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# TALENT MANAGEMENT AT ASHWINI

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# ABSTRACT

Attracting and retaining employees is crucial for success for all organizations. Competitive compensation system, challenging assignments and rapid career progression are offered as carrots to retain employees in for-profit corporate entities. However, small organizations working in social sectors lack such resources and hence have to improvise or innovate ways of retaining employees. Talent is widely accepted to denote competencies that employees possess to help them perform their current duties and to grow within an organization. Therefore, talent management is understood as practices and policies of an organization to attract and retain competent people and to provide a culture that facilitates superior performance. The focus has been on “competent people to be hired and retained.” ASHWINI, on the other hand, has tentatively but consciously embarked on a process that emphasizes more on retention of knowledge, skills and abilities than the more difficult task of retaining people. Along with competent and committed core employees, ASHWINI has been able to attract expert volunteers who have a long-term commitment as alternate talent pool thereby reducing lack of stability and acceptance of poor performance from volunteers and interns. Leadership at ASHWINI is committed to work towards self-reliance of the communities. They serve by focusing on growth and development of local tribal groups transforming them to self-reliant leaders who work towards welfare of their own people through ASHWINI.

# INTRODUCTION

Globally, numerous surveys highlight the increasing struggle for attracting and retaining key talent in organizations. A recent study of more than 1600 organizations world-wide indicates that 72% of them have problems in attracting critical-skill employees and more than 60% have trouble in retaining high-potential employees (Towers Watson 2012). In developing countries such as India, major challenges that lead to talent scarcity are low employability of educated youth and migration to better paid jobs in developed countries by potentially employable youth (Krell 2011). Employee attraction and retention is now seen by CEOs of many Indian organizations as a strategic issue deserving critical attention (PricewaterhouseCoopers 2012).

Given this backdrop, social enterprises in India, which according to recent reports are characterized as 'young but ambitious' (Intellecap 2012), do face a major challenge in attracting right talent. Scholars have pointed out that the scale of social impact by social enterprises is influenced by how well these organizations succeed in developing a set of distinct capabilities (Bloom and Chatterji 2009). A key capability in this set is the ability of the organization to identify, recruit, train and retain top-notch management talent. The question then is, how have India's social enterprises fared in developing this key capability? Evidence to answer this question is hard to come by. The available reports indicate that the social enterprises are competing for talent with the mainstream commercial organizations and in the process, are finding it hard to attract and retain talent. The challenge becomes nearly impossible when they are trying to attract talent in a sector where availability of trained manpower is a scarce resource (as in the case of healthcare professionals). World Health Statistics Report (2011) has ranked India 52nd among 57 countries facing human resource crunch in healthcare. We have 6 doctors and 14 nurses for every 10,000 population[1] as compared to WHO recommendation of 10 doctors per 10,000 people. These numbers do not reflect the rural-urban divide in distribution of availability of healthcare, particularly in remote rural pockets that are traditional living spaces for disadvantaged populations including tribal groups. Acute shortage of health workers in rural areas is true across the world including India[2]. The problem of attracting and retaining qualified health professionals is a worldwide challenge. A recent research study by WHO claims that

*"Such shortages are symptoms of a poorly managed health workforce and health care system. The causes of the crisis are complex, and have to do with insufficient production capacity, but also with an inability to keep the workers that are being produced in the places where they are most needed. Therefore, because of the complex web of factors that influences the mobility of health workers, response to the crisis must be combined with effective measures to attract and maintain both existent and newly trained health workers where they are needed most.[3]"*

In this context, we studied talent management practices of ASHWINI, a community based hospital situated in remote hills of Tamil Nadu, India. ASHWINI has been delivering healthcare to Adivasis (tribal communities) since 1987. It has addressed talent shortages by training local Adivasis to become skilled nurses, by creating internship

[1] http://www.who.int/gho/publications/world_health_statistics/en/index.html

[2] http://www.who.int/hrh/migration/rural_retention_background_paper.pdf

[3] Ibid

positions for attracting local or international talent besides attracting and retaining qualified doctors. This study attempts to conduct a systematic analysis and document the talent management practices by writing an in-depth case study on ASHWINI. In particular, this study tries to answer the following questions:

• What are the different 'unconventional' talent-pools that the organization taps to fill its manpower needs?

• What talent management practices does the organization implement to engage its employees?

• What factors contribute to the effectiveness of such talent management practices?

• What challenges does the organization face in implementing such talent management practices?

# METHODOLOGY

We adopted a case study method for conducting this study. Case study is an empirical enquiry that "…investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2003, p. 13). It has been pointed out that the case study design is particularly suited for research questions that require detailed understanding of social or organizational processes (Hartley 2004). In comparison to other research designs case studies offer 'the greatest potential for revealing the richness, holism and complexity of naturally occurring events (Torracco 1997, pp 130).

Thus, as Stark and Torrance (2005) observe, case studies can achieve a "rich description" of a phenomenon in order to represent it from the perspective of participants and it seeks to illuminate the reader's understanding of an issue. The research questions set out in the previous section involve an understanding of not only the talent management practices adopted but also the context in which these practices or implemented. So the case study is more suited for the task this research demands.

The following table (Table-1) describes the sources of data and data collection tools used in the study.

## Table 1.

**Sources of data**

| Sources of data | Data collection Tools | No. of Participants |
|---|---|---|
| **Primary sources** | | |
| Doctors, surgeons, gynecologists and physicians | Interviews | 6 |
| Health animators, nurses and staff | Interviews, focus group discussion and observations | 12 |
| Other stakeholders from the ecosystem – Animators, Education coordinators, members of Vidyodaya, AMS | Interviews | 12 |
| **Secondary sources** | | |
| Project reports, minutes of key meetings, annual reports and internal studies. | | |

Two of us spent ten days at ASHWINI to observe talent management practices and to conduct the interviews. The third author is an employee of ASHWINI. His experiences as a practitioner – observer provided an insider perspective to the study. The interviews were semi-structured to elicit interviewee's interpretation of the described phenomena. During such occasions the role of the researcher was that of a 'complete observer' (Burgess 1984). In addition, we used a variety of documents -- relevant annual reports, press releases, presentations made to various stakeholders, and internal reports on issues that have a bearing on the research topic – as sources of data to collate "a substantial archival residue" (Gephart 1993: 1469) from the different published sources.
We first had a general reading of the interview transcripts to get a basic understanding of issues covered. Then segments of data – paragraphs, in this case – were blocked and labeled. These labels were mostly 'in vivo' (Van Mannen 1979) and used phrases and terms offered by participants. These were then collapsed into distinct categories, at a more abstract level, to form second-order themes (Strauss and Corbin, 1990). These second-order themes and meta-categories which were earlier identified were presented to ASHWINI team for their feedback as a part of peer debriefing (Lincoln and Guba 1985) and expert validation to enhance trustworthiness of research (Wallendorf and Belk 1989). They were then refined and presented as a coherent case study.

# ASHWINI AND ITS ECOSYSTEM PARTNERS: A BRIEF HISTORY

In 1986, ACCORD (Action for Community Organization, Rehabilitation and Development) was set up to fight rampant land alienation among Adivasis in Gudalur Valley, home of over 25000 Adivasis for many centuries. ACCORD's objective was to help Adivasis become self-sufficient by mobilizing people to form village level organizations called 'Sangams'. In 1988, these Sangams federated to form a registered society, the Adivasi

Munnetra Sangam (AMS), a people's movement bringing five tribes[4] of Adivasis together to fight for their rights. Today AMS covers close to 18000 Adivasis in 312 villages, with nearly 4000 families as its members. In 1987, ACCORD launched an extensive community health program spearheaded by two young doctors. They trained a cadre of Adivasi village women selected by the people themselves, as "health workers". The focus of health workers was to provide preliminary care to the most vulnerable group viz., pregnant women and children under five years. Demand from tribal patients seeking curative care began as the government hospital lacked basic facilities and tribal communities felt ill-treated and private hospitals situated in towns were prohibitively expensive. During the discussions with the village Sangams, the need for starting their own hospital was expressed again and again. In 1990, another doctor couple joined the team and took over the responsibility of starting the hospital. A new charitable society called ASHWINI (Association for Health Welfare in the Nilgiris) was started in 1990 with an objective to establish a health system that is accessible, acceptable, effective and sustainable, and importantly, owned and managed by the Adivasis themselves. Their logo declares their strategic intent as "Health in the hands of communities."

A couple of years later, ACCORD started a school, Vidyodaya, to address the educational status of the Adivasis, though in a limited way. It also started 'non-formal' centers in a few villages; Adivasi youth were trained as Voluntary Teachers and worked on enrolling Adivasi children in Government schools.

## Figure - 1

**Organogram of Gudalur team**


[4] Kurumba, MullaKurumba, Bettanayakka, Irula ,Paniya tribes.

# ASHWINI: ACTIVITIES AND ORGANIZATION STRUCTURE

ASHWINI started as a small community health program primarily targeted at training tribal women on women and child care issues. It is now an important institution owned and managed by the people themselves and comprises of a 40-bedded hospital and 8 sub-centers.

The organization has two verticals - Community Health Work vertical and Hospital-based services. Community Health Work team consists of Health Workers and Village Health guides. Health Workers are appointed by ASHWINI and are part of the Area Center team. Area Centers have been created to facilitate administration and accessibility in eight geographical zones. Each Area Center covers 20 to 70 hamlets. These are common resource centers for all the partner organizations (ASHWINI, AMS and Vidyodaya).The Area Center team comprises of Health Workers (or Health Animators), Education Coordinators, Women Group Coordinators and Area Accountants.

In the initial phases of community work, Health Workers used street theatre as a technique to spread the message and hence, were designated as 'Health Animators'. They are responsible for disseminating health awareness and follow up with chronic patients. They participate in monthly staff meetings at the hospital providing information about chronic patients in the villages and also give feedback about patients' experience at the hospital. They act as a bridge between the hospital and the Adivasi community.

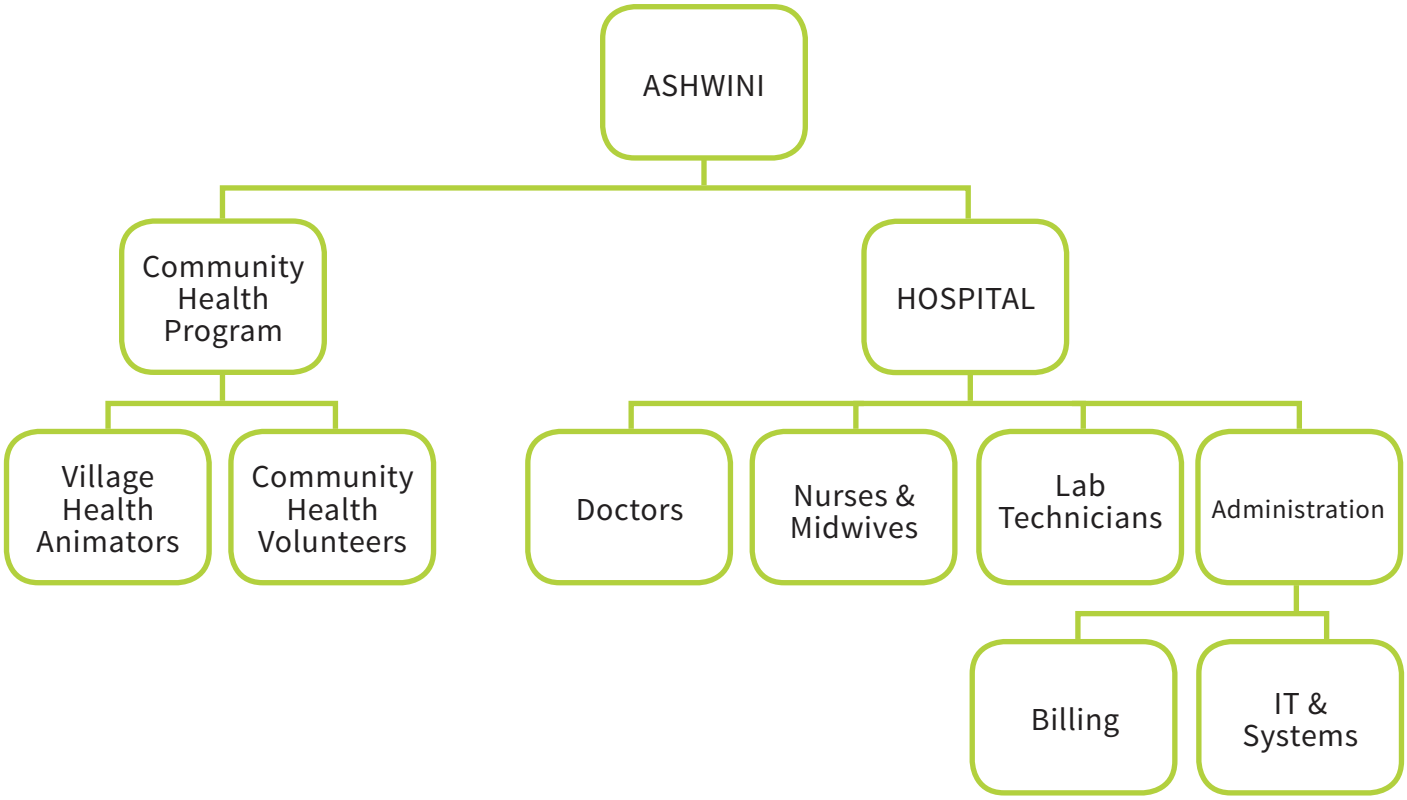
On the other hand, Village Health Guide is a voluntary position. This is typically an Adivasi from that village and acts as the first point of contact for diagnosis and dispenser of medicines for simple and common illnesses. They also take the responsibility for overall health and sanitation of their village and monitoring the progress of chronic patients. A weekly mobile clinic manned by a qualified doctor, visits the villages covered by the Health Animators, to cater to more serious patients.

At the village level, other than Health workers, there are other volunteer workers such as Education Volunteers, Youth Volunteers and Village Leaders (Thalaivar).

At the hospital, the first level of staff consists of nurses, midwives and other administrative staff. These are staffed by local Adivasi employees. They manage hospital operations by actively aiding the doctors in providing primary and secondary level health care for the community. Overlaid on this, are the doctors, surgeons and physicians. These medical professionals are either fulltime employees of ASHWINI, volunteers who visit ASHWINI regularly or medical interns and students who have chosen to work with ASHWINI to complete their course requirements.

## Figure - 2

**Organizational Structure of ASHWINI**




**Details of staff of ASHWINI is provided in Table 2 below**

## Table - 2

**Staffing pattern at ASHWINI**

| | Male | Female | Total |
|---|---|---|---|
| Tribal | 9 | 32 | 41 |
| Non-Tribal Staff | 3 | 14 | 17 |
| Total | 12 | 46 | 58 |

Efficient talent management practices are useful only if it translates into actions and results. The demand for their services has increased so much so that a new hospital complex has been built and inaugurated recently. Infant mortality rate in the villages served by ASHWINI has reduced from 105 per thousand in 1997-98 to 39 per thousand in the year 2012-13. Total tribal deliveries in the same period were 359 and close to 80% deliveries happening in the hospital. Maternal mortality is down to one. Further details are provided in Table 3.

### Table - 3

**Statistics from Community Health program (2012-13)**

| Particulars | No. |
|---|---|
| Number of patients seen in mobile clinics | 9000 |
| Number of health volunteers | 264 |
| Total Tribal Deliveries | 359 |
| % Deliveries in the hospital | 79.1 |
| % Antenatal with more than check ups | 93.3 |
| % Children with normal weight | 64 |
| % Children immunized at 2 years of age | 84 |
| Couple Protection Rate (%) | 46.1 |
| Infant Mortality Rate /1000s | 39 |
| Maternal death | 1 |

These statistics provide sufficient evidence to conjecture that ASHWINI has a positive impact in improving community's health needs and is set to expand to meet the growing demands from the community.

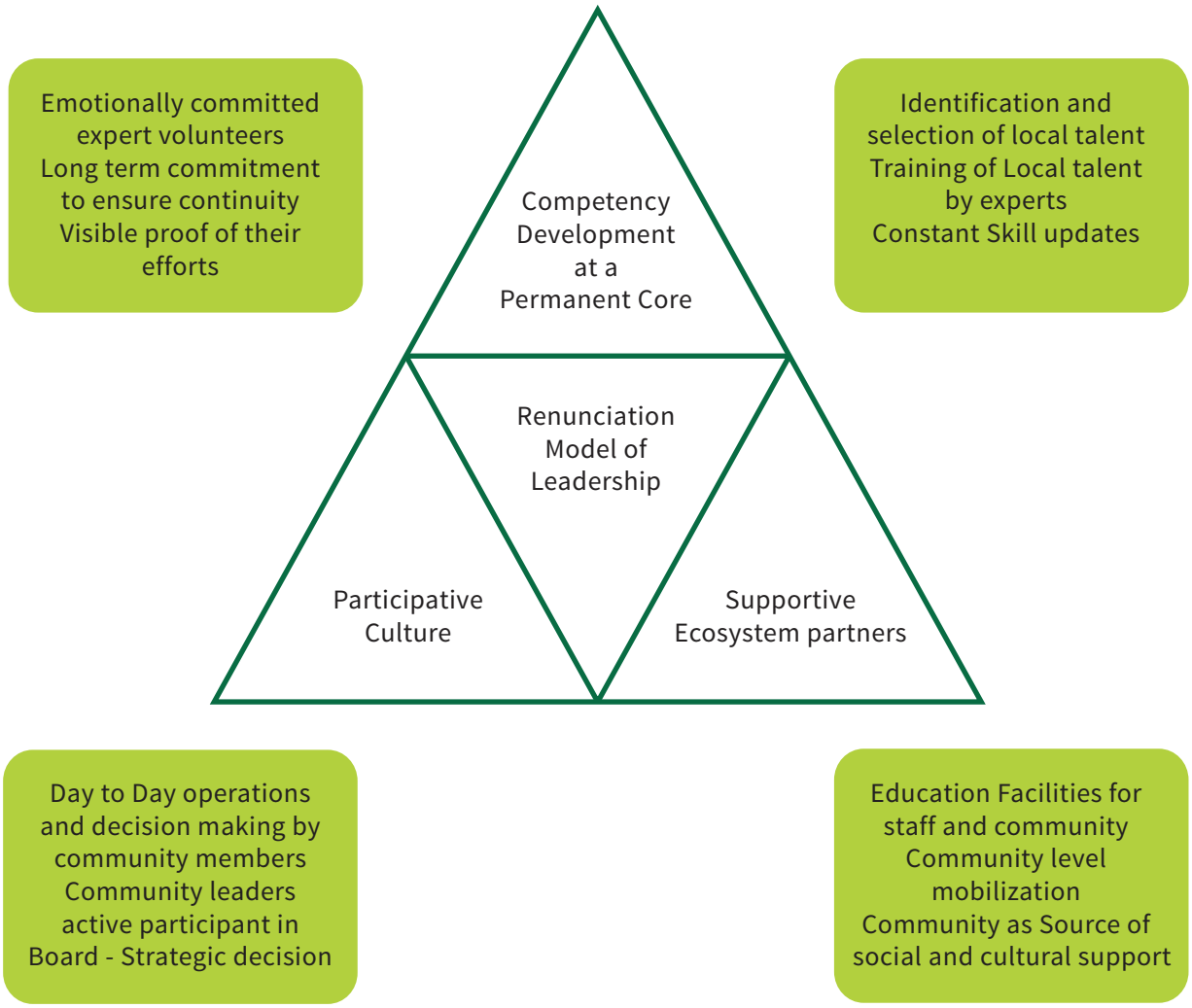
# TALENT MANAGEMENT AT ASHWINI

The key feature of talent management at ASHWINI includes creation of a permanent core team of people who excel in critical competencies needed to run the community health initiatives and the hospital. To support and sustain the permanent core, ASHWINI has developed a participative culture marked by democratic processes and its senior management demonstrated 'renunciatory' leadership style. ASHWINI was also actively supported by ecosystem partners to identify and retain the permanent core. These key themes are represented in Figure 3.

## Figure - 3

**Redefining Talent Management at ASHWINI**

**Figure-3: Redefining Talent Management**




# COMPETENCY DEVELOPMENT AT PERMANENT CORE

This theme is a crucial element in talent management at ASHWINI. The hospital currently has three full-time doctors including a surgeon, gynecologist and a physician. This group is supported by a set of visiting medical practitioners, surgeons and trained mid-wives from across the globe. Most of them offer their services on a voluntary basis or for a nominal payment. As ASHWINI grows to cater to larger number of patients and to handle more complicated medical cases, a typical solution is to hire more doctors and support staff as fulltime or part time employees. Retaining them or making them visit more frequently would be a costly proposition for ASHWINI, increasing the costs to be borne by the patients. Instead, ASHWINI has created a core team comprising of Adivasi employees who have been selected from the communities by the community leaders. These Adivasi staff members have been then trained by experts to attain a high level of proficiency in their chosen fields. ASHWINI

encourages both in house and visiting experts to share their knowledge, formally and informally, with the core staff of hospital. Such knowledge sharing sessions increases the skill level of the core staff and prepares them for increasing their scope of activities. So, ASHWINI has a two pronged strategy- to attract expert volunteers who have a long term commitment to ASHWINI' s cause and to attract and train bright local Adivasi youth to manage the hospital, including day-to-day administration.

## A. Committed Expert Volunteers

Expert volunteers include interns, medical specialists and skilled trainers who visit ASHWINI and offer their services for free or for a nominal fee. They form the alternate sources of talent for ASHWINI. Reputed medical institutions such as St John's Medical College at Bangalore have recognized ASHWINI as field site for their students to complete their rural internship component to qualify for their medical degree. ASHWINI also invites foreign nationals to join their internship program. These interns are paid engagements but ASHWINI is able to attract bright youngsters across the world as the interns get an opportunity to learn under expert guidance. In the year 2012-2013, a total of 12 medical students, mostly from UK, chose ASHWINI for their elective program. Commenting on this internship a medical intern from UK mentioned

*"Dr NK is a wonderful teacher. It is a pleasure to listen to him, to observe him as he treats the patients and to watch him as a surgeon. We also get an opportunity to learn during our visits to the tribal villages. It is an eye opener for us when we see the difficult conditions where tribal groups live. I have seen more cases in one day at ASHWINI than I would have ever seen in months in my home country".*

Along with the opportunity to learn and to serve, ASHWINI offers a friendly and engaging ambience and the interns are well taken care of. Talking about the environment an intern observed -

*"Gudalur's location is a big attraction. Pleasant weather stunning view of the mountains, hiking trips to wild life sanctuary and local tea estates made our stay really interesting. Our stay and food are organized very well. Informal dinners happen so often at the doctors' homes, where we hang out play football and have fun".*

Apart from these international students, 10 M.Sc. Nursing students from St. Johns Medical College in Bangalore and a batch of junior medical students from Christian Medical College, Vellore interned with ASHWINI. Several interns have shared their experiences as blog posts echoing the sentiments described above[5]. Their positive feedback about their experience at ASHWINI ensures a steady stream of interns year after year. Many of them continue to visit ASHWINI regularly after completing their medical degrees.

[5] http://www.travelblog.org/Asia/India/Tamil-Nadu/Gudalur/blog-779780.html
http://www.travelblog.org/Asia/India/Tamil-Nadu/Gudalur/blog-529019.html
http://ucimedindia2011.blogspot.in/2011/10/undergrads-post-what-medical-experience.html (days 8-14)

Other expert volunteers include specialist doctors, general physicians and paramedical staff, who visit ASHWINI regularly, to treat patients. Many of these volunteers have lucrative practices in India and abroad. They visit ASHWINI to fulfill their need to serve the society. Many of them are involved in training local employees to become proficient in paramedical services. An example is Ms Patricia, a key resource person in midwifery training. She claimed

*"When I was looking for a place to visit post tsunami and spend some time serving the poor, a friend of mine mentioned ASHWINI. When I visited Gudalur, I loved it immediately. I have been coming here regularly since then. My husband and children have been here as well. Now, I have retired as a midwife in UK. My husband is a successful physician in UK. As a doctor's wife, I can lead a different life – parties, designer dresses and fun. But I am happiest when I am here teaching my girls. When I heard all of them passed their diploma exams, I was ecstatic and I was in tears".*

The reason why volunteers keep coming back to ASHWINI is because they see their efforts have an impact on the lives of patients, staff and more importantly on them. To quote Ms Patricia

*"In these last ten years, I have seen my students becoming such experts that they do not need me anymore. But I want to come. It is not about them. It is about me. I come here, because I learn from them to be content with very little, to bear pain with smile, to be give generously. I come here, because, it makes me happy."*

While several social enterprises use interns and volunteers as sources of talent, ASHWINI has created a committed pool of experts who have forged a longstanding relationship with ASHWINI spanning decades. The visible impact of their efforts and a supportive system that permits the experts to integrate their activities with the day-to-day activities of ASHWINI ensure continued commitment from these volunteers.

They act as their goodwill ambassadors ensuring regular stream of future volunteers. More importantly, long term volunteers have supported ASHWINI in training local talent thereby creating a permanent local core team.

## B. Selection and Training of Local Talent

While ASHWINI has been able to attract emotionally committed expert volunteers, its uniqueness lies in creating a core team of competent and committed local employees. To do so, it had to develop mechanisms to impart basic skills training to local youth and to constantly update their skills. The challenge was two-fold: in encouraging experts to spend time in training barely literate Adivasi girls and boys to become skilled paramedical professionals and hospital administrators, and in identifying Adivasi youth who could be trained in highly specialized skill sets. The first hurdle was crossed by attracting committed volunteers like Patricia who saw the impact of their work on the lives of her trainees and on the community. The second challenge was in identifying the right people as trainees. When ASHWINI wanted to train local Adivasis to work as support staff, the criteria for selection included basic educational qualifications and the aptitude of candidate to serve their community. A Village leader whom we interviewed in this regard said,

*"When we were recommending our girls and boys to be trained at ASHWINI, we were looking for some basic traits -will s/he be interested in serving the community, has s/he come forward and taken interest in our community's welfare. We ask the community to suggest names of youngsters who will work with them. The person knows community recommended them and community also knows that they have given a chance. It usually works well."*

Involvement of the community in selection of core team provides for a filtering mechanism in identifying right candidates, who are likely to be committed to the cause and continue to be part of ASHWINI. It also ensures that the candidates who are looking at the training as purely as a mechanism for career growth are weeded out early in the selection process.

The original intent of selection of Adivasi staff was to provide a conducive environment for the patients to feel comfortable in a hospital setting. These staff members were aware of tribal belief systems with respect to health, illnesses, and childbirth and so on and also had the ability to converse in their local dialects. This made the Adivasis feel relatively at home in an alien hospital environment and it assuaged any fears they may had. So, community members are incentivized to choose the team carefully, as these are the people who will assist them during their hospital visits. The process also creates a sense of responsibility in the employees and their families to ensure that they continue to work with ASHWINI and serve their community.

Once the right people are identified based on qualifications and aptitude, efforts are made to bring them on par with best people. However, it is not an easy process. Ms Patricia shared her early experiences -

*"When I started training them in midwifery 2002, it was difficult, they would remain silent .I did not know if they understood what I was saying. They were young girls with little exposure to child birth. Slowly they picked up. English had to be taught to them. I adopted many ways to teach them using teaching aids, practical experiences. Now, they tell me, you do not have to repeat, we got it first time. Ambika is the finest midwife I have seen in many decades of experience in UK and India. She can handle any complications. You need a surgeon only for C-Secs and complicated surgeries."*

They have been trained in administering the hospital including managing accounts, patient admissions and discharges, insurance claims and managing purchases of equipment and medicines. Patta, a tribal lady who heads their administrative function noted

*"Mano sir taught us all the procedures. He taught us how to use the computers, how to maintain accounts how to maintain patient records. Today, he is not with us. We do everything by ourselves. We did not have any major audit queries this year."*

The seeming ease with which skill transfer happen between expert volunteers and tribal employees can be attributed to careful selection of candidates for training, the constant mentoring provided to them while they learn these skills backed by the core belief of the leadership team in facilitating self-reliance among community members.

Besides training tribal employees internally, ASHWINI also had initiated steps to expand talent pool available within tribal community by sponsoring right candidates to earn higher qualifications in nursing and medicine. Ms Sheela, a tribal girl, was sponsored to undergo training as a nurse in Kozhikode, Kerala. She narrated her experience of leaving home for further studies as

*"I was very young 15-16 years old when I was left in the hostel. I have never been out of my village. It was very difficult initially to adjust to a city environment and to the rigors of classes. I cried many times. But I stuck it out. I could see my parents only one and half years after joining. I could not come home for holidays. But I was given great opportunity to learn and to work in a large hospital. When I came back, I was made in charge for BSS training. Even though my marriage is fixed, I want to continue my work with ASHWINI. I am happiest here. In the other place, there was so much pressure. Doctors and senior nurses do not treat us well. They used to scold me for minor mistakes. Here the atmosphere is free and friendly. I can always go to the doctors for advice and I am free to give suggestions to them as well. Doctors here listen to us and treat us with respect. This is our hospital."*

She is now responsible for conducting a government sponsored program to train tribal candidates in nursing. The first batches of students who were trained by Sheela and her team have cleared all the requisite exams. And more importantly, these tribal candidates have opted to come back to ASHWINI for their posting, though they could have taken up a job as a paramedic in any health institution of their choice – a strong evidence for the efficacy of the community-backed selection mechanism and the nurturing culture of ASHWINI.

## C. Constant Skill Updates

Regular trainings are conducted to update knowledge of doctors, nurses and staff on current trends in medical field. Senior doctors involve themselves regularly in training programs teaching Health Animators and nursing staff. They use lectures and inexpensive flipcharts to clarify doubts. Some staff members have been identified and trained in specialized areas to meet the growing demands. For example, a junior member was sent for a radiology training so that internal capacity existed when ASHWINI purchased its X- ray machine.

## D. Alternate talent pool as expert visitors vs. Committed long term volunteers

Many social enterprises depend on alternate talent sources such as interns and expert volunteers. In her seminal work on organizational behavior of volunteers, Pearce (1993) identified reliability as the key differentiator between volunteers and employees. As volunteers face uncertainty about their roles and have less powerful incentives to remain with the organization, they are perceived to be more unreliable (Pearce 1993). Farmer and Fedor (1999) propose that volunteers look for clear and visible indications that their work is actually contributing to the mission and goals of the organization' and thus need to receive timely and helpful feedback on the results of their efforts. In the absence of timely feedback they are dissatisfied and withdraw from their volunteering efforts

ASHWINI has been successful in its emphasis on long term relationships among many of their volunteers by ensuring outcome of efforts are clearly visible and recognized as showcased by Patricia. Her efforts in teaching tribal girls midwifery has resulted in remarkable improvement in knowledge and skill levels of her students. Her efforts are appreciated by doctors, her students and the community. Same is the case with long term volunteers who could visibly see improvement in health of their patients and in the communities due to their individual efforts and collective contribution of ASHWINI and its partners. Secondly, the founder members and senior employees make the stay of volunteers memorable not only by their passion and commitment to work but also their spirit that exudes joie de vivre making it a place to visit again and again alone or with families as a retreat from their regular mundane jobs.

## E. Talent management as people retention vs. Knowledge retention

The most important aspect of ASHWINI's model is in disengaging people from talent. When firms focus on retention of talent, they focus on retaining people, usually highly paid experts, in their rolls. So talent retention strategies are devised to reduce attrition among this critical manpower. Such approaches use compensation mechanisms and employment engagement activities to retain these star performers. These strategies are expensive as salaries need to be hiked continually to retain these talented experts. Excess attention on key resources leads to a feeling of discrimination among other employees who act as support staff for the star employees. This in turn leads to low morale, growing dissatisfaction, poor commitment, and high attrition across levels, including the star performers. In an effort to increase the pool of star performers many firms chase these performers leading to competition for these scarce resources and there-by driving job hopping among these performers. Such a trend is seen among professionals, particularly doctors, who practice in several hospitals increasing their earnings. Hall (2002, 2004) has discussed the impact of protean career choices among professionals and its impact on talent management practices among organizations.

ASHWINI's model shows us that it is possible to retain talent by retaining knowledge and skills within the system than trying to retain talent by retaining people. Process mapping of jobs into various activities, identifying competencies needed to carry out these activities and training locally available talent to carry out most of these jobs (leaving out specific activities that need higher order expertise or specific educational qualifications) has a potential to be replicated across firms. Thus, ASHWINI hopes to continue its services by constant knowledge transfer to its relatively permanent core of employees who are selected carefully from the community they serve and are nurtured to excel in their fields.

# PARTICIPATIVE CULTURE AND DEMOCRATIC PROCESSES OF DECISION MAKING

One of the primary objectives of ASHWINI was to enhance the competencies of the Adivasi community to the level that they could manage the hospital on their own. In an effort to do so, the core group of employees is encouraged to play an active role in the day-to-day administration of ASHWINI health system. Activities such as shift planning for nurses and doctors, periodic area visits by doctors, managing volunteer and doctor schedules, procurement of medicines and supplies for pharmacy and mobile vans, admission and discharge processes, fee collection , insurance collection and recovery of fees through bed grant schemes of government is handled by tribal staff with minimal supervision by doctors.

Decision making process is democratic where the employees across levels discuss various facets of an issue. An all-staff meeting is held every month where all the employees of the hospital and the employees of community health teams participate. Each meeting lasts four to five hours. Open discussions are held on various topics from visitors to hospitals to disciplinary issues. Healthy debating and consensus building is encouraged across various levels of employees.

As part of our data collection, we attended two monthly meetings and browsed through the meeting registers maintained for the last ten years. Typical items in the agenda include patient-related issues, community follow up and area reports, financial reporting and planning, including proposals and follow up with funding agencies, employee related issues and ad-hoc events such as visitors and other activities. The staff presents summary status of patients, any specific cases that need to be discussed, specific programs they carry out such a sickle cell anemia, HIV – AIDS reduction etc.

## A. Hospital Administration

Several administrative issues like patient care, canteen management, equipment and medicine related issues, shifts, training calendar, leave approval and replacements for staff on leave are discussed regularly. A senior doctor recounted an episode to describe the active roles the tribal employees play in dealing with external agencies including government officials.

*“Gudalur is situated between three states –Tamil Nadu, Kerala, and Karnataka. Our bed grant schemes that provide free treatment for Adivasis are from Tamil Nadu. Malathi, our administrative person, made an appeal in a meeting with senior government officials, claiming Kozhikode Hospital in Kerala is closer to us that Coimbatore in Tamil Nadu and the hospital facilities are good. The officials were expecting doctors to attend these meetings and were surprised to see this young tribal woman arguing so well. Now, Tamil Nadu government has passed an order that tribal patients from Gudalur can be treated in Kozhikode and claim reimbursements for Tamil Nadu.”*

## B. Financial Management

ASHWINI has a transparent financial management system where the income streams and expenses are communicated to staff members who participate in the budgeting process. Describing the process, a senior doctor said,

*"We discuss all financial matters in the monthly meetings. Funds position, how much ASHWINI has received from funding agencies and donors, expenditure incurred on account of new buildings, cost of medicines, insurance claims, salaries and increments. Patta and her team manage entire accounts department. They meet up government officials who come for inspection of claims and so on. These officials are amazed at the way they manage these queries."*

Day-to-day accounting processes and payments are managed by employees themselves. The quantum of fees to be collected from tribal and nontribal patients is decided through consensus. These meetings are also used to discuss strategic options such as hospital expansion, but the final decision is made by ASHWINI's board that consists of tribal employees, community leaders and medical professionals.

## C. Employee Management

Recruitment of support staff for office administration, selection of candidates for training as nurses and other paramedical professions are carried out entirely by senior tribal employees with minimal support. A senior doctor claimed that they no longer participate in these recruitment interviews. The tribal team works closely with Community Health team to identify the right candidates.

*"Some of our tribal patients may look very unkempt, may not have had a bath for many days, they may have oozing sores all over. But they are our family members. Anybody who feels uncomfortable around them - be it doctors, volunteers or our own tribal members - cannot fit here."*

There is complete transparency regarding salaries received by all levels of staff members. Salary hikes are discussed before implementation keeping in mind the financial situation of ASHWINI.

Whenever an employee is found slacking at work or indulging in unacceptable activities, senior members consider it their responsibility to advise him or her. If he/she chooses to ignore their advice, they are informally warned about the consequences. Finally, the matter is brought up in the all-staff meeting for suggestions and decisions. The all-staff team takes final decision on disciplinary issues. The senior doctors are available for consultation but not for final decision-making. The employee is called for a discussion to explain his action and decisions are taken after long deliberations. A case in point was action taken against Mr. P -

*"Staff members presented a case of disciplinary issue against Mr. P as there were frequent complaints of absenting and negligence of work. They wanted the all-staff team to take a decision on the way forward for both of them. The team discussed the issue from multiple angles claiming 'we have spoke to him several times before, nothing seems to be working; if we take action, his family will be affected and his community may be upset if we terminate him but, if we do not do so, our patients welfare will be affected and also other staff may take advantage and be irregular*

*as well' and so on. After initial hesitant discussions, followed by heated arguments for and against action, the team decided not to renew his employment contract."*

During our second visit, we found Mr. P who was asked to leave on disciplinary issues attending monthly meeting. When enquired, we were told that Mr. P has been recommended for position in a government Public health centre near his village. When probed further, a senior member of the community said,

*"We have punished him for the mistakes that he committed by terminating him. But we are also responsible for his family and his career. So we recommended him when an opening arose. Mr. P has learnt his lesson and is doing well in his new job."*

Though there was no formal mechanism for appeal, informally, Mr. P could appeal to his community leaders for a review of the decision. Since most employees are part of the Adivasi communities and share multiple personal bonds besides organizational roles, they are sensitive to the repercussions of their actions on the person, his family and on the community.

Data from observations and interviews quite clearly indicate that such participative decision making culture acts as a bond and reinforces the concept of ownership. Interviews also indicate that such a culture acts as a powerful retention mechanism.

## D. Democratic processes vs. Top down development

In ASHWINI, the work systems have evolved to nurture democratic and participative decision making among employees across the organization. The employees act as owners of the hospital, owning responsibility for patient care, for efficient hospital administration and for welfare of fellow employees.

ASHWINI is a living example of High Performance Work Systems (HPWS). Decentralized decision making, and self managed teams, extensive information sharing on all aspects of management including financial aspects and absence of marked status barriers among employees are characteristics of High Performance Work Systems (Pfeiffer 1985; Scotti et al. 2007).

Many organizations struggle to implement HPWS as they have to overcome obstacles of hierarchy, hesitance in sharing information and resources across the organization and so manage people by controlling information and controlling rewards and punishments. ASHWINI, on the other hand, has created a dynamic, highly committed team that works towards the organizational goal without compromising employee welfare.

Though the spirit of participative decision-making prevails across the organization, it has its boundaries. For instance, while day-to-day administrative decisions have been decentralized, strategic decisions requiring boundary-spanning capabilities, still remain in the realm of senior management. For example, strategies for funds or grants generation, manpower planning at senior (Doctor) level and growth strategies are still deliberated with the support of senior management level. At this point in time given the limited capabilities it is, but inevitable, as

members of senior management point out. While the senior doctors' plan for the future is optimistic, processes need to be laid out to create support structures. They may be in the form of either a professional middle level or an advisory board comprising of dedicated management professionals committed to ASHWINI's cause, who might then have to hand hold the community through strategic decisions.

# SUPPORTIVE ECOSYSTEM PARTNERS

ASHWINI is embedded within a network of interdependent organizations and teams that collectively provide essential services for the Adivasi community. In addition to health services, this network consists of organizations that provide education services for Adivasi children, a tea plantation for creating community wealth and a tea leaf marketing society for the procurement and marketing of tea. Strong linkages among these entities help individual components leverage and add to the collective strengths of the network.

For example, VIDYODAYA[6] or the education initiative was established initially to educate children of members of ACCORD to address the needs. Soon, it was expanded to include tribal children. In 1995, leaders of Adivasis met and decided to have a school for their children taught by their people in their native languages and Vidyodaya rose up to meet the demands of the community. Today, Vidyodaya runs a school for both tribal children and nontribal children of employees, is involved in training Adivasi teacher trainees who are employed in government schools, runs a study centre and a mobile library to cater to their needs. It is also involved in many more State and Central government educational initiatives. Vidyodaya continues to meet its initial goal of providing quality primary education to children of staff who have chosen to work with ASHWINI and its ecosystem partners. Children of junior resident doctors continue to study at Vidyodaya while the elder children have passed out to join other schools and complete their schooling and higher education. While its impact on tribal education is clearly visible from the enrollments, its role as an employee retention tool particularly, those with young children, needs to be highlighted.

Another important node in this network is the Adivasi Munnetra Sangam (AMS) which is actively involved in working with the Adivasi communities to create sense of self pride and self-reliance. Their role has been instrumental in initiating community health program that later grew to become ASHWINI. Their role in working with illiterate Adivasi communities who were terrified of modern medicines and hospitals cannot be underestimated. It is their efforts that led to a 1995 leader meeting that demanded for a hospital. So roots of ASHWINI are in the community health initiatives of AMS and ACCORD.

AMS's active role in mobilizing communities to achieve self-reliance is also instrumental in creating confidence among Adivasi employees to consider ASHWINI as their hospital and to take on hospital management responsibilities as their responsibility and duty to their community.

The third factor is the common resource centers in the form of Area Teams. To maximize impact across ecosystem partners and to provide a common face, several multi-disciplinary teams of Adivasi youth drawn from these

[6] http://www.adivasi.net/vidyodaya.php

organizations have been created at the area level. These Area Teams (ATs), as they have been called, spearhead various economic, health, education and cultural initiatives. ASHWINI not only acts as a critical node of this network but also uses it for facilitating its talent management practices.

First, the network is used as a vehicle for talent attraction. The ATs through their constant and intensive interaction with the community not only offer services but also implicitly 'signal' to other educated Adivasi youth on what they can become. Though the numbers are limited, the educated Adivasi youth do not find suitable employment opportunities in these areas. By observing the ATs and interacting with them, some of the young members of the community find the job attractive and often join the team.

For example, a young compounder who works with ASHWINI said,

*"I was studying at this school when I started interacting with team members…I was quite interested in all the meetings that they were conducting with the community and I used to accompany the team members during their field visit… it was all voluntary. I was quite interested in what they were doing and asked them whether they could find me some employment in their organizations and that's how I came here"*

Second, the network also acts as a filter by devising context relevant selection process as discussed earlier. Though conducted in an informal way, the process is a mixture of observation and feedback from the community on the integrity and acceptability of the candidate. Though not a perfect process, it ensures selection of employees who would fit with the broader ethos of the network.

A senior functionary in the network commented on this process by observing

*"…when we see a boy participating in Sangam meetings, comes forward to write petitions on behalf of his community, meets officers, we know he has interest and initiative to work for the community. Some others attend meetings, talk but do nothing. There are others who will take active part, they are all the time aware of what is happening, can mingle easily with community members; when there is a task, they will go meet people, collect money and get it done. For example, Seetha, even when she was a young girl, spoke in a meeting, in front of a huge gathering. She is bold and not afraid. We are also particular about the person's integrity particularly dealing with money."*

Third, as most of the employees are from the Adivasi community and have been, to some extent, exposed to the working of the hospital both as a patient and through their interaction with ATs, the induction into the system becomes relatively smooth. It also ensures, as most of the nurses indicated, tremendous job satisfaction for the employees. The retention is also facilitated by training programs that employee groups such as nurses undergo. Some of them are also sponsored for formal degrees in nursing.

Finally, it acts as a monitoring and enforcing mechanism reducing defaults and disciplinary actions against employees. When candidates have to be censured for their poor practices, they provide safe spaces to have these conversations at a personal level to seek clarifications for inappropriate behavior, to provide sufficient warnings, to monitor improvements and, if need be, to take strict action. More importantly, it provides adequate community

support for the offender to reform. A founder member narrated an instance of employee disciplinary issue.

A founder member narrates,

*"One of our employees was sent out due to financial irregularities. Many of us spoke to him, tried to find out what really happened and then the entire team felt he should be sent home. That evening when we went for a field visit, we found the same men who were pushing for his termination, were drinking with him and making merry. We were astounded. When asked, they told us in tribal culture we think the deed is wrong, not the man. We have punished him for his mistake. But we also want to show him we still think he is part of our community. And he should be given every chance to change."*

So, ecosystem partners Vidyodaya and AMS and common Area Centers contribute significantly to ASHWINI's unique talent management practices.

# RENUNCIATION MODEL OF LEADERSHIP

This theme is the fulcrum of the entire ASHWINI model as it defines the core belief of the founders. From the initial stages, leaders across ecosystem had clearly articulated their goal was facilitating local communities to take charge of their lives. The interventions, according to these leaders, were time bound with the ultimate objective of withdrawal as and when Adivasi communities were ready to take on managing these institutions. Hence, conscious efforts were taken to ensure community participation at all levels of decision making. Interactions with the senior management of ASHWINI and analysis of relevant reports clearly outline the primary intent behind the setting up of the hospital - to transform the beneficiaries into owners of these institutions. The development philosophy, according to ASHWINI's annual report, is

*"…empower the Adivasi to achieve self-reliance through their own endeavor and active participation. (Adivasi Mutual Health Insurance Program, 2009)"*

This push towards 'self-reliance' is, to a large extent, driven by a style of leadership that firmly believes in 'handing over' the reins to the community. It involves two symbiotic elements viz., respect for indigenous knowledge and capabilities of the people who are being served and letting go of the need to be in control as a leader.

# A. Respect for indigenous knowledge and capabilities of people served

A crucial motivator for 'renunciatory' leadership is trust and belief in the capabilities of people served. It stems from respect for divergent values and beliefs of people they serve. The ecosystem partners such as Vidyodaya and AMS take efforts to preserve local languages and traditional knowledge systems. The staff is fluent in multiple local languages –Tamil, Malayalam and in their native tribal languages. While efforts are taken to teach English to the nurses, there is no subtle pressure to conform to language norms. Minutes books are recorded in any of the three languages-Tamil, English or Malayalam depending on the ability of the person who is recording the notes.

The whole hospital is designed to be an open, airy and comfortable space unlike the typical fear-inducing hospital buildings. The hospital and doctors are willing to alter their protocols to meet their patients' demands. The approach is non-judgmental and respectful to people and their traditions. As an example, a senior doctor recounted

*"When we started the hospital, our patients were uncomfortable in using high hospital beds. We had mattresses on the floor to make them feel at home. They usually consult their medicine men before getting admitted. We are fine with it."*

Similarly, their treatment protocols take into consideration the difficult situations of their patients.

*"In a city, we may say take this medicine for fever and if it does not subside meet me after three days. We cannot do so here. How can a sick child walk several miles up the mountain paths in rains come and see us after three days? So, if they want to get admitted in the hospital, we let them do so. Same is the case with pregnant women. Some of them come here two-three months before their due dates. Some of the places are so steep; I cannot imagine how a full term pregnant lady can climb these areas. Sometimes, we have rogue elephants camped for weeks in a place making it inaccessible. So, they come here, have healthy food, gain weight, have a normal delivery stay for 2-3 months more and leave. Pregnancy related deaths and neonatal deaths have gone down drastically as a result. We have to be sensitive to their needs and cannot follow rules mindlessly."*

A junior doctor shared her experiences

*"Unlike a typical doctor-nurse relationship where an implicit knowledge gap on the part of support staff is assumed and the doctor is deemed to be an expert, in ASHWINI, doctors are expected to heed to the advice of more experienced tribal nurses. The tribal nurses know a lot about their patients and their case histories. Sometimes new doctors who come here do not understand it. Neither do they heed to the suggestions given by our tribal nurses. They do not last long here. Even if you are a specialist or a senior doctor, you must be willing to learn from our people".*

## B. Entrusting Responsibilities

Though a slow process, the senior management has actively encouraged employee decision making. Such a leadership style requires conscious disengagement from certain decision making processes and actively encouraging employees to take decisions. A senior doctor spoke about an example that described the process

*"We wanted to increase the tribal visiting fee at hospital. The discussion started with us, it went on to staff meetings, area meetings and to the villages. We let them know that the average cost is Rs. 120 and you are paying Rs. 10 and to keep the program running can you pay Rs. 10 more. And it took them a year to say yes. Here, we do not want to take that easy route. But then that takes a lot of patience. It will take you only half a minute to announce that the fee will be Rs. 20 from tomorrow. But if we do so, we cannot expect them to take decisions by themselves."*

Entrusting responsibilities is not equivalent to abdication. The senior doctors are supportive and are available for consultation but insist the final decision has to be taken by the team through a process of consultation and consensus building. This leadership style has become a crucial factor that differentiates candidates who will fit into ASHWINI from those who have difficulties in doing so. This sense of belonging could be illustrated by quoting a senior doctor's advice to a tribal employee

*"If you are a worker, you can work 9 am to 5 pm; take leave whenever it suits you. But, you are the owner. You have to work long hours, because this is your hospital, not ours. We are your employees getting paid by you."*

The creation of a participative culture, which in turn positively impacts talent management practices (for example, higher rate of retention within the core group) is primarily driven by the renunciation model of leadership. The current constitution of the board reflects this philosophy. President, Secretary and Treasurer Positions are held by tribal leaders while senior doctors are invited as need be to join the board meetings.

The senior management team's view of their style of leadership and future can be summed up with this quote

*"What we are doing is not anything saintly. We are doing this for ourselves, we have a lot of fun doing our work, and we enjoy all pleasures of living a happy productive life in a beautiful place. We are not terribly worried about what will happen when we are not here-our people are capable; they will find better doctors who will come to run the place. We strongly believe in it."*

## C. Renunciation: Entrusting vs. Be in Control

The underlying theme that brings all the factors together is the leadership style at ASHWINI. While many organizations, both for profit firms and not for profit organizations, use alternate talent pools, train local people to handle complex activities, most of them are leader-led organizations, where the visionary leader sets directions for the firm to follow. In early stages of these organizations, the leader's charismatic presence is crucial to the survival and growth of these entities. Extant leadership studies propose "servant leadership" as a quality of these leaders who are driven by their need to serve (Greenleaf, 1996). What differentiates ASHWINI's leaders is their need

to serve is not supported by their need to be in control of their teams who translate their vision into action. ASHWINI leaders serve by nurturing their people and letting the team grow into leaders who then enact their combined vision. There has been a remarkable consistency in style of functioning from their stated goal to action on field.

This deeply held value system that is prevalent across ASHWINI is the central core that directs all their activities, including talent management practices and processes. The dimensions of their leadership style are belief in innate competencies of people to learn and rise to be leaders, willing to invest time and efforts to mentor people to reach their potential, consistent demand for excellence from team so that patients get the best possible care and celebrating all successes, however minor, as another step towards the end goal.

# SUMMARY AND WAY FORWARD

Several lessons can be learnt from ASHWINI's model of talent management. Creating and sustaining committed volunteer pool, 'renunciatory' leadership styles and democratic decision making styles have greater ability to be generalized and applicability across organizations.

Identification of community talent to serve as future leaders is unique to social enterprises that are actively involved in providing community based services. World-renowned organizations such as Aravind Eye Care System have institutionalized such practices. In Aravind Eye Care System, initial processes relating to patient care are handled by paramedical staff. Similarly, Aravind Eye Hospital's success is also in training local populace in manufacturing of the lenses needed during surgery and spectacles needed for correcting vision. Most of these trainees are local girls who have completed their school education. Aravind also uses information technology extensively in planning their surgeries and post operative care.

This strategy blurs the separation between the firm and its customers. Community of customers work along with experts to provide sustained service at a low cost by freeing experts to concentrate on crucial skill based activities while the community offers its services in operating the firm. However, what differentiates ASHWINI and other such initiatives is the democratic process of decision making that is the core of ASHWINI's talent management practices. This boundary less co-creation of services between experts and their clients using democratic participatory process facilitated by 'renunciatory' leadership style may be a unique contribution of ASHWINI's talent management process.

However, the organization has several issues to address as it grows larger and older. ASHWINI has to work with ecosystem partners to ensure at least some of the bright children are able to become medical professionals who are willing to come back and serve their communities. Senior employees already opine that they do not have sufficient time to mentor new employees to create a sense of belonging with ASHWINI. The newcomers have been given sufficient skill training to perform their roles. However, efforts to create a strong organizational identity need to be initiated and sustained by senior members to retain the unique ASHWINI culture.

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