Mosse, Julia Cleves; Cassels; Andrew : Reproductive and child health in India: A health systems development agenda. Social Change. Sep-Dec 1996. 26(3-4). p. 6-13.

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# Reproductive and Child Health in India: A Health Systems Development Agenda

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*This paper looks at sector investment approaches as instruments for delivering development assistance. It asks whether a sector wide approach would be useful in the Indian context for health and population assitance. It raises some of the complications of sector wide assistance, but concludes that some of the systemic problems addressing the family welfare sector might be very well addressed by taking the kind of perspective afforded by sector wide approaches.*

## Introduction

The Government of India has adopted the 1994 Cairo agenda with speed and commitment at the highest level, recognising that improving reproductive health, including family planning, is essential to the development of the family welfare programme. The changes now being put in place signal a significant shift from a programme measured primarily by contribution to declines in fertility and population growth rates, to one which recognises the need to satisfy the needs of individuals for a variety of high quality services, as well as contributing to demographic objectives.

The new agenda has tended to focus - at a programme level - on the range of services that should be available to deliver an RCH programme characterised by: "high quality, client-centered approaches that address a range of reproductive health needs, including safe motherhood and family planning, as well as other problems such as reproductive tract and sexually transmitted infections" (Measham and Heaver 1996a: 11). Much of the preparatory work that has been undertaken has sought to define at which level of service delivery (community/sub-centre/primary/first referral units/district hospitals) particular health interventions should be available (Pachauri 1996). In other words, the focus has been on missing inputs that would need to be added to the existing MCH and family welfare services to address the broader RCH agenda.

The second main characteristic of the GOI's new policy is generally referred to as the Target Free Approach (TFA). The name derives from the desire to replace centrally defined family welfare targets based on demographic objectives with

locally determined measures of performance. However, the term also subsumes several new policy directions: a focus on quality and responsiveness to users; decentralisation of planning and management responsibilities; and new expressions of community involvement. These policy changes initiated in the context of the RCH programme coincide with structural changes in the organisation of government - notably a strengthened role for panchayati raj institutions. The TFA Manual attempts to explain and operationalise these policy changes, but is widely acknowledged to be a preliminary attempt and will require much additional work.

The focus on decentralisation has tended to emphasise the district as the unit for analysis, for example: UNFPA's Fifth India Country programme will focus on 36 districts in five to six States; the local capacity enhancement component of the World Bank supported project is likely to take a district focus; and GOI has recently decided to classify not whole States, but districts, according against key health indicators.

There are therefore a number of emerging pieces in the policy and operational picture: the range of services, the focus on decentralisation, and the centrality of the district. In addition, preparation for the World Bank supported RCH project has identified other key systems issues: the need for Technical Support Institutes to provide support at State level; improved funding flows to ensure both accountability and rapid transfer of resources; revised management information systems; and the importance of training.

The hypothesis of this paper is that while in themselves the changes described in the previous paragraphs are of considerable significance, they are unlikely per se to deliver the fundamental changes in quality of care and availability of services that are being vested in them. A significant agenda of health systems issues remains to be defined and addressed, which is likely to be critical to safeguarding the paradigm shift in policy and service delivery.

**Seven Principles in a Health Systems Development Agenda**

The following sections of this paper set out a series of principles or hypotheses that help in defining a broader health systems agenda. The intention is to stimulate more detailed discussion - in both operational and policy terms - than is possible within the somewhat restricted parameters of the current debate.

It is important to be clear from whose perspective these principles might be useful. Firstly, from a donor perspective, they shift the discussion away from a continuing focus on projects, whether large or small scale, to a view that locates donor support within an analysis of the family welfare/RCH sector as a whole.

From a government perspective, whether state or central, a health systems approach provides an opportunity to view both their own resources and those of donors within a shared policy framework, as well as to identify and address systemic difficulties in programme implementation.

These seven principles are necessarily somewhat tentative. They are presented here as a first attempt to broaden the context in which RCH is being discussed. In summary they are: the need to understand the "archaeology" of the present activities that fall under the Department of Health and Family Welfare; the need to define sectoral priorities rather than projects; the need to build on existing experience in health and family welfare; the need to focus on the design of system for planning, managing and supporting service delivery; the need to define the most appropriate level for designing the systems development components of the programme; the importance of a shared analysis among all stakeholders; and the value of drawing on the principles underlying a sectoral investment approach.

**Principle 1: Understanding the Archaeology**

The present programmatic structure of the Family Welfare Department of the MOHFW is complex and has built up over time. New projects and programmes have been added to the original core of family planning (for example EPI, MCH, CSSM). Each new programme tends to reflect new priorities (CSSM grew, in part, from a growing concern over rates of maternal mortality, for example), but tends to share some inputs and to be implemented through the same infrastructure as existing programmes. Disagregating and understanding the relationship between existing projects and programmes is a critical first step. An example may help to clarify this point. Donors supporting new RCH pilots at district level may wish to fund an enhanced range of services, and also provide support for decentralised service planning. However, given the fragmented programmatic structure the trend is to provide support for a particular sub-set of services (for example, the services included in the CSSM programme) which represent only a segment of what actually goes on within family welfare/RCH at district level. When it comes to planning, again the trend is to focus on programming activities, which use the additional inputs. This has a number of undesirable consequences. First, it undermines local priority setting. Secondly, the focus on additional resources means that the potential for improving resource allocation across the board, and addressing the main causes of inefficiency at district level through decentralised planning, is limited.

**Principle 2: Sectoral Priorities Rather than Projects**

Having disagregated the levels of input and activity that make up the existing portfolio of the DOHFW, the second principle puts it back together again. Under RCH, the activities of the DOHFW need to be understood, not as a set of overlapping projects (family welfare, CSSM, RCH) but as a single sectoral programme. Within this overall programme, there is a need to define overall priorities for investment, rather than adding another layer of project activities. The danger of the new RCH approach is that it could do precisely that, add additional services, for example services for RTI and STD, to a system that is already challenged by the delivery of basic family planning services. In the context of a single sectoral programme, based on a clearly articulated set of policies, the need is to take a strategic view as to the purpose and composition of GOI support to States. This will include decisions about the balance between investment and recurrent support, salary and operational costs, and the provision of inputs in cash or kind.

**Principle 3: Building on Existing Work**

The last two years has seen the development of a considerable and rich body of policy, programme and software development work, providing a valuable starting place for a continued analysis of the sector. Work sponsored by government, donors, and NG0s in different parts of India - in both family welfare and health needs to be drawn upon and developed. There is clearly a requirement for more rigorous analytical work of practical programme experience, in order to draw out principles and approaches that can be effectively replicated in other projects and programmes.

At the same time as building on existing work, however, it is important to be clear that the design of new programmes need not and should not be confined by the project structures that have already been established.

**Principle 4: Support for Delivering Essential Services**

Much work that has been done to date has focused on defining, which services should be delivered at which level of the system. The matrix prepared by Saroj Pachauri for example comprehensively presents the package of essential services needed at different levels of India's system of health services (Pachauri, op cit). The same level of attention needs to be paid to the design of systems for planning, managing and supporting service delivery.

These systems will include planning (situational analysis, prioritisation, options appraisal, budgeting); the development of management systems and structures

(MIS, human resource development, financing and funding flows, performance monitoring, and logistics management systems); and systems to support the implementation of service delivery (protocols and methods; service delivery training and skills development; provision of infra-structure, equipment and supplies; and changes to the structure of family welfare service delivery). Of these systems, most work to date has been done on the third component, particularly on developing protocols and training specifications.

**Principle 5: Defining Levels of Intervention**

Having identified the support required for delivering essential services, the next principle seeks to define the most appropriate level for designing the systems development components of the programme. This needs to be done in terms of key functions (i.e. what functions are needed); levels of the systems (i.e. at what level: centre, state, district, periphery; and thirdly, capacity development needs (to put these systems in place, what kinds of capacity development needs to take place).

The process of defining levels of intervention for systems support will necessitate a process of refining the functions themselves. Take human resource development as an example. At the centre, decisions about systems for human resource development will be governed by civil service rules and procedures, and by a need for rational workforce planning. At State level, HRD will need to address issues of staff and skill mix (leading to rational training plans and more efficient use of scarce skills), personnel management, polity for performance incentives, and allocation of resources for appropriate staffing levels, training, remuneration etc. At district level HRD is more likely to be concerned with skills development and training, supervision and monitoring of performance.

None of these systems issues is isolated from the others: there will be important synergies between the development of different systems. For example, each and all of the systems development components will have resource implications. The tendency to decentralise functions without decentralising responsibility, particularly over financial allocations, is unlikely to deliver the desired or expected results. For example, it is frequently stated that district level health professionals are not good managers. The remedy is perceived to lie in management training programmes, even though these are unlikely to be effective unless other chances are made, that ensure that managers actually have some control over resources.

**Principle 6: Developing a Shared Analysis**

Each of the principles discussed so far points to the need to developed a shared analysis between GOI, and donors, or State governments and donors of sectoral priorities and arrangements for funding and implementation. Developing a shared analysis between donors also becomes increasingly desirable, and essential in any form of shift towards a sectoral investment approach. The move away from individual donors defining their own priorities and programmes, to government coordinating donors in support of the sector, whether at centre or state, requires the development of an agreed analysis of the systemic problems within the sector, as well as common implementation arrangements.

**Principle 7: Moving toward a Sectoral Investment Approach**

The principles underlying Sectoral Investment Programmes (Harrold and Associates, 1995) may be helpful in (i) developing a coherent view of the whole RCH programme (ii) two setting priorities and (iii) framing questions about implementation arrangements and monitoring performance.

A sectoral investment approach has a number of characteristics. It is characterised by policies and programmes that are sector wide in scope; is based on a clear sector policy framework and strategy; is prepared by local stakeholders; includes all donors active in the sector; involves common implementation arrangements; and minimises the use of long-term technical assistance. Put very simply, a sectoral investment approach obviates the need for donor-specific planning, accounting, monitoring and reporting systems; and counteracts the trend for donors to be associated with specific geographical areas or programmes. It shifts the financing of the sector away from a government-funded programme, supplemented with projects supported by individual donors, to one in which government, in partnership with donors, articulates a coherent framework and strategic plan, costs it, calculates all available resources (from domestic and external sources), and estimates the "funding gap". Donors provide unearmarked funds to fill this gap, and monitor the performance of the programme as a whole rather than discrete part of it.

There are several reasons why the implementation of a sector investment approach in the way that is being attempted elsewhere in the world may pose problems in the context of India. Firstly, unlike many countries in which SIPs are being developed, donor funding represents a very small proportion of total health expenditure. Secondly, for the sector investment approach to succeed is likely to require that the presently fragmented systems through which health and population activities are financed be reformed. This in itself is a major undertaking. Thirdly, there are few precedents for applying this approach in a

federal system. The fact that major investment decisions are made at both central and state level adds considerably to the complexity of the task. Despite these complexities, some of the principles underlying this approach might well be of value in the context of implementing the new RCH policy.

The value of the sector investment approach is that it provides the conceptual underpinning for making progress on several of the principles defined in this paper - particularly in relation to the development of a shared, coherent view of the whole RCH programme. First however, it is necessary to define what is meant by the sector in this case. A starting point would be to flame the definition in terms of the whole range of programmes and activities funded by the GOI Department of Family Welfare. Defined in this way the sector is incomplete in that it does not include programmes funded by the GOI Department of Health, nor does include the resources provided from State Non-Plan budgets attributable to the FW programme. Nevertheless, this definition fulfils an important purpose by making it possible to focus on the overall GOI/donor contribution to FW activities, and thus recognises the need to rationalise the internal structure of this programme, and to make decisions about investment priorities within the overall Departmental portfolio. Taking a longer view, it may also be valuable to apply the sector investment approach to the combined Health and Family Welfare sector at State level.

The strategic approach to RCH has been defined in broad terms. However, applying the principles of sectoral investment helps to define the steps necessary to implement principle two. These will include: reviewing the purpose, composition and balance of GOI financial and technical support to States; developing systems for estimating overall programme costs and developing a new programme budget structure; reviewing funding priorities in relation to a realistic projection of resource availability from domestic and external sources; developing mechanisms for allocation funds between states; establishing funding channels for use by GOI and donors, which both ensure accountability and allow states the opportunity to review their overall investment priorities; defining criteria to be used by GOI for monitoring the performance of states; and establishing effective (GOI to State) monitoring systems.

**Conclusion: Business as Usual or a Health Systems Approach?**

To avoid repeating the problems of the past, it is clear that new systems are needed to ensure the success of the RCH approach. The principles presented above present a range - or hierarchy - of approaches. Being clear about the complexity of the FW/RCH programme, and the shared functions that the different programme components already have in common is an important starting point. Recognising that for an well-integrated, and stable programme,

the focus should be on the shared functions, rather than on different programme objectives, is, from a health systems perspective, an important perspective to maintain. The next level in the hierarchy is to be clearer about the kinds of systems support that must be in place if the essential RCH service delivery package is to have any chance of success. Instead of focusing primarily on missing inputs (e.g. services for adolescent girls), we need to focus on the missing processes (such as support decentralised planning, resource allocation and personnel management). Developing a programme of health systems support will entail asking the questions, "which systems, level and how?". At the highest level of the health systems development hierarchy, we have tried to show that applying the principles of sectoral investment would help in bringing about a fundamental shift from fragmented projects to a coherent programme.

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