

The Profile and Job Perceptions of Block Programme Managers in Karnataka

Jeroen F De Man¹, Bheemaray V Manganawar², Arupa J Das³, Bart Criel⁴, Narayanan Devadasan⁵

^{1,2,3,5}Institute of Public Health, Bangalore, ^{1,4}Department of Public Health, Institute of Tropical Medicine, Belgium


***Corresponding Author:**

Email: jero.deman@gmail.com

Abstract

One of the strategies of the National Rural Health Mission (NRHM) was the appointment of Block Programme Managers (BPMs) to support the management of the rural health system. This descriptive study provides first insights on who BPMs are, what they do, and what they perceive as barriers to their well-functioning. Data were collected through a semi-structured and self-administered questionnaire from 117 BPMs of Karnataka. Seventy four percent of the contacted BPMs responded. Their average age was 30.4 years, 85% was male, 88.8% had a Master in Business Administration. Self-reported performance and perceived ability is high. BPMs report low salary, lack of cooperation from higher level and field staff, lack of training, lack of logistic support and lack of authority as important barriers to their work. This study suggests that the BPMs require capacity building and supportive supervision with regular feedback to improve their performance. We encourage more research on this important element of NRHM.

Key words: National Rural Health Mission, Block Programme Manager, job perception, rural health system, performance, profile

Access this article online	
Quick Response Code:	Website: www.innovativepublication.com
	DOI: 10.5958/2394-2738.2016.00005.4

Introduction

India launched the National Rural Health Mission (NRHM) in 2005. The objective of the NRHM was to “carry out necessary architectural correction in the basic health care system... to improve the availability of and access to quality health care by people, especially those residing in rural areas, the poor, women and children”¹. One of the five key approaches of the NRHM is “Improved management”². The strategy was to create project management units at the national, state, district and sub-district level. Each of these project management units would be staffed by programme managers who would then strengthen the management information systems, monitor health programmes closely, and provide support for administrative and financial management matters¹. To realize this, the government hired programme managers, accounts managers and data managers, on a contractual basis across the country. Each state had some flexibility in defining the exact role of these managers and in appointing them. As of 2012, 90% of the districts had a district programme manager (DPM) and a district accounts manager (DAM), however less than 50% of blocks (sub-districts) had a block programme manager (BPM)³.

While much has been written about other aspects of the NRHM, there has been hardly any documentation

of the roles and performance of the DPMs and BPMs under NRHM. Most of the common review missions at the maximum mention whether Block Programme Management Units (BPMU) are in place or not in place, they do not comment on the performance of these BPMUs at all.⁴⁻⁷ An independent evaluation by the Planning Commission in 2009 does not make any mention of the BPMs or the DPMs⁸. The Mission Director of NRHM in an article in 2009 again focuses on the service delivery and financing and hardly talks about strengthening management in the districts⁹. Evaluations by the Planning Commission also do not talk about the BPMs or the DPMs, all they talk about is the strengthening of management at the district level^{10,11}. There is just one study done on DPMs in Madhya Pradesh which mentions that they do not have adequate orientation to the health services and that their main focus is on planning and monitoring¹².

It is to fill this gap in knowledge in the context of the Indian health system that we decided to study the BPMs in Karnataka to understand their profile, their roles and responsibilities as well as their performance. We also try to understand how they perceive their work and what are the barriers to better performance.

Methods

Study site: Karnataka is India’s ninth biggest state with a population of 61,130,704 and is divided into 30 districts and 176 taluks¹⁴. Among the major states of India, Karnataka ranks seventh on the Human Development Index¹⁵. The health status of Karnataka’s population corresponds to the average Indian, but has wide disparities between and within districts.¹⁶

Study population: In October 2013, the Government of Karnataka had sanctioned 176 positions for BPMs. Eleven of these positions remained vacant and four of

the BPMs were on long leave. The remaining 161 BPMs were considered as the population of this study and contact information was obtained from the Joint Director of Health and Family Welfare Services.

Data collection: An online semi-structured self-administered questionnaire was used with questions in different formats: open-ended, multiple choice, yes/no or on a 5-point Likert scale. We used “Google forms” to create an online questionnaire, piloted by two experienced researchers and one former BPM. The link to the questionnaire was shared with the study participants through a personal email sent on the 24th of October 2013. Two days later, non-responders received a courtesy call and a second email. Remaining non-responders received a weekly courtesy call during the following month. At the end of November 2013, we stopped data collection.

Ethical Issues: Ethical clearance was received from the Ethical Committee of the Institute of Public Health (IPH) in Bangalore. Participants were informed about the study and could opt out at any moment. Informed consent was taken from all participants.

Statistical analysis: Data were analyzed using descriptive statistics.

Results

From the 161 BPMs we contacted, 119 BPMs responded (response rate of 74%). Two of these did not

give consent for the study, so only 117 responses were analyzed.

The median age of the 117 participants was 30 years (95% CI = 29.04, 30.96) and 85% of them were male. The 117 respondents represented 28 of the 30 districts in Karnataka, and 117 of the 176 talukas. Only BPMs from Bangalore rural and Bangalore urban districts did not respond at all. On average, they had been working as a BPM for 3.8 years with a range from 0 to 6 years. A majority (88.8%) of the BPMs had a post graduate qualification in business administration, most of them with an orientation in finance, marketing or human resource management. From the 117 respondents 83.6% had prior work experience: 31.9% with a finance related job; 24.1% with a marketing related job, 4.3% with a human resources related job and 20.7% with a job in another field. Only 4.3% of the BPMs said that they had worked in health care services prior to joining the current BPM post.

In Table 1, we present the actual activity performed by the BPMs in their respective taluks in order of priority.

A lot of their work is centered on maintaining accounts and the health facility database. They are then expected to create reports that are presented at the review meetings. For those who responded not to do a specific activity listed in table 1, we asked to select the most important reason from a set of given options. The most frequent answer was “*nobody will check if I do this or not*”. Other frequent responses were: “*others do this task*” and “*this is not my responsibility*”.

Table 1: Proportion of BPMs who are doing their prescribed activities

Activity	% of BPMs that agrees they do this activity
Visit the field to supervise	96
Assist in maintaining accounts	96
Update taluka database	95
Monitor HMIS submission	95
Identify processes that need improvement	94
Encourage capacity building	94
Prepare consolidated reports	92
Prepare the plan for the taluk	90
Collect financial reports	88
Participate in review meetings	83
Change the processes that need improvement	68

From table 2 we note that, overall, BPMs felt capable of doing their work. Even those who joined recently have confidence in their work. We do not note any significant difference between both groups, except when it comes to maintaining databases or identifying problems in the field.

A similar assessment by gender did not show any difference between the perceptions of male and female BPMs. For each activity listed in table 2, participants were requested to select the most important element needed to fulfill that particular activity from a set of given options. For each activity, a majority of BPMs selected the item “Cooperation from others (from higher level or lower level)” as the most important one. On average, 44% of the BPMs selected “cooperation from others”; 14% selected “Training”; 13% selected “experience” and 9% selected “logistic support”. In an open question, BPMs proposed the following elements to fulfill their tasks: “cooperation

from private hospitals to keep the taluka database updated”, “Tally software for accounts maintenance” and “a proper forum for the preparation of the Programme Implementation Plan”.

Table 2: Self-reported ability of BPMs to do their tasks by length of time in position

Activity	No. and Proportion (%) of BPMs that feel able to fulfill the activity				
	BPMs in position for < 3 years		BPMs in position for 3 or more years		
	No.	%	No.	%	
Prepare the pip on time	15	83.0	90	92.0	
Obtain approval for resource allocation from district level	15	83.0	93	94.0	
Provide assistance in account maintenance	16	89.0	96	97.0	
Participate in review meetings on financial reports	18	100.0	96	97.0	
Obtain the SOE in time	14	78.0	89	90.0	
Maintain the taluk database	14	78.0	94	95.0*	
Encourage capacity building of staff	18	100.0	89	92.0	
Identify processes that need improvement	17	94.0	68	69.0^	
Change processes that need improvement	16	89.0	69	70	
		* $\chi^2 = 6.32, p = 0.011$		^ $\chi^2 = 4.87, p = 0.027$	

Table 3 looks at their working conditions. It is clear that, while most are satisfied with the physical support and the support they receive from their colleagues, their main grievance was the lack of training and orientation as well as the low salary that they receive.

In response to the open ended question on the type of additional training that they deemed to be necessary, financial management and administration were the most common answers. They also wanted more training on new national health programmes, including ‘Reproductive and Child Health’ and immunization. They also sought help with the ‘Health Management Information Systems’, developing the ‘Programme Implementation Plan’, accounting software and human resource management. Other than the demand for higher salaries, they also wanted more power to properly execute their work.

Table 3: Working conditions of the BPMs

Working conditions	Proportion of BPMs that agrees with the statement (in %)
I have the necessary equipment to work	73.0
I have the necessary infrastructure to work	65.0
I have been trained sufficiently to do my work	47.0
My role was well explained to me before joining	58.0
We need more refresher training	95.0
I am respected as a BPM by my co-workers	84.0
Other staff cooperates with me	72.0
I receive sufficient support from my superiors	73.0
The salary that I receive is sufficient	3.0
This job is too demanding	63.0

Discussion

Our exploratory study is one of the first studies on BPMs in India. Ten years after NRHM was introduced, there is very little information about one of its main components – strengthening the management of the health services. Our study shows that most of the BPMs are young males trained in business administration and with little or no exposure to the health sector. They have been posted into this important sector with hardly any orientation and are expected to learn on the job.

While this may be possible for marketing soaps or making financial statements, it becomes very difficult in a complex and technical field like health care. This is likely the reason why many request more training to upgrade their skills and improve their performance.

It is interesting to note that most of the BPMs were able to do their work, especially when it came to maintenance of accounts and databases. However, probably because they are lower in the health department hierarchy, they are not able to make any

changes. This is reflected in their responses to the open ended question, when they specifically mention that they could do a better job if they had the cooperation of the others in the department, both above and below them.

In general, they were happy with the service conditions, except that they felt that their salary was too low for a manager with a postgraduate degree. Many of them compared their salaries with their friends in the private sector and felt that they were being deprived.

While our sample is nearly representative of Karnataka (28 of the 30 districts) and reflect the status of BPMs in this state, we also realize that our study has some limitations. One main limitation is that we did not directly assess the capacity of the BPMs, rather we relied on their self-reported statements. Thus though the BPMs may give a very positive report of their capability, it may be different in reality. We could have either introduced an assessment questionnaire or interviewed their immediate superiors to understand their skills.

To improve the performance of the BPMs in Karnataka and to ensure that they contribute significantly to the health services, we would recommend that: a) they are being provided with a round of basic training on their job requirements; b) their roles are clarified not just with them, but also with other staff in the department, so that they can obtain the necessary cooperation; and c) they are being supervised regularly by the district staff. This supervision needs to be supportive so that they learn on the job and improve their performance.

A final remark is that more in-depth research on their performance, also through input from other staff, is recommended. This will contribute to a better understanding how BPMs can be offered a more enabling work environment and be more productive.

References

1. Ministry of Health and Family Welfare. National Rural Health Mission: Mission document. New Delhi: Government of India; 2005. 1-17 p.
2. Ministry of Health and Family Welfare. Four years of NRHM: Making a difference everywhere. New Delhi;2009.
3. Husain Z. Health of the National Rural Health Mission. *Econ Polit Wkly*. 2011;xlvi(4):53-60.
4. National Rural Health Mission. First common review mission. New Delhi; 2007.
5. National Rural Health Mission. Second common review mission. New Delhi; 2008.
6. National Rural Health Mission. Third common review mission. New Delhi; 2009.
7. National Rural Health Mission. Fifth Common Review Mission. New Delhi: Ministry of Health & Family Welfare; 2011. 252 p.
8. Gill K. A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM): Findings from a Study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan. New Delhi; 2009. Report No.: 1/2009.
9. Sinha A. In Defence of the National Rural Health Mission. *Econ Polit Wkly*. 2009;XLIV(14):72-5.
10. Programme Evaluation Organisation Planning Commission. Evaluation Study on National Rural Health Mission (NRHM) in Seven States: Volume II. New Delhi; 2011.
11. Programme Evaluation Organisation Planning Commission. Evaluation Study of National Rural Health Mission (NRHM) In 7 States Volume 1. New Delhi; 2011.
12. Nandan D, Pal D, Toppo M, Gupta S, Nair K, Khattar P. A Study of Functioning of DPMUs and Their Role in the Delivery of Services in Various Districts of Madhya Pradesh. New Delhi; 2009.
13. Ministry of health and family welfare. (2013). National health mission: evaluation study of NRHM in 7 states. Retrieved from <http://nrhm.gov.in/publications/evaluation-study-of-nrhm.html>.
14. Government of India. Census of India 2011.
15. Government of Karnataka. Karnataka Human development report. 2005.
16. International Institute for Population Sciences (IIPS). District Level Household and Facility Survey (DLHS-3), 2007-08 India, Karnataka. 2010.