This paper suggests that with decentralization there is going to be a drop in programme performance which is often referred to as a “performance dip.”

This phenomenon has been studied within many single private sector organizations and often happens in response to even the most subtle of changes, such as the replacement of a top manager in an organization. In this public sector case, a performance dip is highly probable given that multiple organizations are involved. Nevertheless, the dip must be endured in order to achieve long-term programme effectiveness, and if the changeover is managed effectively, it will be relatively short term (1-3 years).

The analysis as below (chart 1) addresses the program’s institutional, organizational, and managerial issues from two perspectives - macro, how the program fits within and operates in its overall context, and micro, how the program is organized and managed internally. Both of these follow the stages in the management cycle - planning, implementing, monitoring and evaluation - as the framework for analysis.

Chart-1: Analysis of Programme Issues and their Macro Profile

<table>
<thead>
<tr>
<th>Management Stage</th>
<th>Progress/Performance Cycle</th>
<th>Needed Strategic Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy &amp; Strategic</td>
<td>In the program definition there are a set of TB program-related policies. The program outlines how each is to be realized during the program’s life. However, there does not seem to be a living process within the public sector for regular objective policy analysis and planning. Also there is no process for a year strategic plan, which is critically needed for India’s TB situation.</td>
<td>These functions need to be started immediately, so that all parties can understand and agree on the policy-to-practice pyramid, the priorities within different time frames, the macro division of labor, and the macro resource allocation requirements. This should be the main focus of Govt. Of India (GOI) Ministry of health (TB) management, Central TB Division ie the CTD.</td>
</tr>
<tr>
<td>Institutional</td>
<td>The relationships and interactions for TB among India’s health institutions [public, private, Non Government Organisation [NGO] are broadly set out in the description. However, the process of planning these interactions seems to be a function of program preparation only.</td>
<td>Given the realities of the mix of health care-seeking behavior among the Indian public, building a process to ensure these institutional interactions is critical. These cannot merely represent an “add-on” to public sector implementation.</td>
</tr>
</tbody>
</table>
Management Progress/Performance

Implementing Policy & Strategic Progress on the given set of policies is very uneven - on several, of them no significant progress has been made. There seems to be no operating systems to ensure that what is defined in a multi-year plan is connected to implemented actions.

Strategically, the creation of two TB program management streams (one for RNTCP and one for SCC/NTP) from the central level will cause high levels of managerial dissonance within the program and will not improve overall performance.

Institutional Realization of these plans has had a very slow start.

Monitoring Policy & Strategic The only systems for the macro-monitoring of policy and strategic achievement are international reviews. While the requirement for these is a regular part of international agreements, how they are conducted is far from systematic. It is also dependent upon international projects which are not internal to India’s TB program.

As with above, there is no system to monitor progress or performance in this area. To date, all monitoring information is ad hoc and anecdotal - there is no framework for assessing performance or providing objective feedback to operational program managers.

Evaluation Most of the same issues outlined for monitoring actions and systems apply to evaluation. The difference is that evaluation is periodic and needs to be less integrated into macro-management systems. There have been previous evaluations of India’s TB program. The World Bank project’s Mid-term review in September of 2000 (2) could be considered something of an evaluation, but other than that no overall evaluation has been called for by the program to date.

Needed Strategic Change

Those responsible for program management should consider some systems that provide better “live links” between planning and implementing. There are stipulations and recommendation in project documents for macro management cycle system, starting from design and applications, as for example, those incorporated in the World Bank project.(1) This application is no end in itself, but its use forces the discipline of connecting plans to operations, and it can display how policies are translated into practice (per each strategy) in real time. This will assist in re-unifying central program management, (ie CTD)

Once a planning or decision-making framework has been agreed upon for this area, it must be made a high-action priority. Since there are no rewards in the public sector for these types of cooperative efforts, the facilitation actions to build operational relationships (on the GOI’s behalf) should be contracted out.

As with the design and application of any good management cycle, the monitoring and evaluation processes and content should be rooted in the planning process and content. If and when GOI implements a systematic policy and strategic planning process, the monitoring process and tools can be designed.

In order to complete the macro-management cycle system, this part must also be developed as an integral component so that performance is measurable and supervision objective. If this is implemented by contractors, the process of monitoring would be set out in the contract.

Designing and implementing an evaluation system or framework will be relatively easy if the above planning, implementing, and monitoring systems are put in place.
<table>
<thead>
<tr>
<th>Management Cycle Stage Planning</th>
<th>Progress/Performance</th>
<th>Needed Strategic Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Annual Workplanning</td>
<td>Planning systems in place are piecemeal and largely focused on the technical aspects of program planning. They are not directly wedded to budgets or other resource requirements. These are only in place at the central level.</td>
<td>A system of integrated, 10-year strategic as well as annual work planning needs to be developed and installed at the central, state, and district levels. The annual financial, Health Resources (HR)/training, and Information Education Communication (IEC) planning would be integrated into this umbrella planning process.</td>
</tr>
<tr>
<td>Financial Planning</td>
<td>Overall funding requirements for the program have been ratio and formula driven. Actual planning (or decision-making) about requirements and releases has been done on a short term, ad hoc basis. Within the framework of general financial requirements, there is no system for local planning which allows for analyzing and matching of operating context to funding needs</td>
<td>A system of integrated, five-year real-term &amp; annual nominal term budget planning needs to be developed and installed at the central, state, and district levels. This system's annual planning sub-system should be tied to the actual funding allocation decision making.</td>
</tr>
<tr>
<td>Human Resources (HR) &amp; Training Planning</td>
<td>Overall HR requirements for the program have been ratio and formula driven. Actual planning (or decision making) about staffing and training has been done on a short term, ad hoc basis. Within the framework of general HR program requirements, there is no system for local planning which allows for analyzing and matching of operating context to HR needs.</td>
<td>A system of integrated, five-year HR &amp; training planning needs to be developed and installed at the central, state, and district levels. This system should also have an annual planning sub-system tied to funding allocations.</td>
</tr>
<tr>
<td>Information, Education &amp; Communication (IEC) Planning</td>
<td>There has been no planning system or any significant effort in this area.</td>
<td>A system of integrated, five-year IEC [mass media and IPC] planning needs to be developed and installed at the central, state, and district levels. This system should also have an annual planning sub-system tied to funding allocations.</td>
</tr>
<tr>
<td>Organizational and management development Planning</td>
<td>There has been no planning system established, or any significant effort exerted in this area. Efforts in this area took place when program planning focused largely on the district. There is general agreement on the need for decentralization, and an initial plan has been drafted, but it focuses largely on the transfer of technical functions and decision-making, not on the development and transfer of managerial systems. (3)</td>
<td>A system of integrated, 10-year organizational planning needs to be developed and installed at the central, state, and district levels. This system should also have an annual planning sub-system tied to funding allocations. This is often a complex process, but it can begin by visioning organizational units and their relationships, [see Figures 1 and 2 below]</td>
</tr>
</tbody>
</table>
Management Cycle  
Progress/Performance  
Needed Strategic Change

**Implementing**

Program - Technical  
Within the operating framework that has been elected [central-district], this has been done very well thus far for the Directly Observe Treatment Short Course (DOTS) stream of the TB program. The two other streams have relatively been left on “autopilot.”

**Program - managerial**

While there is a call in the World Bank project’s Credit Agreement for the states to implement the Project..”(2) how that was to be done was not completely explicit in neither the Credit Agreement nor the more detailed project document. Therefore, the evolution of the CTD-district relationship as the dominant managerial relationship, (ignoring the state levels) is not a violation of explicit agreements.

There were start-up problems in the area of procurement, logistics, and transport - some very serious. The financial management systems remain in chaos.

**Monitoring**

Monitoring systems  
As above, the technical monitoring systems are complete and in robust operation in the DOTS districts. The other two intervention streams, SCC and NTP, have designed systems, and tools and skills are available. However, these also operate mostly on auto-pilot.

The management monitoring systems, as BIS exemplified by the financial system, are in uneven states of development.

However, most are under-developed or lack development completely.

**Supervision**

Technical supervision from the central and most DOTS district levels has been rigorous and effective. However, it has been implemented with high levels of non-government staff (some expatriate). This is not building sustainable capacity.

**Evaluation**

Intra-government program evaluation systems for TB have not been planned as such. Major TB program reviews, such as the joint review in February, 2000 and the Mid-term Review could be considered types of evaluations. (2) (3)

The technical managerial capacity that has been developed at the district level needs to be “re-centralized” up to the state level. This should be facilitated by the Central TB Division (CTD). A detailed system of managing the technical aspects of the transition from Short Course Chemotherapy (SCC) or National TB Programme (NTP) to DOTS needs to be developed and trained to all state staff not already in DOTS areas.

It is now recognized that managing the program with a central-district relationship was only feasible for a startup phase. With 540 districts the ratios are untenable. In addition, bringing many operational decisions back to Delhi not only slows down the speed of decision making, but it will also reduce the quality of decision making in the long term. Thus the central-states-districts management structure/relationship has to become the formula for expansion - genuine decentralization.

The middle management of the technical monitoring systems has to be transferred to the states.

The monitoring of the management/administration systems has to be developed and transferred to the states.

States must begin district supervision of all types with occasional support from the central level.

The CTD must supervise the development of state capacity.

The government must begin a process of institutionalizing evaluation into the national processes of India’s TB program.
**Overall Analysis and Strategic Priorities**

1. **System Building** - One of the overall themes discussed above is the need to systematize organization and management processes and procedures, starting with the planning function. This has been found to be a critical first step for any process of rapid decentralization. For managers who are on the brink of new authority, responsibility, and accountability, this provides a framework and opportunity to do the following:

* learn the requisite skills through job-specific management training in these systems;
* understand how their decisions, actions, and performance fit into the larger system; and
* objectively self-evaluate and create a framework for objective interaction with their supervising managers (it must be accepted that most managers in a decentralized system should and have to spend over 95% of their time making independent actions and decisions).

2. **Organization and Management Interfaces**

- It is extremely ironic that within a mature public sector such as this, programs are allowed to operate outside some of the traditional public sector systems. Everywhere in the world, the public sector tends to be budget-driven as opposed to performance-driven. However, this is because, typically, public sector organizations (and the units within it) must prepare some type of budgeted plan in order to procure funds for the next operating period. In this case, the centrally sponsored scheme demonstrates the powerful effect of simply eliminating that planning-budgeting requirement from the process. Although a substitute funding transfer mechanism has been implemented to bypass the normal civil service central-state-district process, a parallel planning system was never developed or implemented because it was not required. Consequently, funds were transferred into loci of operations without programmatic or financial management accountability. Although the perfunctory audit functions were performed, from a program management cycle perspective, these functions were meaningless. Instead of effectively ensuring accountability, these functions represent only an attempt to prevent fiscal abuse.

   The other way to “work-around” the existing systems is to short-cut changes in staffing by contracting some critical program staff on a short-term basis. This is becoming more common in public sector practices, but is only defensible for tasks/jobs that require response to an “emergency” situation or have a clear end-point that is within 3-5 years. Additionally, this practice can be justified when it is clear that the public sector cannot hire or retain staff with the requisite skills. However, in this case, neither condition applies. Tuberculosis control in India will be a priority for at least two more decades, and the necessary programs should present opportunities that are attractive to skilled and potentially long-term staff. Furthermore, many state organizations already suffer from over-staffing. Although many states have already begun to examine their contracting practices, several other states would do well to follow suit.

   Instead of maintaining the over-staffing trend by continuing to temporarily contract staff-members, states could re-organize the human capital they already have. For instance, groups of staff whose jobs no longer match programmatic needs could be trained for TB-related tasks. However, those positions that encompass the functions, activities, decisions, and organizational relationships that allow the TB program to directly interface with normal public sector systems, could remain. For example, because the selection, deployment, and other personnel actions of program managers (at the state level and below) are subject to normal state procedures, their status would remain unchanged.

3. **Degree and Nature of Change and its Sustainability** - Assessing the nature and degree of change for a health system or a program within it is complex and somewhat subjective. The first task in this process is to define and agree upon the measuring scales according to the given situation, assessment of collective feasibility and sustainability, and facility of re-planning. The guiding principle is that large organizations or systems cannot rapidly undergo many fundamental changes and then sustain them.

   The Fig 1 is an example of an assessment tool for a national health sector. If the GOI is interested in this process, a similar one could be developed specifically for the TB program, with an accompanying analysis and (evaluation).

4. **Strategic Trade-off** - At this point, it must be made clear to all concerned, that with decentralization there is going to be a drop in program performance which is often referred to as a “performance dip.” This phenomenon has been studied within many single private sector organizations and often happens in response to even the most subtle of changes, such as the replacement of a top manager in an organization. In this public sector case, a performance dip is highly probable given that multiple organizations are involved. Nevertheless, the dip must be endured in
### Fig 1: Sustainability of Organizational Change - Example: Likely Sustainable

<table>
<thead>
<tr>
<th>What is to be Changed</th>
<th>Symbolic</th>
<th>Socialist</th>
<th>Comprehensional</th>
<th>Wellness-oriented</th>
<th>Entrepreneurial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Leadership/Managerial Style</td>
<td>Authoritative/Exploitative</td>
<td>Authoritative/Benevolent</td>
<td>Consultative</td>
<td>Participative</td>
<td></td>
</tr>
<tr>
<td>Organizational Structures</td>
<td>Functional</td>
<td>Program</td>
<td>Matrix</td>
<td>Circle/Web</td>
<td></td>
</tr>
<tr>
<td>Culture &amp; Decision Practices</td>
<td>Family</td>
<td>Eiffel Tower</td>
<td>Guided Mistletoe</td>
<td>Incubator</td>
<td></td>
</tr>
<tr>
<td>Health Technology &amp; Practices</td>
<td>Inadequate for needs</td>
<td>Basic</td>
<td>Developed</td>
<td>Sophisticated</td>
<td></td>
</tr>
<tr>
<td>Model of Central Management</td>
<td>Information Processing</td>
<td>Regulator</td>
<td>Interventional</td>
<td>Partnership</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Score</th>
<th>8 Year Goal</th>
<th>10 Year Goal</th>
<th>8 Year Change</th>
<th>10 Year Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total Change Score:** 4

**Average Change Score:** 0.7

### How Change Will Happen

<table>
<thead>
<tr>
<th>Scope &amp; Participation</th>
<th>Internal Unit</th>
<th>Whole Org-Limited</th>
<th>Whole Org-All</th>
<th>External-Limited</th>
<th>External-All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

**Choice at:**
- Choice at Choice at
- Best Fit
- Best Fit
- Best Fit

**Beginning:**
- 5 years
- 10 years

###Operating and Driving Change

<table>
<thead>
<tr>
<th>Rational/Emotional</th>
<th>Normative-reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Political Authority**

**Economic Authority**

**Political Authority**

**Technical Authority**

**Managerial Authority**

**Personal Authority**

**Operational Authority**

**Strategic Authority**

**Organizational Authority**

**Institutional Authority**

**National Authority**

**International Authority**

**Global Authority**

**Fig 2: “Publicness”: Political and Economic Authority**
order to achieve long-term program effectiveness, and if
the changeover is managed effectively, it will be relatively
short term (1-3 years). Advocates of maintaining central
control are quick to say “see I told you so” after
witnessing the performance dip that commonly
accompanies the initial phases of decentralization.
However, this phenomenon cannot be used as a reason to
re-centralize, which many countries have done. The
clinical and epidemiological comparison is one between
efficacy and effectiveness - the former being the
demonstration of desired outcomes in a controlled context
and the latter demonstrating impact in uncontrolled,
real-world environment. Demonstrating efficacy doesn't
necessarily lead to effectiveness. In the context of
decentralization, some people seem to believe it can be
done in a controlled environment so that efficacy can be
reasonably expected. However, decentralization is a
messy, real-world process and only effectiveness can be
anticipated. In addition, it will always have a fairly
long lag time. These issues are at the heart of planning,
organizing, and managing long-term national programs.

5. Demand and Performance Driven - The

The evolution of the funding mechanism in this and other
centrally sponsored schemes by GOI presents a
convenient opportunity to fundamentally alter the drives
of the TB Program's operation and performance so that
it is more responsive to local needs and situations. Down
to the sub-district level, operational units and higher
levels of management should establish time-based
agreements which are built around incremental levels
of program performance. The initial agreement
negotiation would require that all parties define the
resources needed to operate and achieve the mutually
agreed upon performance levels. Subsequent negotiations
could take place on an annual basis to ensure that
consequences of performance, above and below the
established levels, would be made very explicit at the
time each annual agreement is made. The monitoring
and supervision systems are then built around or adapted
to the structure of these agreements. This system
provides the framework for a demand-driven (local needs
and situations) and performance driven program, as it
should provide tangible rewards and sanctions for
variance in performance. The elements of such a system
have already been developed by some district managers
through their own innovation.

6. Comparative Advantage and Public-
Private Partnerships - As the graphic below displays
(Fig 2), the driving forces behind the public sector and
the private sector are poles apart, leaving the NGOs to
occupy the “middle ground.”

Although polarity certainly exists, there is a
major need for collaborative efforts in the delivery of an
effective nation-wide TB Program because, in the short
term, the government cannot alter the public’s care-
seeking or service-seeking behavior.

Fortunately, this collaboration will also

introduce an element of healthy competition. The public
sector needs to re-energize the TB program, and the shift
in the technological paradigm alone will not create
sustainable high levels of public sector program
performance. Organizational life-cycles have been well-
studied and major programs exhibit similar patterns
(see graphic at Fig 3 below). According to this life-cycle
pattern, India's TB program reached the decline stage
about a decade ago. The creation of meaningful working
relationships with external partners in the program
should provide continuing stimulus to re-grow the
organizational and programmatic efforts. Essentially,
it should re-start the program’s life-cycle.

7. Timing, Sequencing, and Priority Setting

- Priority setting, time management, and activity or
decision sequencing are generic problems of the public
sector worldwide. Civil service managers must cater to
many influences in their decision-making processes, as
well as in responding to requests for non-substantive
use of their time. Indeed, the primary influences
represent those of their political partners. In the field of
international assistance, recipient countries must juggle
these competing demands in concert with further
demands from the donor organizations' managers. In
the case of the TB Program, a number of time-bound
requests for decisions and actions have been made by
donor organizations with low marginal return thus far.
However, this situation could be turned around to create a
“win-win” situation, in terms of the program's
effectiveness. If a joint (national-donor) regular (at least
annual) program planning process was engineered; then
the goal, the time-frame, and the sequence would be clear
and agreed upon by everyone. The program managers
could use the donor organizations (and the related legal
international agreements) as a defense for unreasonable
political demands that seek to alter the program's
decisions, activities, or resource allocations.

8. Technical and Non-Technical
Management Symbiosis - A reasonable division
of labor between these two types of health
management has been achieved in the Indian
public sector. Nevertheless, natural conflicts
have been created by the differing factors (or
criteria) that each group of managers applies when
making its respective decisions (see graphics at
Fig 4 & 5 below). These differences can generate
significant cross-impact on the other group’s program performance. These conflicts can be somewhat reduced by better clarifying who makes which decisions and how. A matrix tool to begin this type of process was tested at the TB project’s Mid-term Review meetings with state managers in India. It divided the decision-making process into technical and organization/management components; however, it went no further. To be most effective, after agreement has been reached on these matrices, a cross-over analysis should be conducted among the two groups. After this is complete, major and regular decisions should be defined explicitly in words and mapped to different levels and types of management. The descriptions of these decisions should also define the nature of the information used to make the decision (including its source, frequency, etc.).

9. Learning Organization - Lastly, but possibly most importantly, is the need for modern health organizations and programs worldwide to become managed as, what is now referred to as, “learning organizations.” This adjustment is essential because professional and technical health staff members are “knowledge workers.” The application of their knowledge in varying and complex situations is the key ingredient in performance. In other words, the application of their knowledge is the “engine” of production. Therefore, managers must plan and manage to ensure that the “fuel and lubrication” for this engine-new knowledge- is readily and frequently available to staff. Consequently, this system must include both technical and

national implementation is achieved in this program, it will involve about 500,000 full and part-time staff. Accordingly, the system for their initial and refresher training constitutes a huge effort requiring military-like precision. It also must be decentralized, and must be a high priority program. Many other countries have created national programs which integrate the training function with supervision. Trainers are not necessarily the only supervisors, but they must play a direct and meaningful role for staff members. This marriage is symbiotic. Trainers must learn job realities in order to ensure that training is more job-specific; moreover, staff members need opportunities to change procedures by supplementing the training with on-job interactions and needs assessments.

REFERENCES:

