion to direct recruitment – 1:1	Relaxed for person serving with the Govt of Gujarat	Same as above	Same as above	
			By transfer from Gujarat public health services Class I services having qualification for direct	Same as above	Same as above	Same as above	

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
			recruitment				
8	District Leprosy Officer	Class I	Direct recruitment	40 years or less	MBBS, Training in Leprosy at institute recognised by the govt of India or diploma /doctor in venereology and dermatology	3 years experience of working as medical officer class II in leprosy hospital or leprosy programme	2 years.
			By promotion Ratio promotion to direct recruitment – 1:1	Relaxed for person serving with the Govt of Gujarat	Same as above	Same as above	
			By transfer from Gujarat public health services Class I services having qualification for direct recruitment	Same as above	Same as above	Same as above	
9	IEC Officer	Class I	By promotion only		IEC Officer Class II	7 years as IEC Officer Class II	
10	District Malaria Officer/ Filaria Officer/ Asstt Entomologist/ Biologist (Non-medical)	Class II	Direct recruitment	21-33 years	Degree in Science from a recognised university	5 years experience of working Malaria/filaria organisation	2 years. The candidate shall have to serve the government for a period of 3 years under a bond
			By promotion Ratio promotion to direct recruitment – 2:1	Relaxed for person serving with the Govt of Gujarat	Same as above	7 years experience of working as Assistant Malaria Officer Class III/ Asstt Entomologist/ Biologist Class III under Malaria/filaria eradication programme	
11	Civil Surgeon/ Superintendent/ Resident Medical Officer	Class I	By promotion All the posts of RMO will be filled from qualification (i). Of the remaining, 50% will be filled by qualification (ii) & (iii)		i) MBBS degree from recognised institution with 8 years experience as Medical Officer Class II or ii) PG Diploma in Ob& Gynae /paediatrics/ENT/ Anaesthesia/ radiology/ psychiatry/ clinical	As given	

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
			while rest shall be filled by transfer from specialist Class I cadre		pathology with 2 years experience as Medical Officer Class II or iii) MD/MS in Gen Medicine/ pathology/ anaesthesia/ Ob& Gynae /paediatrics/ radiology/ psychiatry/ Gen Surgery/ ENT/ Ophthalmology/ orthopaedics with 5 years experience		
12	Specialist	Class I	Direct recruitment	35 years or less	MBBS degree & Post Graduate degree		2 years
			By promotion		MBBS degree & Post Graduate degree	2 years experience as Medical Officer Class II	
13	Medical Officer	Class II	Direct recruitment	35 years or less	MBBS degree from recognised university		2 years. The candidate shall have to serve the government for a period of 5 years under a bond
			By promotion	Relaxed for person serving with the Govt of Gujarat	MBBS degree from recognised university	7 years experience of working as medical officer class III in Gujarat public health/medical services	
14	Medical Officer (Ayurved)	Class II	Direct recruitment	35 years or less	BAMS or DSAC or Ayurved Visharad degree from recognised institution or diploma in Ayurveda with 5years experience of dispensary or 3 years experience of hospital		2 years. The candidate shall have to serve the government for a period of 5 years under a surety bond
			By promotion	Relaxed for person serving with the Govt of Gujarat	As above	5 years experience of working as medical officer class III in Gujarat public health/medical services	
15	Health Education Officer/ Health Educator	Class II	Direct recruitment	28 years or less	Degree from recognised university, Diploma in health education from All	experience of health education work preferred	

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
					India Institute of Hygiene & Public Health or PG degree in Sociology, Social Science and Social Work		
16	Research Officer	Class II	Direct recruitment	21-30 years	Second class degree or PG degree in arts/science/ from a recognised university with statistics/mathematics or economics as the main subject and certificate for basic computer knowledge	Prior experience in statistical research and training from statistical institutes preferred	2 years.
			By promotion	Relaxed for person serving with the Govt of Gujarat	Same as above	7 years experience of working as Research Assistant Class III in the Gujarat statistical service and Certificate for basic computer knowledge	
17	Research Assistant	Class III	Direct recruitment	20-28 years	Second class degree or PG degree in statistics or Second class degree or PG degree in arts/science/ from a recognised university with statistics/mathematics or economics, commerce, sociology or agriculture as the main subject and diploma in statistics or experience of application of modern statistical methods	Prior experience in statistical research preferred	1 year
			By promotion Ratio promotion to direct recruitment – 2:1	Relaxed for person serving with the Govt of Gujarat	Same as above	3 years experience of working as statistical Assistant Class III in the Gujarat statistical service and Certificate for basic computer knowledge	
18	District Extension Educator	Class III	Direct recruitment	25-40 years	Second class degree in arts with 3 years experience as BEE or non graduate with 5 years experience as BEE	PG qualification in Sociology or PG diploma in social sciences preferred	1 year
			By promotion	Relaxed for person	Same as above		

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
				serving with the Govt of Gujarat			
19	Lab Technician	Class III	Direct recruitment	28 years or less	BSc degree with chemistry or microbiology as main subject or master inorganic chemistry or microbiology from recognised university and certificate of having passed lab technician course recognised by the govt of Gujarat Certificate for basic computer knowledge	Prior experience preferred	1 year The candidate shall have to exercise surety and security bond
			By promotion	Relaxed for person serving with the Govt of Gujarat	Passed matriculate/ secondary school certificate exam or higher secondary exam with English, physics & chemistry and certificate of having passed lab technician course recognised by the govt of Gujarat	7 years experience of working as Lab Assistant	
20	X ray Technician	Class III	Direct recruitment	28 years or less	BSc degree with physics as one of the subjects and certificate of having passed X-ray technician course recognised by the govt of Gujarat and Certificate for basic computer knowledge	Prior experience in X-ray work preferred	1 year The candidate shall have to exercise surety and security bond
			By promotion	Relaxed for person serving with the Govt of Gujarat	Passed matriculate/ secondary school certificate exam with English, physics & chemistry and certificate of having passed X-ray technician course recognised by the govt of Gujarat	5 years experience of working as X-ray Assistant	
21	Junior Pharmacist	Class III	Direct recruitment	28 years or less	Degree or diploma in pharmacy and registered with Gujarat pharmacy	Prior experience in dispensing preferred	1 year

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
					council and Certificate for basic computer knowledge		
22	Ophthalmic Assistant	Class III	Direct recruitment	25 years or less	Higher secondary school certificate and diploma in ophthalmic techniques or optometry or certificate course in ophthalmic care from recognised institution	Prior experience in X-ray work preferred	1 year The candidate shall have to exercise surety and security bond
23	Senior Leprosy Supervisor	Class III	By promotion only			5 years experience of working as Leprosy supervisor or health educator leprosy	
24	Leprosy Supervisor	Class III	By promotion only		Passed matriculate/ secondary school certificate exam with English, physics & chemistry and certificate of having passed X-ray technician course recognised by the govt of Gujarat	2 years experience of working as Non Medical Assistant (Leprosy) or 5 years experience of working as Leprosy Assistant	
25	Leprosy Assistant	Class III	Direct recruitment	25 years or less	Passed secondary school certificate exam with English or equivalent exam and sanitary inspector's exam from recognised institution		
			By promotion	Relaxed for person serving with the Govt of Gujarat	Passed secondary school certificate exam with English or equivalent exam and sanitary inspector's exam from recognised institution	Prior experience of working as BCG technician/ vaccinator	
26	Physiotherapist	Class III	Direct recruitment	30 years or less	Degree in Physiotherapy or diploma in physiotherapy with two years experience	Prior experience preferred	1 year
			By promotion	Relaxed for person serving with the Govt of Gujarat		5 years experience of working as Masseur or assistant physiotherapist	
27	Sanitary Inspector	Class III	By promotion		Passed secondary school	Prior experience of working	

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
					certificate exam with English or equivalent exam and sanitary inspector's exam from recognised institution. Exempted for person with 10 years experience as vaccinator	as BCG technician/ vaccinator	
28	Statistical Assistant	Class III	Direct recruitment	25 years	Degree in statistics/ mathematics/ economics/ commerce, agriculture or sociology as the main subject and certificate for basic computer knowledge	Prior experience of at least 6 months in statistical research or diploma in statistics preferred	1 year
			By promotion Ratio promotion to direct recruitment – 1:2	Relaxed for person serving with the Govt of Gujarat	Same as above	3 years experience as computer in the health department	
29	Computer	Class III	Direct recruitment	25 years	Passed secondary school certificate exam with mathematics		1 year
30	Public Health Nurse	Class III					
31	Block Extension Educator	Class III	Direct recruitment	25-40 years	Graduate	degree in Sociology preferred	1 year
			By promotion			5 years experience of working as Field Worker	
32	Female Health Supervisor	Class III	By promotion only			5 years experience of working as Female Health Worker	
33	Multipurpose Health Supervisor	Class III	By promotion only		Passed secondary school certificate exam or equivalent exam and have taken MPHW training & passed final exam.	5 years experience of working as Multipurpose Health Worker	
34	Multipurpose Health Worker	Class III	Direct recruitment		Passed secondary school certificate exam or equivalent exam and passed sanitary inspector's exam and completed 3 months MPH (M) bridge course.		

S. No.	Type of Staff	Category	Recruitment	Age limit	Qualification	Experience	Probation
35	Auxiliary Nurse Midwife (Nursing cadre)	Class III	Direct recruitment	40 years or less	Passed auxiliary nurse midwife certificate exam		
			By transfer from general cadre of ANM				
36	Administrative Officer (family Planning)	Class I	Direct recruitment	35 years or less	Second class degree in arts Science, commerce, law or equivalent qualification. Knowledge of finance and accounts preferred	7 years experience in responsible position	2 years
			By promotion		Working as Personal Assistant Class II in medical & health department		
			By transfer from officer of Gujarat State Civil Services Class I (Deputy Collector)				
37	Office Superintendent /senior auditor-cum-senior accountant/ Senior Accountant	Class III	By promotion		Passed qualifying examination for computer knowledge	5 years experience of working as head Clerk/Senior Assistant/ Accountant/ store officer in medical & health department	
38	Head Clerk/Senior Assistant/ Accountant/ store officer	Class III	By promotion		Passed qualifying examination for computer knowledge	5 years experience of working as senior Clerk/ Upper Division Clerk/ Store Keeper-cum-accountant/ cashier (class III) in medical & health department	
39	Senior Clerk/ Upper Division Clerk/ Store Keeper-cum-accountant/ cashier	Class III	By promotion		Passed qualifying examination for computer knowledge	5 years experience of working as Junior Clerk/ Clerk/-cum-typist/Lower Division Clerk/Typist (class III) in medical & health department	