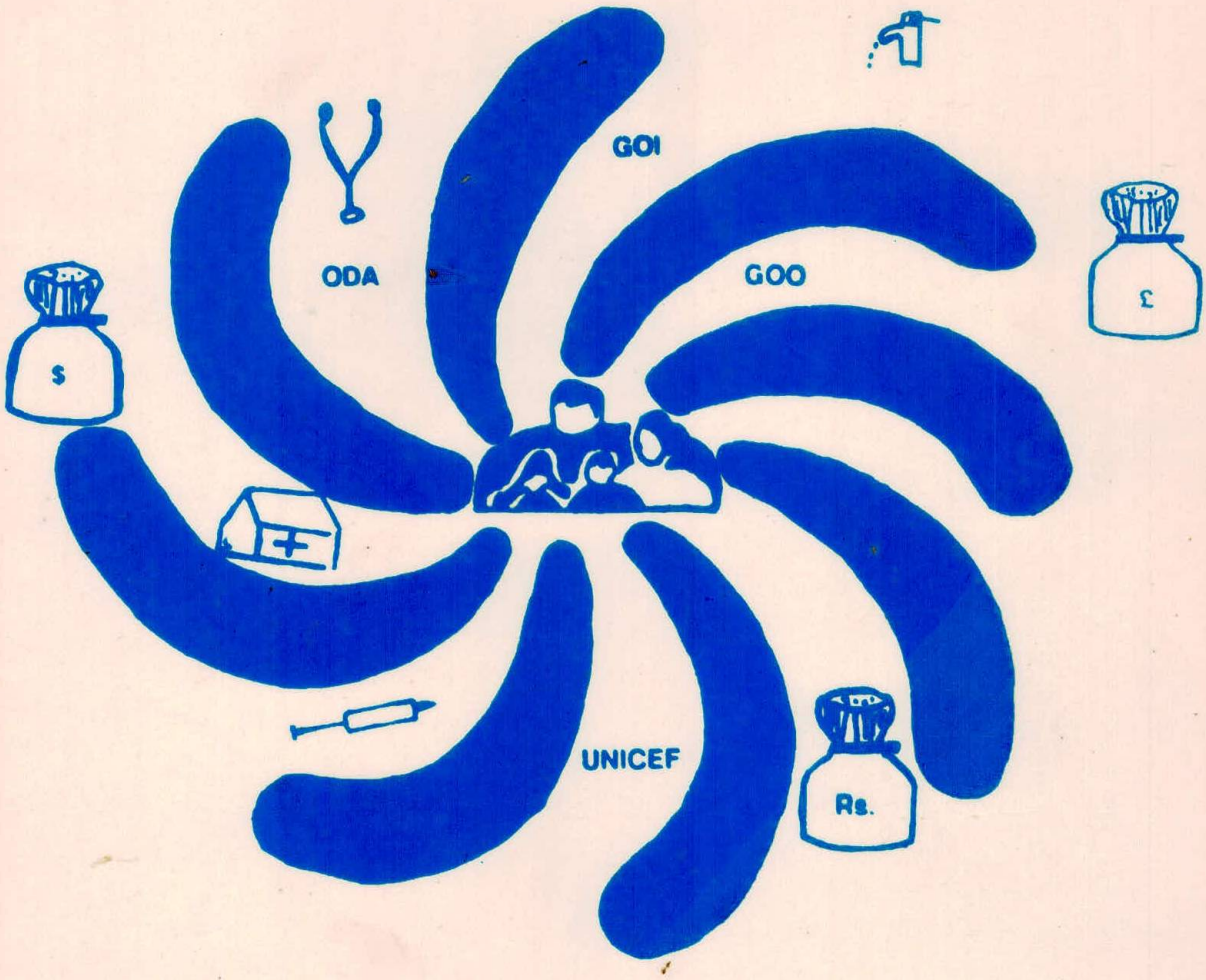
OPERATIONALISING HEALTH & FAMILY WELFARE
A MANAGEMENT PLAN
ORISSA



DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF ORISSA
JANUARY 1993

CONTENTS

CHAPTER - I

1. NATIONAL HEALTH POLICY PRINCIPLES AND PRIORITIES

One of the most important land marks in the development of Health Services was the adoption of the **National Health Policy** by the Parliament of India in December 1983. The National Health policy has made the follow profound pronouncement which is directing and guiding the process of Health Services Development in India.

India is committed to attaining the goal of "Health for all by the year 2000 AD." through the universal provision of comprehensive primary health care services. The attainment of this goal requires a thorough overhaul of the existing approaches to the education and training of medical and health personnel and the reorganisation of the health services infrastructure. The National Health Policy gives priority to:

1.1 POPULATION STABILISATION

Irrespective of the changes, no matter how fundamental, that may be brought about in the over-all approach to health care and the restructuring of the health services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation.

1.2. HEALTH MANPOWER-EDUCATION-TRAINING AND DEVELOPMENT

It is also necessary to appreciate that the effective delivery of health care services would depend very largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as an integrated team, each of its members performing given tasks within a coordinated action programme. It is, therefore, of crucial importance that the entire basis and approach towards medical and health education, at all levels, is reviewed in terms of national needs and priorities and the curricular and training programmes restructured to produce personnel of various grades of skills and competence, who are professionally equipped and socially motivated to effectively deal with day-to-day problems, within the existing constraints.

1.3. PRACTITIONERS OF INDIGENOUS AND OTHER SYSTEMS OF MEDICINE AND THEIR ROLE IN HEALTH CARE

The country has a large stock of health manpower comprising of private practitioners in various systems, for example, Ayurveda, Unani, Sidha, Homeopathy, Yoga, Naturopathy, etc.

This resources has not so been adequately utilised. The practitioners of these various systems **enjoy high local acceptance and respect** and consequently exert considerable influence on health beliefs and practices. It is,therefore, necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously, planned efforts should be made to dovetail the functioning of the practitioners of these various systems and integrate their services, at the appropriate levels, within specified areas of responsibility and functioning, in the over-all health care delivery system, specially in regard to the preventive, promotive and public health objectives.

1.4. ENVIRONMENTAL PROTECTION

While preventive, promotive, public health services are established and the curative services re-organised to prevent, control and treat diseases, it would be equally necessary to ensure against the haphazard exploitation of resources which cause ecological disturbances leading to fresh health hazards. It is, therefore necessary that economic development plans, in the various sectors, are devised in adequate consultation with the Central and the state health authorities.

1.5. MATERNAL AND CHILD HEALTH SERVICES

A vicious relationship exists between high birth rates and high infant mortality, contributing to the desire for more children. The highest priority would, therefore, require to be devoted to efforts at launching special programmes for the improvement of maternal and child health, with a special focus on the less privileged sections of society. Such programmes would require to be decentralised to the maximum possible extent, their delivery being at the primary level, nearest to the doorsteps of the beneficiaries. While efforts should continue at providing refresher training and orientation to the traditional birth attendants, schemes and programmes should be launched to ensure that progressively all deliveries are conducted by competently trained persons so that complicated cases receive timely and expert attention, within a comprehensive programme providing antenatal, intranatal and post-natal care.

1.6. HEALTH EDUCATION / IEC

The Health Programmes would bear only marginal results unless a nation-wide health education programme, backed by appropriate communication strategies is launched to provide health information in easily understandable form, and to motivate the development of an attitude for healthy living. The public health education programmes should be supplemented by health, nutrition and population education programmes in all educational institutions, at various levels. Simultaneously, efforts would be required to promote universal education, specially adult and family education, without which the various efforts to organise preventive and promotive health activities, family planning and improved maternal and child health can not bear fruit.

1.7. MANAGEMENT INFORMATION SYSTEM

Appropriate decision making and programme planning in the health and related fields is not possible without establishing an effective health information system. A nation-wide organisational setup should be established to procure essential health information. Such information is required not only for assisting in planning and decision making but to also provide timely warnings about emerging health problems and for reviewing, monitoring and evaluating the various on-going health programmes. The building up of a well conceived health information system is also necessary for assessing medical and health manpower requirements and taking timely decisions, on a continuing basis, regarding the manpower requirements in the future.

1.8. MEDICAL AND HEALTH SERVICES RESEARCH

Priority attention would require to be devoted to the resolution of problems relating to the containment and eradication of the existing, widely prevalent diseases as well as to deal with emerging health problems. The basic objective of health research and the ultimate test of its utility would involve the translation of available know-how into simple, low-cost, easily applicable appropriate technologies, devices and interventions suiting local conditions, thus placing the latest technological achievements within the reach of health personnel, and to the front line health workers, in the remotest corners of the country. Therefore, besides devotion to basic, fundamental research, high priority should be accorded to applied, operational research including action research for continuously improving the cost effective delivery of health services.

1.9. INTERSECTORAL COORDINATION

All health and human development must ultimately constitute an integral component of the overall socio-economic developmental process in the country. It is thus of vital importance to ensure effective coordination between the health and its more intimately related sectors. It is, therefore, necessary to set up standing mechanisms, at the Centre and in the States, for securing intersectoral coordination of the various efforts in the fields of health and family planning, medical education and research, drugs and pharmaceutical, agriculture and food, water supply and drainage, housing, education and social welfare and rural development.

CHAPTER-2

2. HEALTH STATUS IN ORISSA

2.1. Health Status in Orissa

2:1.1 General

- Orissa is one of the 25 States of the Indian union, on the east coast between latitude 17.5° and 22.5° North and between 81.5° and 88° East in longitude. It shares boundaries with four States, Madhya Pradesh on the West, Bihar on the north, West Bengal on the north east and Andhra Pradesh on the south east. The Bay of Bengal forms the eastern boundary.

- Orissa has 17 revenue districts, 58 Sub-divisions, 314 developmental blocks and 4928 grampanchayats and 50972 villages. A classification is made on the districts based on the problems.

  Category I

  Balasore, Cuttack, Puri and Sambalpur - more developed districts and share 46% of the total population.

  Category II

  Ganjam, Gajapathy, Keonjhar, Mayurbhanj, Dhenkanal and Sundargarh. 30-40 % of the popultion of these districts live in difficult areas. These districts share 31 % of the total state population.

  Category III

  Phulbani, Kalahandi, Koraput, Malkangiri, Raygada, Navrangpur and Bolangir - highest proportion of Scheduled tribes and shares 23% of the total population. These are the least developed districts.

  About 40% of the total geographical area of the state is hilly, inaccessible and poorly connected with any means of communication - railways, roads and others. The Schedule Caste and Tribes constitute more than one third of the population. About 42.8% of the population live below the poverty line.

- Demographic Data - (1991 Census)

Total Population	-	31, 512, 070
Males	-	15, 979, 904 (50.7%)
Females	-	15, 532, 166 (49.3%)
Sex Ratio (Females/1000 Males)	-	972
Absolute increase in Population (1981-91)	-	51, 417, 99
Decadal Growth Rate (percent 1981-91)	-	19.50
Density (Persons/Sq.Km)	-	202
Literacy Rate (%) 7 Plus	-	
Total	-	48.55
Males	-	62.37
Females	-	34.40

2:1.2 Population

Crude Birth Rate	-	30.0 (SRS 1990)
Crude Death Rate	-	11.7 (SRS 1990)
Infant Mortality Rate	-	122 (" ")
Total Fertility Rate	-	3.6 (" ")
Total Marital Fertility	-	5.1 (" ")
Mean Age at Marriage	-	
Male	-	24.17 (1981- Year book Family Welfare 1989-90)
Female	-	19.04 " "
Eligible Couples / 1000 Population	-	165.7 (1981 - IPDS Dept. of FW, GOI, 1987)
Couple Protection Rate	-	40.2% (GOI Bulletin 1992 March)

The major problem is the static birth rate. The decadel growth rate 19.50 is lower than the national average of 23.50. But the average family size ranges from 2+3 to 2+4. Population explosion is a threat to Orissa with the present high IMR.

2:1.3 Child Survival and Safe Motherhood

a) **Child Survival**

Infant Mortality Rate - 122/1000 Live births (SRS 1990)

The following figures indicate proportion of infant deaths as per UNICEF report

Low Birth Weight (LBW) - 35 % (Source_UNICEF CSSM Plan of Action for Orissa)

Tetanus - 06 %

Measles - 11 %

Acute Respiratory Infection (ARI) - 15 %

Acute Diarrhoeal Diseases (ADD) - 28 %

It is estimated that around 115,334 infants die every year in the state, 316 infants every day and 13 infants every hour.

b) Safe Motherhood

No reliable data are available for maternal mortality rate. Nearly 81.3 % of the deliveries are home deliveries and are attended by untrained birth attendants (source_SRS 1989).

Maternal mortality rate in India is estimated at 400-500/100,000 live births. Based on this data, it is estimated that nearly 11,200 mothers die due to child birth in this State every year, and 30 mothers die every day.

The major causes of maternal deaths are :

Bleeding	- 22 %	Anaemia	- 20 %
Peripheral Sepsis	- 12 %	Toxaemia	- 12 %
Abortion's	- 12 %	Obstructed Labour	- 10 %

Source : UNICEF - Plan of Action for Orissa.

2:1.4 Malaria

Orissa contributes 14 % of the total malaria incidence, 33 % of Falciparum infection, and 48 % of deaths due to malaria in India. Malaria is a serious public health problem, especially in the tribal belts.

2:1.5 Acute Diarrhoeal Diseases

ADD is highly prevalent in the Coastal districts i.e, Balasore, Cuttack, Puri and Ganjam, as well as in Koraput. The case fatality is around 16-17 % (as per the survey done by NICD in Koraput epidemic).

2:1.6 A Comparison is made for Orissa to the indicators to be achieved by 2000 A.D.

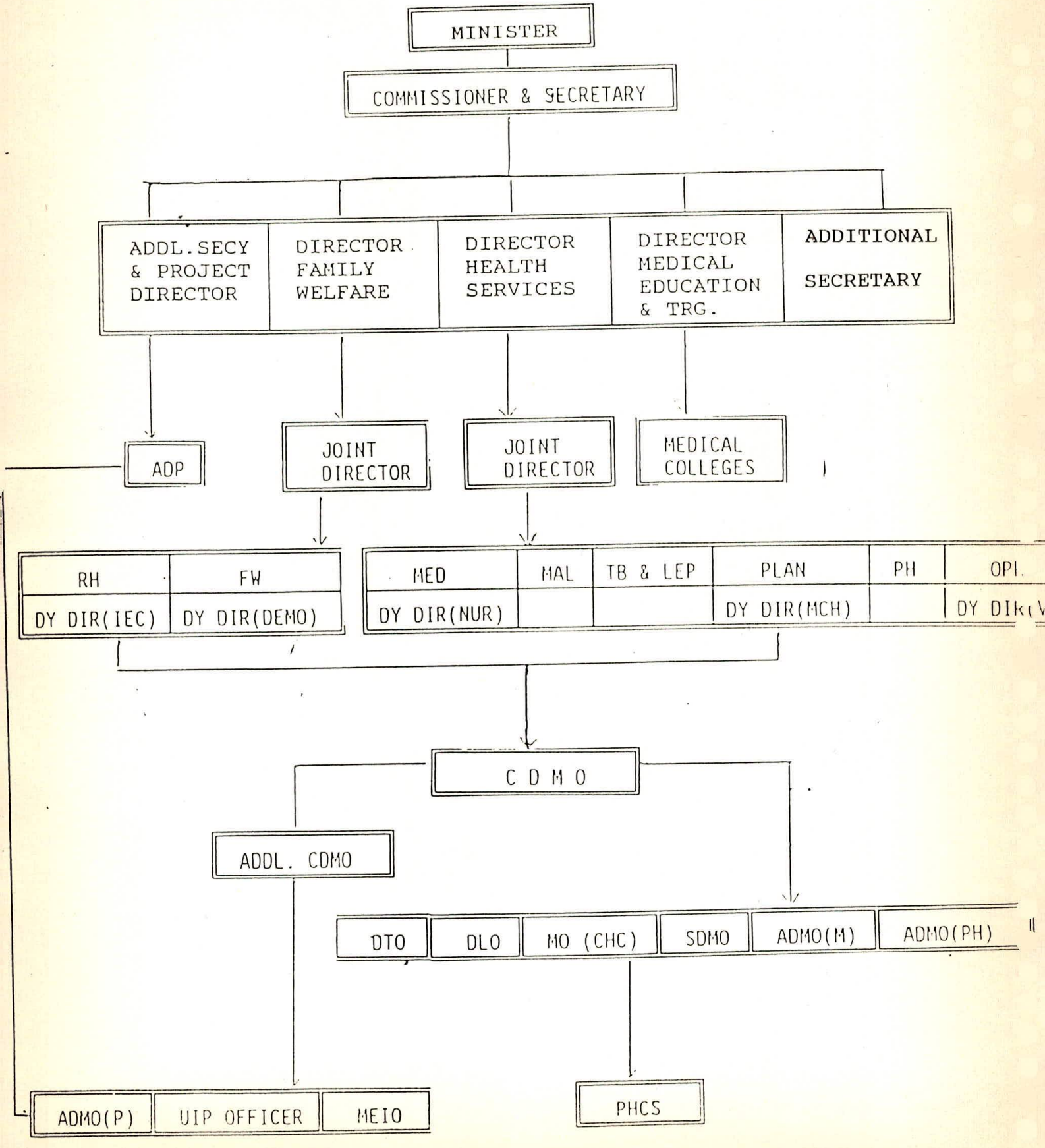
SL. NO	INDICATORS IDENTIFIED FOR HFA 2000 AD.	TO BE ACHIEVED/ 2000 AD (NATIONAL LEVEL)	FIGURES IN ORISSA
1.	Infant Mortality Rate	< 60	122
2.	Crude Death Rate	9.9	11.7
3.	Mortality (1-5 Yrs.)	10.0	N.A
4.	Maternal Mortality Rate	< 2.0	5.5
5.	Life Expectancy at Birth (Yrs.) Male Female	 64 64	 57.7 56.6
6.	Low Birth Weight (LBW) %age	10	38-40
7.	Crude Birth Rate	21	30
8.	Effective Couple Protection (%age)	60	41.3
9.	Net Reproduction Rate	1.00	N.A
10.	Growth Rate (Annual)	1.20	1.95
11.	Family Size	2.30	5.14
12.	Antenatal Care to Pregnant Mothers (%)	100	
13.	Deliveries by Trained Birth attendants (%)	100	23.9
14.	<u>Immunisation (%)</u> Infants : BCG DPT OPV Measles <u>Tetanus Toxoid</u> Mothers 10 Yrs 16 Yrs	 85 85 85 85 100 100 100	 N.A
15.	Leprosy-% of assisted cases out of those detected	80	4.59 % (PR)
16.	TB-% of assisted cases out of those detected	80	2.39 % (PR)
17.	Blindness - Incidence %	0.3	N.A

* N.A - NOT AVAILABLE

* P R - PROVISIONAL

2. DEPARTMENT OF HEALTH & FAMILY WELFARE – ORGANISATIONAL STRUCTURE

FLOW – CHART



1.1 SECRETARIAT

Secretary heads the department, being assisted by Addl. Secretaries, Joint Secretaries & Deputy Secretary. The major functions of the secretariat are policy, planning and finance.

1.2 DIRECTORATES

1.2:1 Director of Health Services

DHS is responsible for :

- Preventive, promotive and curative care at block, subdivisional and district level.
- Implementation of the National Health Programmes
  - ♦ Malaria Eradication Programme
  - ♦ Leprosy Eradication Programme
  - ♦ Programme for Control of Blindness
  - ♦ AIDS Control Programme
  - ♦ TB Control Programme
- Collection and compilation of vital statistics
- Planning
- Co-ordination with ICDS
- Enforcement of Prevention of Food Adulteration Act
- Enforcement of Civil Registration Act

1.2:2 Director of Family Welfare

DFW is responsible for :

- National Family Welfare Programme
- Child Survival and Safe Motherhood Programme (UIP Plus)
- Inservice Training Programmes
- Health Education Activities
- Collection & compilation of demographic data & information

1.2:3 **Director of Medical Education & Training**

DMET is responsible for :

- Medical Education
- Nursing Education
- Deputation to Incountry & Overseas Training

1.2:4 **Director of Area Development Programme**

Project Director of ADP provides support for the strengthening the basic health care services in rural and tribal areas. ADP functions as the major catalyst for the overall development of health care service delivery system in the State.

1.2:5 **Externally assisted programmes**

1.2:5.1 **AREA DEVELOPMENT PROGRAMME**

Ministry of Health & Family Welfare Govt. of India developed a Model Plan for Area Development in health sector with the following main objectives :

a) Strengthening health and family welfare service delivery system by integrating health and family welfare services.

b) Improving utilisation of existing facilities.

c) Increasing the health and family welfare infrastructure through extension of the health sub-centre system.

d) Improving the referral system from village and SHC level through Primary Health Centre (PHC) sub-divisional hospital to district hospital.

e) Improving the quality and coverage of services by :

- Strengthening health & family welfare management.
- Improving professional skills of health care and family welfare personnel.
- Re-orienting the health and family welfare staff towards community work and involvement.

f) Creating demands within the community for health and family welfare services.

g) Creating responsibility within the community for its own health needs and for mobilising local resources in solving health problems.

The Components of ADP includes :

- Physical Infrastructure - construction, renovation, water supply, electricity, furniture equipment, vehicles.
- Human Resource Development
- Information, Education & Communication
- Management Information System
- Alternate approaches to health care delivery services
- Community participation

In Orissa, the British Overseas Development Administration provides technical and financial support to the development of ADP. ADP covers 11 out of 17 districts for strengthening physical infrastructure and the whole state for HRD/IEC/MIS. The external aid investment, since inception, will total about £ 32 million.

1.2:5.2 **CHILD SURVIVAL SAFE MOTHERHOOD PROJECT**

Jointly financed by IDA (WB), UNICEF and Govt. of India.

Major Objectives are :

a) **Child survival**

- Sustaining the universal immunization programme
- Diarrhoeal diseases control and management
- Control of acute respiratory infections
- Prophylaxis against blindness due to Vit A deficiency
- New born care
- Breast feeding

b) **Safe motherhood**

- Prophylaxis and control of nutritional anaemia
- Birth spacing and timing
- Strengthening and further development of community based maternity care
- Provision of support to First Referral institution and strengthening essential obstetrics care capabilities (E.O.C)
- Safe delivery and safe delivery kits

c) Institutional system development

- Training
- Work routines
- Information, education and communication
- Programme monitoring
- Materials and supplies management
- Health equipment maintenance
- Community participation/ Mother's meetings

CSSMP is being implemented in phases in Orissa from 1992 onwards.

1.2:5.3 Integrated child development services project (financed by IBRD/IDA (World Bank)

Major components are :

a) Service delivery

Covering pregnant women, nursing women, children 6-36 months, children 3-6 years of age etc. through Anganwadi workers at villages.

b) Work organisation, supervision, facilities, supplies and equipment, therapeutic food supplementation, health-nutrition co-ordination, nutritional rehabilitation, pre-school education training, communication, and community mobilisation are the other important elements of the project.

ICDSP under WB funding will cover 191 blocks in Orissa.

1.2:5.4 DANISH INTERNATIONAL DEVELOPMENT AGENCY (DANIDA)

In Orissa, DANIDA provides technical and financial support to :-

- Multi drug treatment programme for Leprosy
- Drinking water project

1.2:5.5 PROJECTS IN PIPELINE UNDER WORLD BANK ASSISTANCE

- National Programme for Control of Blindness (NPCB)
- National Leprosy Eradication Programme (NLEP)
- National Malaria Eradication Programme (NMEP)
- National Tuberculosis Control Programme
- Secondary Level Health Care Development
- Social Safety Network Project

1.2:5.6 UNICEF ASSISTED PROGRAMMES

Besides supporting the CSSM programme, UNICEF is also encouraging demand generation and mass health educational activities. They are supporting a revolving fund for grassroot level transport, and incentives to good performers (presently only to MPHW(F)) in the field of total immunization.

UNICEF is supporting a chemoprophylaxis programme for mothers and preschool children on Malaria in Keonjhar. This will be extended to Bolangir and Sundargarh districts.

1.2:7.7 CARE

Care is already involved in the state's nutritional programme in ..... districts and training of AWWS in Dhenkanal. Their expertise in training of skills and motivational aspects is being extended to another district.

1.2:5.8 NEED FOR COORDINATED APPROACH

All the above mentioned programmes are only supplements to the regular ongoing health and population programmes in the State. The objectives, approaches and the target groups are almost the same for all the programmes.

Therefore, it is very important to co-ordinate all these projects and the future ones in such ways as the beneficiary receives all the benefits and the provider will be able to meet the demand and to provide quality care.

In order to reach the goals of HFA 2000 well in time. This co-ordination becomes very crucial.

This is discussed further in the chapter on training. For other aspects the State Govt. has proposed.

1.2:6 District

Chief District Medical Officer is overall in charge of all health and family welfare activities at the district level. He is assisted by Addl. CDMO who is directly responsible for - Family Welfare, Child Survival & Safe Motherhood programmes, Area Development Programmes, and number of programme officers for individual national programmes.

1.2:7 Health Manpower Availability

Primary Health Care

1.	Multipurpose Health Workers (F)	7004
2.	Multipurpose Health Workers (M)	4755
3.	Health Assistant (F)	1102
4.	Health Assistant (M)	176
5.	Pharmacist	1772
6.	Computor	314
7.	Block Extension Educator's	329
8.	* Staff Nurses (CHC/UGPHC)	2060
9.	Public Health Nurses	104
10.	Medical Technician - Lab Technician X-ray Technician	114
11.	Medical officers (PHC/CHC) A/S TOTAL	2603

* Source : Dept. of Family Welfare, GOO

Secondary Health Care (SDH/District Hospital)

1.	General Doctor's	TOTAL-3056
2.	Specialists • Medicine • Surgery • O & G • Paediatrics • Orthopaedics • Opthalmology • ENT • Cardiology	 36/13=49 36/13=49 73/26=99 55/13=68 8/11=19 -/32=32 -/13=13 -/1 =1
3.	Nurses - Staff Nurses	2133
4.	Medical Technicians • Laboratory Technicians • X-ray Technicians	 351

* Staff Nurses : 2133 & Nursing Sisters 235.

* Source : (BM) & (D)

1.2:8 Availability of Health Facilities

a)	Sub Centres	5927
b)	Primary Health Centres	824
c)	Community Health Centres	152
d)	Sub Divisional Hospitals	37
e)	District Hospitals	14
f)	Teaching Institutions	3

* Source Data :Surja Patnaik

CHAPTER - 3

3.1 STATE HEALTH PRIORITIES

Government of Orissa identified 5 major health problems as immediate priorities and all the intervention and support programmes should address the five health priorities.

FIVE PRIORITIES

- Population
- Child Survival & Safe Motherhood
- Diarrhoeal Diseases Control & Prevention of Deaths
- Malaria Control & Prevention of Deaths
- Special focus on reduction of incidence and prevalence of Tuberculosis, Leprosy and AIDS.

3. 2. BROAD STRATEGIES

- Strengthening health promotion & social mobilisation (Demand generation)
- Strengthening physical infrastructure
- Quality care & coverage
- Strengthening training & manpower development
- Strengthening the management information system
- Encouraging innovative activities.

3.2.1 Health Promotion & Social Mobilisation

To create awareness and to motivate the community to generate demand for preventive, curative and referral care services available to them.

The proposal is indicated in Chapter - 4.

3.2.2 Physical Infrastructure

The infrastructure necessary for providing Promotive, Preventive & Curative services are :

a) Sub-Centre (SC) at the village level

b) Primary Health Centre (PHC) at the sector level

c) Community Health Centre (CHC) at the block level

d) Logistics and Support

3.2.3 **Development of system for Quality Care and Coverage for services**

The demand for basic health services proposed to be generated has to be matched by providing quality care in the SC, PHC, CHC and higher referral level institutions like the sub-divisional, district, teaching hospitals.

One of the accepted ways on preventive quality care is through **Skill & Competence Development.** This could be done through :

- By organising on the job skill oriented training programmes.
- By planning the management information system appropriately designed for each activity.
- By ensuring uninterrupted supplies and resources through proper management.
- By integrating the basic health services with nutritional, educational services & weaker sectoral programmes.

3.2.4 Quality care depends heavily on an effective management information system (MIS). A separate chapter has been provided for this.

3.2.5 **Innovative Schemes**

Simultaneous with the above programmes, a few specific innovative activities are proposed to be developed in collaboration with the agencies participating in the State health activities.

3.2.5.1 **Population Control**

- Social marketing of contraceptives
- Community based distribution of contraceptives

3.2.5.2 **Child Survival & Safe Motherhood**

- Social marketing of Oral Rehydration Salts (ORS)
- Social marketing of Safe Delivery Kits (SDK)
- Establishing a distribution centre in every village, stocking ORS packets, contraceptives, vitamin 'A' tablets and safe delivery kits.

3.2.5.3 **Malaria Control & Prevention of Deaths**

- Use of chloroquine as a prophylactic in all the endemic areas of the state
- Introduce the use of impregnated mosquito nets
- Social mobilisation for quick slide collection, examination and radical treatment

3.2.5.4 **Others Innovations**

a) Using alternative sources of energy for sterilization of medical equipments, for running cold storage equipments and for providing potable water in brackish and saline belts.

b) Encouragement to the NGO and the private sector to participate in the above priority health programmes of the State including provision of curative services.

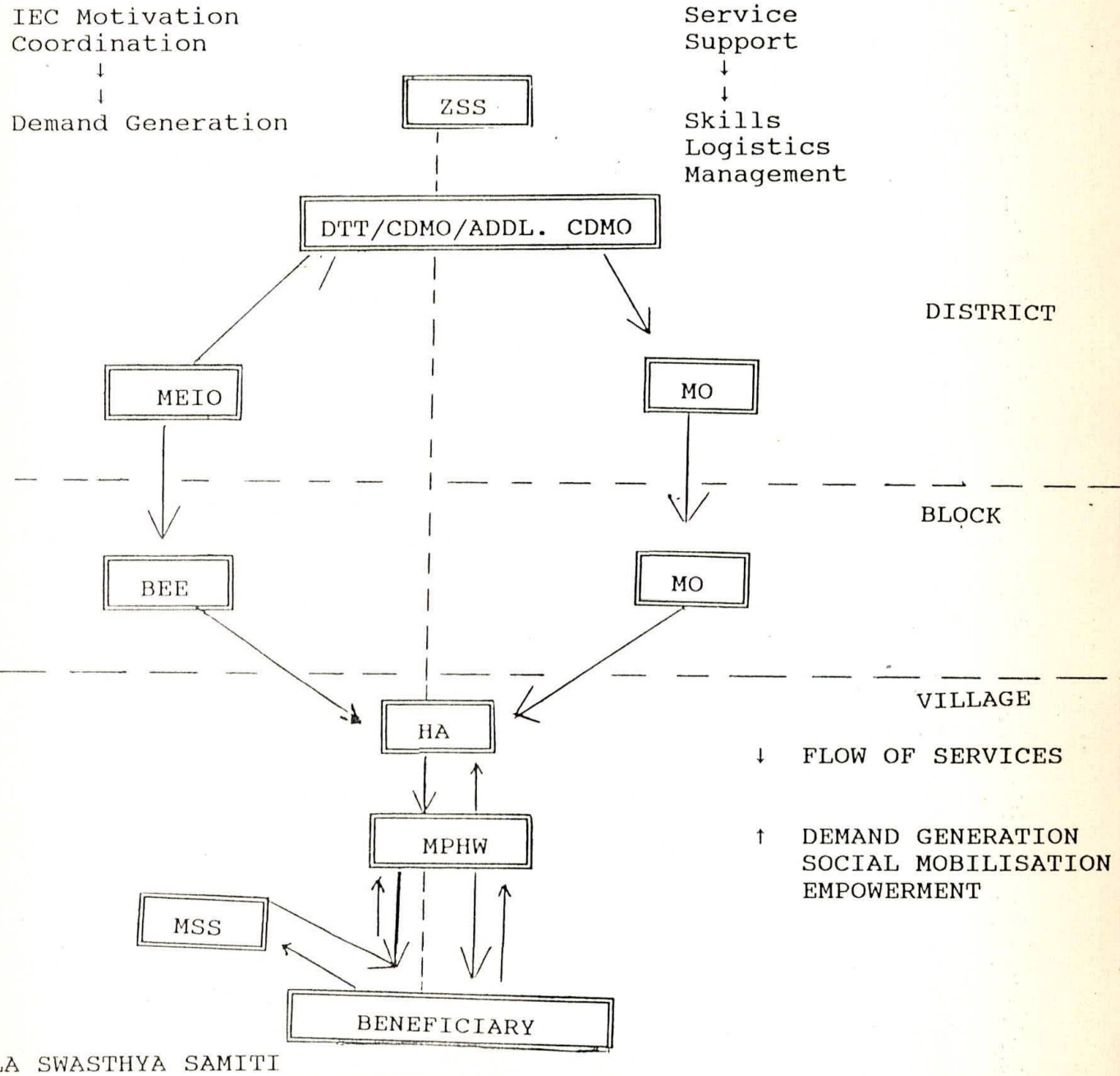
c) By initiating programmes to make the paying section of the society contribute towards curative services.

d) Administrative and financial innovation.

STATE'S HEALTH STRATEGY AND ACTION PROGRAMMES

4.1. Demand Generation

The proposed strategies identified in para 2.2 relating to health programmes, social mobilisation and demand generation is proposed to be achieved involving the voluntary sectors and the sister departments of the State Government. At the village level, the Mahila Swasthya Samiti (MSS) and the Youth Club (YC) are proposed to be formed. At the district level all the NGO's working in the field of health and family welfare are proposed to be coordinated through another NGO and finally at the State level, the district level NGO coordinators are proposed to be guided by a State level NGO. Appropriate linkages by the NGO with the district administration and the state administration is proposed to be formed. The details are indicated below.



ZSS - ZILLA SWASTHYA SAMITI
CMO - CHIEF DISTRICT MEDICAL OFFICER
MEIO - MASS EDUCATION INFORMATION OFFICER
BEE - BLOCK EXTENSION EDUCATOR
MO - MEDICAL OFFICER
HA - HEALTH ASSISTANT
MPHW - MULTIPURPOSE HEALTH WORKER
MSS - MAHILA SWASTHYA SAMITI
DTT - DISTRICT TRAINING TEAM

4.2 **The first battle ground in delivery of primary health care is the Health Sub-Centre.** Each HSC covers a population of 3000 - 5000, or 600 - 1000 households, 3 - 5 revenue villages, 3 - 5 TBAS, 3 - 5 Anganwadi Workers, 3 - 5 Primary school teachers.

Therefore, HSC is the first point for convergence of basic services like education, health and nutrition.

2. <u>VILLAGE GROUPS</u>

Otherwise called Mahila Swasthya Samiti (MSS) or Youth clubs (YC). They will be encouraged to empower themselves with all socially acceptable decision making and implementation.

3. <u>MAHILA SWASTHYA SAMITI</u>

a) In each HSC village, a MSS will be formed with representatives from the local mothers selected in the ratio of 1 per 10 households. The other informal and interface functionares like traditional birth attendant and village health guides will be the support members. (Responsibility MPHW & HA)

b) MSS will be supported by a group of grassroot level workers like :
- ♦ Multipurpose Health Workers
- ♦ Anganwadi workers
- ♦ Primary/Secondary School Teachers
- ♦ Other Departmental village staff like forest guards, home guards
- ♦ Village N.G.O (VINGO)
- ♦ Practitioners of Indian system of medicines

c) MSS have already been formed and functioning in the following districts under a GOI scheme (temporary)

DISTRICTS	NO OF MSS FUNCTIONING
Dhenkanal, Sambalpur, Bolangir, Cuttack, Balasore, Puri & Ganjam	599

* Source : Dept. of Family Welfare, GOO

♦ In 93-94, the State's endeavour will be to extend this programme to all the other districts and increase the numbers.

d) PROGRAMME

- The MSS will be encouraged to met on a fixed day every month (First/Second/Third/Fourth Thursday of every month or the First/Third Friday)

- The members will decide what are the village/community's problems and what they would like to discuss with the health staff. The health staff will provide such information but will continuously guide the discussions towards preventive health education, especially in the five priority areas. The health workers will assist the MSS in all aspects of communications, stressed on locally acceptable/modes/ways.

- MSS will be encouraged to organise mass awareness camps on prevention of dehydration due to diarrhoea (May, June, July, Aug, Sept), prevention of malaria (pre and post monsoon), on family planning, immunisation, nutrition.

- MSS or YC will be encouraged to be the village Distribution Centre. It will keep ORS packets, Contraceptives, Vit-A, Chloroquine, and Safe Delivery Kits.

  These special quarterly drives are planned in such a way that the awareness programme precedes the actions.

- MSS along with village NGOs (VINGO) will organise the periodic disinfection of drinking water sources and to motivate people to ensure environmental sanitation. In places where the community demand is high for sanitary latrines, VINGO will be provided with support through Govt. programmes.

- HA/ BEE will provide the technical support to MSS at village level and the MO will provide the finance support either from DFW or ADP.

e) The MPHW (F) will be the facilitator of the MSS meeting.

f). MONTHLY MEETING

- IEC centre with the assistance of ADP, UNICEF, CARE will develop appropriate materials Example : Photo folders, flip books, slide tapes & videos. The themes & messages will cover the 5 major health priorities of the State.

- MSS will also take up special village contact drives to coincide with every local festival where mass community participation is expected.

- IEC centre, in consultation with the ZSS will select the best performing MSS and congratulate them in the Republic Day celebration at the district and State level.

g) YOUTH CLUBS

a) Similar action to involve the Youth clubs on the same day will be initiated by the MPHW (M) and HA (M).

b) A major responsibility of the youth club will be to identify persons and transport which can be used at short notice to move elders, mothers and children to referral centres.

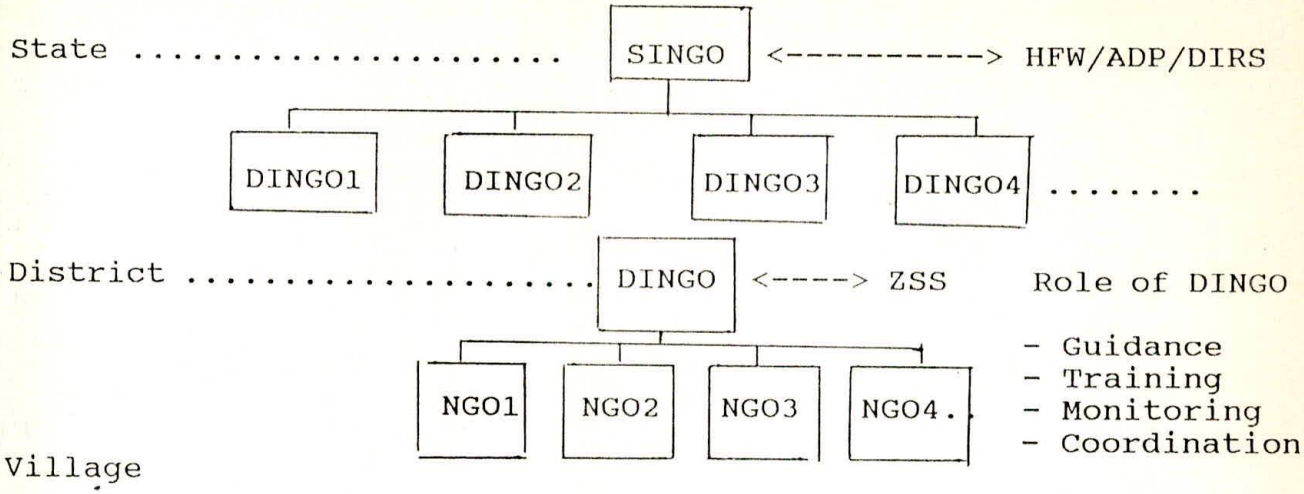
4.3. DISRICT LEVEL NGO GROUP

An exercise has already been initiated to bring together all NGOs working in each district the field of health and family welfare. They are in the process of selecting one amongst them as the district coordinator (DINGO). The DINGO, by being a member of the ZSS would then play an important role in guiding and monitoring the activities of all NGOs.

Ghunsum Mahila Samiti is the DINGO for Phulbani. Other districts have not confirmed.

4.4. STATE LEVEL NGO GROUP

The DINGOs would decide who will be their State level coordinator (SINGO). The SINGO will perform the same guiding, training, coordinating and monitoring functions at the State level, as each DINGO does for the district level.
The SINGO will have a direct link with the Health and Family Welfare Department, and its Directorates.

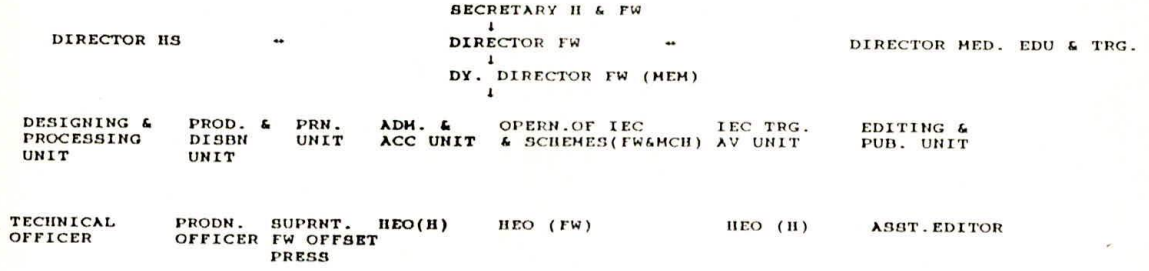


* SINGO - STATE NGO
* DINGO - DISTRICT NGO

4.5. State IEC Centre

In order to plan and develop IEC activities in the State, relating to H&FW issues, different IEC units in the Health Directorate were combined under the umbrella organisation. The State IEC Centre was constructed and equipped to carry out its tasks through the staff attached to the District and Block health administration units.

IEC STATE STAFFING PATTERN



IEC DISTRICT/BLOCK STAFFING PATTERN

District Mass Education & Information Officer

↓

Deputy District Mass Education Information Officer

↓

Block Extension Educator

The IEC structure has not risen to its expectations probably because :

- its top management are not IEC professionals
- the control structure in the field is dual, and
- the personnel have been neglected in training and motivational aspects

The awareness generation programme involving the NGO's and Sister departments will need the active support of the IEC organisation. This is proposed to be achieved in the following ways :

- by recruiting competent people, including professionals on contract basis, and by continuous upgradation of skills and knowledge
- by converting the IEC Centre into an independent Directorate
- by placing the field personnel under direct administration command of the IEC
- by building a mechanism for coordination with the service providing units at :
  - the State (DHS, DFW),
  - the District (CDMO)
  - the Block (MO) levels
- by linking it with the State Institute of Health & Family Welfare, when it comes up

4.6. Strengthening the Quality & Coverage of Services

Quality and Coverage of health services largely depend on:

- Availability of physical infrastructure
- Logistics & Support
- Training to improve Skill and Competence
- Health Information System to provide support for planning & monitoring

4.6.1 Physical Infrastructure

The table below indicates the requirement of Subcentre, Primary health centre and Community health centre in the State as per the National norms, the number presently available and the backlog.

ESTABLISHMENT :

TYPE	NO. REQUIRED AS PER NATIONAL NORMS	AVAILABLE	BACKLOG
SC	6467	5927	540
PHC	1035	824	211
CHC	227	152	75

* Source : Surja Patnaik

It is essential that 75% of the SC's, 50% of the PHCs and 25% of CHCs need to be upgraded in terms of buildings, logistics & support and manpower. Preference to tribal areas.

4.6.2 **Strengthening the First Referral Unit**

The PHCs/CHCs will be strengthened to provide the first referral care in terms of qualified manpower, improved diagnostic facilities & upgraded specialist care. The concept of Block Health Teams will provide adequate scope for improving :

- Health promotion & social mobilisation
- Provision of quality care & coverage of basic health services effective.
- Use of health information system for effective planning & monitoring

4.6.2 **SUPPLY MANAGEMENT**

In order that the demand generation matches with the health care service, an essential and continuous input of supplies of all types is essential. This is over and above the basic that is prescribed for every institution.

The list of such supplied are indicated for each Sub-centre, Primary Health Centre and CHC for the CSSM programme is available in the 1991 CSSM Plan of Action. The requirement under the Population Control Programme is available. Other programmes need few equipments. An attempt is necessary to combine all these prescribed equipments under various programmes, Sub-Centre wise, and make it available to each Sub-Centre as their bare requirement for the 5 priority programmes. A similar exercise should be done in respect to each of the following: -

1. Basic furniture
2. Basic and minimum stationary
3. Basic facilities for postal communication
4. Provision of mopeds for increasing mobility and outreach.

4.6.3 Human Resource Development

HRD being the most acceptable way of improving the quality of services, a separate chapter on it has been provided for in the document.

4.6.4 Health Information System

Collection of relevant data at appropriate levels, in manageable quantities, its analysis for planning etc. is proposed to be strengthened by continuous efforts. The village-wise and family-wise health registers being maintained in the Sub-Centre provide the most basic source of all planning information. However, as different programmes have tended to prescribe different formats for such data collection, including the recently introduced Health Card system, there is need to ensure that the health worker finds it possible to collect the information and understand its usage. An effort at the State level to discuss the various * reporting formats to avoid duplication is also necessary.

Coordination excercises between different programmes * prescribing data collection from the village and subcentre levels has to be undertaken.

The information which is to be kept by a family as a part of its health education, knowledge and follow-up requirements, and should also be subject to periodic field testing and review in order to make it effective.

The most efficient way of collecting such basic information and analysing it at various levels for management function is the next step that is proposed to be taken. Appropriate and co-ordinated development of Management Information System will be attempted as a priority item. Assistance of participatory agencies will be sought.

4.6.5 A separate chapter has been provided on managerial effectiveness.

4.7 Specific Action Programmes

Specific action programmes relating to some crucial state specific problems

4.7.1 Strategy for reduction of infant mortality

Field Level practicability.

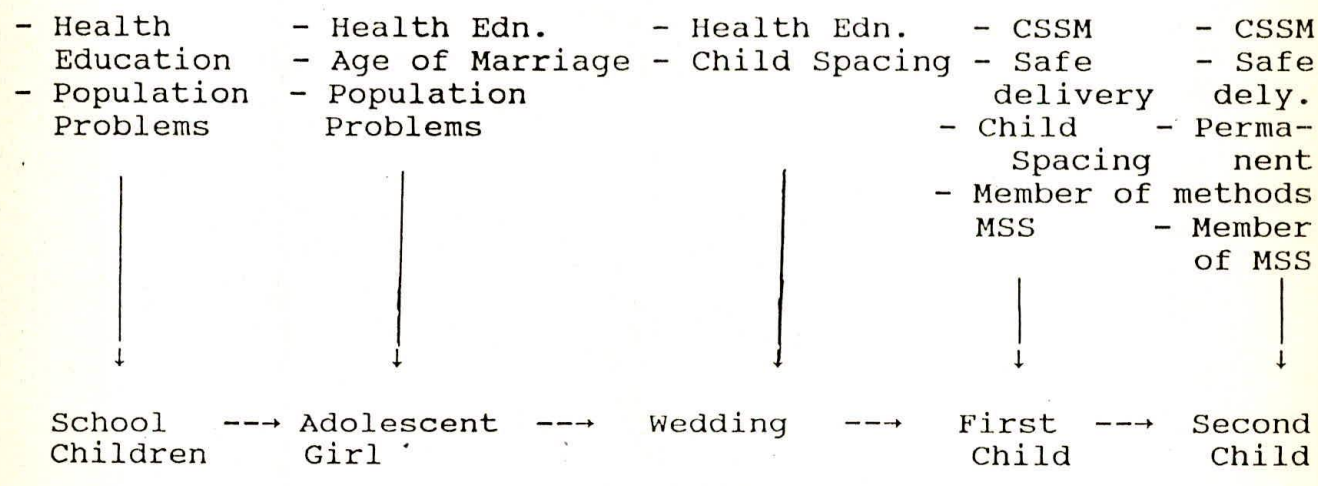
At any sub-centre level, number of births every year will be of the order of 150 (if the CBR is 30/1000). If the IMR is 122/1000. then the infant deaths for every 150 births will be 18-20 per year. The full package of programmes under the CSSM is expected to have a definite impact on the reduction of such infant mortality in every sub-centre area. Therefore, this programme will be sincerely followed. Mother-inlaw training will be stressed as 81.3% of all deliveries are conducted at home.

4.7.2 Strategy for population control

A national strategy of population control has been formulated. A state strategy paper is under finalisation. The broad aspects cover education for the female, employment for the female, the age of marriage, awareness promotion about the need for small family and the facilities available for adopting a small family. Incentives for individuals and communities have also been proposed.

Specific strategies related to the development of a package of programmes aimed at the girl child from adolescent stage still she becomes a mother of two children. At every point along this development, a basic input in terms of information and service is proposed to be given.

Diagram indicating package of services under FW.



4.7.3 Strategy to reduce deaths due to diarrhoea

Diarrhoea as such has to be accepted in any community. We can only reduce the incidence as well as the deaths arising out of diarrhoeal dehydration. Accordingly, the present strategy to control diarrhoea is three-fold.

(a) To bring about awareness on sanitation and personal hygiene

(b) Immediate intake of fluids to counteract losses and continuation of normal feeding.

(c) Judicious and restrictive use of antibiotics and anti-diahorreants.

The strategy proposed in the Govt of India Diahorrea Management programme is to be continued, especially promotion of the use of ORS packets for moderate and acute cases.

ILLUSTRATION

Under 5 population in SC area will be 12% i.e; 600. If each child gets 3 episodes of diarrhoea, the total episodes will be 60 * 3 = 1800. This could be controlled.

- Education - 90 % - Home Available fluids + ORS (1620 episodes)
- Services - 9 % - HFA + ORS + AB (162)
- Referral - 1 % - IV fluids (18)

4.7.4 Strategy to reduce Incidence and deaths due to Malaria

The present strategy for controlling malaria and reducing malarial deaths has two aspects. The first one aims at controlling the breeding of mosquito (Source Reduction) and the second is aimed at immediately treating the person affected by malaria, so that he does not become a source for further spread of the disease.

Since the present strategy has been found to be inadequate in controlling malaria in India, the Govt. of India are in the process of developing a "tribal area specific strategy". However, pending further inputs on this aspect, a set of basic strategies are proposed to be continued with innovative interventions in some areas. Pre-monsoon and post-monsoon spraying to control the breeding of mosquito, preventive doses

of chloroquine for all fever cases, immediate examination of slides and radical treatment are the measures proposed to be continued. In some areas like Keonjhar, Bolangir, Phulbani and Koraput, the use of chloroquine as a prophylactic by mothers and preschool children will be continued. The results received after one year's experiment should indicate any definite trend. Similarly in these districts programmes to introduce impregnated bed nets will also be tried.

4.8 Special programmes for tribal areas

The same 5 priority items of work are proposed to be carried out in the 118 tribal blocks of the State but with added inputs in terms of infrastructure, mobility, resources etc. wherever possible. The immediate areas identified are

a) Accommodation for Sub-centres and Primary Health Centres

b) Adequate provision of preventive and basic medicines especially of the type they are habituated to.

c) Involvement of the practitioners of the Indian system of medicines by providing them with similar facilities as extended to the allopathic and other para-medical health workers.

d) Supporting the development of local talent for the demand generation as well as for service delivery.

e) Supporting innovative schemes in tribal areas integrating health, nutrition, education and economic activities.

4.9 **Strengthening the network of interface workers**

Efforts will be made to establish strong linkages with the interface workers like :

- Traditional Birth Attendants
- Anganwadi Workers
- Link women volunteers
- Village health guides

The SC with these strong linkage and support from the interface workers and MSS will be in a better position to function more effectively in the delivery of quality care and coverage of basic health services.

CHAPTER - 5

HUMAN RESOURCE DEVELOPMENT

MACRO STRATEGY FOR INSERVICE TRAINING OF HEALTH & FAMILY WELFARE PERSONNEL

5.1 JUSTIFICATION

5.1.1 Though the effectiveness of health care delivery services may be dependent on multiple factors, perhaps the most important is the competence of the personnel involved in delivering the services.

5.1.2 The current practices in Continuing Education of the health functionaries suggest that :

- the training efforts had been adhoc in nature
- lack of uniformity in duration, emphasis and methodology
- training is subject and theory-based rather than skill and programme oriented
- no clear cut policies for deploying all the categories of staff for training at defined intervals
- low priority for training and not linked with promotional policy

5.1.3 As the newer approaches and programmes are introduced, enormous funds are spent on providing training on one isolated activity (eg) UIP/ARI/ADD Control. The result is that same functionaries rotates in training many a times yet not getting a comprehensive package of training. Various programme Officers with WHO/UNICEF assistance tend to conduct unilateral training programme in technical and supervisory aspects at all levels which result into excessive disturbance into the health care delivery system. Moreover, there is no system to monitor the effectiveness of these training programmes.

5.1.4 Keeping the above perspectives in view, there is a need to develop a comprehensive, broad-based combining management and technical aspects and integrated training strategy for in-service training of health personnel at all levels. The objectives of this training system have to be appropriately linked with the required objectives of the health care delivery system and they should aim to improve :

- Technical competence
- Managerial effectiveness
- Communication skills
- Building training competence of the trainers
- Development of appropriate learning materials

5.2 OBJECTIVES

5.2.1 To improve the efficiency of human resource development and training systems by developing a systematic plan for competence based continuing education programmes where each functionary gets a chance to be inducted in the specific job, receives periodic update and on the job reinforcement of knowledge and skills.

5.2.2 To strengthen the existing training capacity and expand it to meet the proposed training requirements.

5.2.3 To improve the quality of training by dovetailing supervision with training.

5.3 STRATEGIES

5.3.1 National Institute of Health & FW (NIHFW) New Delhi developed the document on **" MACRO STRATEGY FOR INSERVICE TRAINING OF HEALTH & FAMILY WELFARE PERSONNEL ".**

The document clearly specifies the training needs and the programmes upto district level. NIHFW is also involved in developing the training system in 11 states in the country.

The approach for Orissa has been adopted from this document with modification to suit the local needs.

5.3.2 Development of different types of training courses as required by each category (eg)

A. **Induction Course**

B. **Promotional Course**

C. **Continuing Education**

- Fixed periodicity institutional based - 2 weeks duration once every 3-4 years

- Minimum periodicity - on the job training 3 days once in three months

- Dissemination of Health Information such as Handouts, Newsletter, Bulletins etc.

D. **Special training** - 2 weeks duration in surgical skills for MOs at PPC/Dist HQ and HW (F) in child spacing at CHCs

E. **Advanced training** - Laboratory/X-Ray technician at Public Health laboratory and management and educational technology at NIHFW, IIMS/ASCI/outside India

5.3.3 Strengthening the training facilities at all levels with adequate and appropriate infrastructure, training of trainers programmes, systematic development of learning materials based on the training needs and revised and updated curricula.

5:4 APPROACHES

5:4.1 VILLAGE LEVEL (HEALTH SUB CENTRE)

(a) HEALTH PROMOTION & AWARENESS

Training on communication of health related information, and training on selected interventions like ORS use :

- by MPHWS, AWWS, Teachers
- on fixed days
- on areas of their concern
- with IEC support from HWS, & BEES
- to **MSS & YCS.** They are to be motivated to communicate this information/training to every village household.

IEC and resource materials will be provided by the IEC State Hqtrs., non-governmental and private agencies, and as far as possible using local folk media groups.

(b) STRENGTHENING SERVICE DELIVERY THROUGH INSERVICE TRAINING BY VILLAGE TRAINING TEAM

b-1. TRADITIONAL BIRTH ATTENDANT

3 days on the job skill oriented training will be provided to TBAs by the HW / HA (F).

The focus will be on :

- Identification of Antenatal cases for early registration with HSC

- Identification of High Risk Pregnancy :

(EG)
- Short statured
- Primi
- Multipara
- Previous Bad Obstetric history
- Odema
- Conduct of safe and clean delivery using disposable delivery kit.

b-2. **ANGANWADI WORKER**

One day orientation once a month will be provided by HW / HA (F) on the Child Survival Safe mother hood programme.

5:4.2 **PRIMARY HEALTH CENTRE - BLOCK LEVEL - BLOCK TRAINING TEAM (BTT)**

a) **COMPETENCED BASED CONTINUING EDUCATION**

a-1 Block Health Team Comprising of :

- Medical Officer
- Health Assistant (M) & (F)
- Block Extension Educator
- Computer

will be organising the on the job, skill oriented training to a group of HWS & HAS at PHC/HSC level on a rotation basis.

a-2 The training duration will be for 3-4 days once in 3 months and 3 slots will be provided every year.

This method has many advantages :

- Field staff need not be drawn too many times for training
- All the programmes are integrated like ADP/CSSM/ICDS
- Each worker will get reorientation every year (5% the working days)

a-3 Proposed Slots

Slot I - Focus on maternal & child health (CSSM)

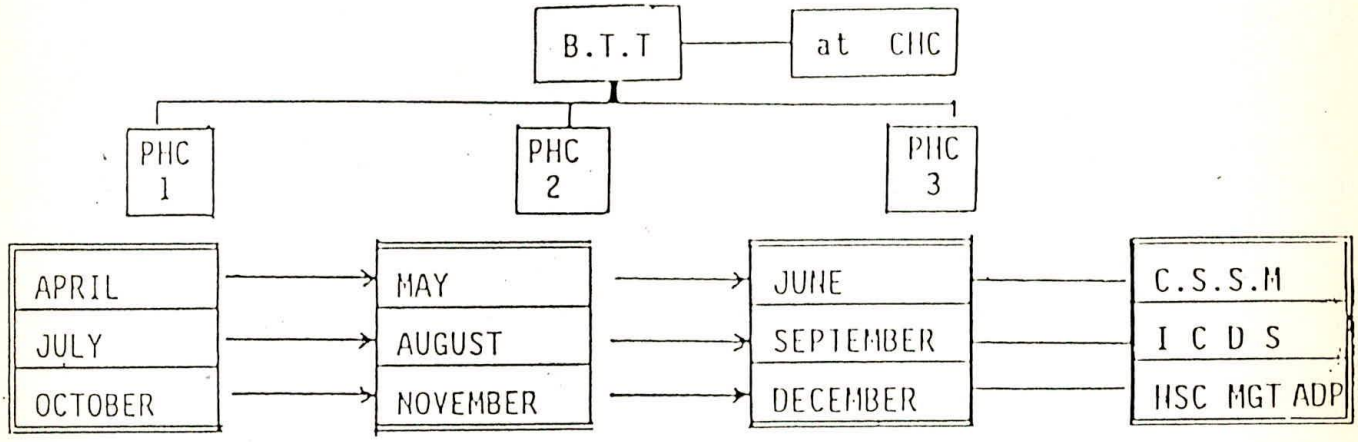
Slot II - SC work planning, managing the resources and preventive maintenance (ADP)

Slot III - Nutrition (ICDS) and control of communicable diseases

By this way, all the five health priorities of the state will be covered under the training programme.

FIVE PRIORITIES OF THE STATE
:
POPULATION
CHILD SURVIVAL & SAFE MOTHERHOOD
CONTROL OF COMMUNICABLE DISEASES
MALARIA
DIARRHOEA
LEPROSY & TB

a-4 The field training programme will commence from April and close by December.



a-5 Training Materials

B T T will be provided with Training Resource Materials prepared by :

- National Institute of Health & FW
- C S S M
- Operational guide for HSC management & maintenance (to be prepared by ADP)

b) SPECIAL TRAINING

ON CHILD SPACING

B T T / D T U will organise 2 weeks intensive training on child spacing methods with special focus on IUD and OP for the HW(F)/HA(F). The training resource materials will be prepared by ADP with guidance from NIHFW.

5:4.3 DISTRICT TRAINING UNIT

Under the revised strategy, it is proposed to establish One District Training Unit (DTU) at district head quarters.

- There were 19 ANM Schools spread over 13 districts
- 3 Schools which were functioning in a rented building were closed and the staff have been rearranged within the system.
- 2 Schools i.e; one at Sambalpur and one at Jeypore (Koraput) were retained for basic training
- 14 Schools were converted as centres for continuing education which will be taken over by District Administration as District Training Unit. The detailed break up is given in the next page for reference.

SL. NO.	DISTRICT	LOCATION OF ANMTS → DTUS
1.	Bhubaneswar	To new districts
2.	Daspalla	To new districts
3.	Puri	Puri
4.	Cuttack	Kendrapada
5.	Balasore	Balasore
6.	Mayurbhanj	Baripada
7.	Dhenkanal	Dhenkanal
8.	Keonjhar	Keonjhar
9.	Bolangir	Bolangir
10.	Phulbani	Phulbani
11.	Ganjam	Berhampur
12.	Kalahandi	Bhawanipatna
13.	Sundargarh	Sundargarh
14.	Sambalpur	Deogarh

* New buildings will be constructed for District Training units in the newly formed district and the staff at the ANMTS will be deployed to fill up the newly established DTUS, other training institutions and districts.

a) **STRATEGY**

a-1 **ESTABLISHING THE DISTRICT TRAINING UNIT**

Faculty : Each ANM School has 7 teachers

- One Principal Tutor
- 4 Public Health Nurses
- 2 Sister Tutors
- Support Staff

Additional Requirement :

- Medical
- Health Education
- Statistics

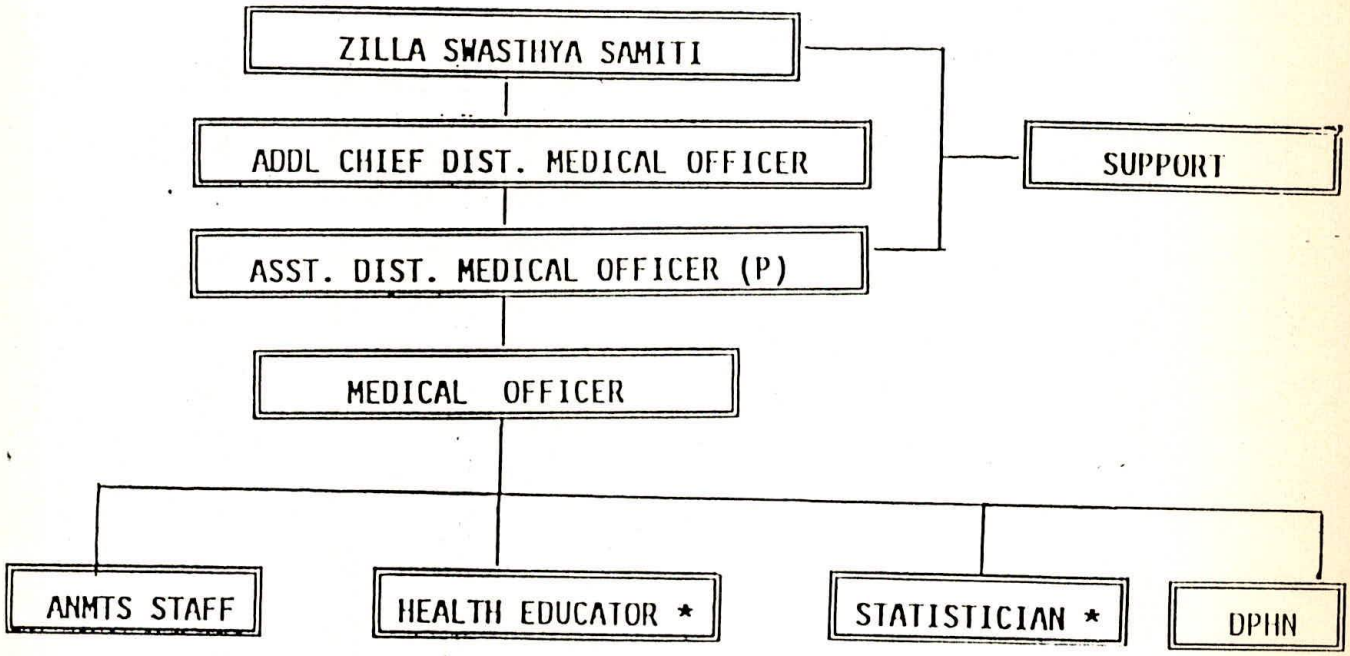
Proposal :

Under the new strategy, the Addl. CDMO is the Training Coordinator at the district level supported by Assistant District Medical Officer (Project). The faculty requirement could be drawn as follows :

1. Medical Officer : from leave reserve port (preferable O & G/ Paediatrics/Public Health)
2. Health Education : BEE/Dy. MEIO from mass media wing
3. Statistics : District statistical assistant (could be used as resource persons)
4. MCH Field Programme : District Public Health Nurses

(1,2,3,4 will be drawn as resource persons)

ADMINISTRATIVE STRUCTURE OF THE DTUS



* Could be drawn as resource persons.

a-2 **Training of Trainers**

Trainers at DTU (About 10) will be trained for 10 days every year Jan-Feb. The content include :

- Training skill & Methods
- Training Resource Materials
- Management of Training Course
- Developing Annual Training Plans for district

When it comes up (SIHFW), DTU members will be trained in Regional Training Centres (HFWTC/RHTC) with support from State Institute of Health & FW (SIHFW).

For 1992-93, DTU members will be trained by Scientific Illustration and Educational Technology (SIET) with local support i.e; trainers/teachers drawn from HFWTC/Districts. From 93-94 onwards NIHFW will take up the responsibility of training of trainers of DTUS.

a-3 **Training Resource Materials**

NIHFW modules will be utilised for the training courses with necessary modifications to suit the local needs. SIHFW will prepare trainer's book and trainee guide for the new training programmes (the ones NIHFW have not prepared) with technical guidance from NIHFW.

a-4 **Training Programmes at District Training Units**

a-4.1 **Training of Block Training Team**

* BTTs will be given 6 days training on :

- Skill development for Quality Care and Coverage of services at Subcentres.
- Support Supervision and Supplies to strengthen the Quality.
- Monitoring, Performance appraisal and feed back.
- Communication skills

* 4 BTTs could be trained as one batch i.e; 4 * 5 = 20. 2 courses could be done in every month i.e; 8 Blocks could be covered/month. All the blocks could be covered within 2-3 months.

SCHEDULE - APRIL - MAY - JUNE	-	ALL BTTs TRG.

a-4.2 **SUPPORT STAFF TRAINING**

- Pharmacist - Logistics/Stock/Stores (Materials Management)
- Clerk cum Store Keeper - Administration
- Lab Technician -
- X-ray Technician - | Technical Training

The trainees will be housed in the DTU and theory classes will be conducted in the DTU and the practical demonstration will be organised in the district hospital.

Each programme will be organised by a Core group trainers at the district level.

The schedule for the support staff training is given below for reference.

PHARMACIST	MATERIALS MANAGEMENT	SEPTEMBER
CLERK	ADMINISTRATION	OCTOBER
LAB. TECHNICIAN	TECHNICAL	NOVEMBER
X-RAY TECHNICIAN	TECHNICAL	DECEMBER

a-4.3 **Special Training** - **JULY/AUGUST**

- DTU has the flexibility to accommodate special training for HW(F) & HA (F) in child spacing methods. With special focus on IUD insertion, Oral Pills. The training resources materials will be prepared by ADP with technical guidance from NIHFW Schedule for special training.
- Special training on communication packages will be taken up in pilot districts by training groups and organisations who have significant contributions to make. For instance, **CARE, GANDHIGRAM, PSI.**

ACTIVITY SCHEDULE

SL NO	ACTIVITY	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
1.	TOT-BTT	--	--	--									
2.	SPECIAL TRAINING ON CHILD SPACING				--	--							
3.	MATERIAL MGT. PHARMA-CIST						--						
4.	ADMINISTR-ATION CLERK							--					
5.	LAB. TECH TRAINING								--				
6.	X RAY TECH. TRAINING									--			
7.	DTT - TOT										-		
8.	PREPARATION OF ANNUAL TRG. PLAN											-	
9.	MOBILISATION OF RESOURCES											-	-

a-5 **Learning Resource Materials** (Including IEC)

Financial and technical assistance to develop & procure the LRM would be sought from :

- ADP
- State level institutes
- National Institute Health & FW
- World Health Organisation (SEARO)
- UNICEF
- Local folk media unit production

a-6 **Furniture**

Financial support will be provided for furnishing the District Training Units.

a-7 **Physical Infrastructure**

- A condition survey is proposed for the 14 ANM schools and renovation plans will be prepared to upgrade them as DTUs. Financial support will be provided.
- For the new districts like Malkangiri, Rayaguda Gajapathi, and Navrangpur, feasibility study either to convert existing facilities with renovation or to construct new building will be conducted.
- For the districts of Koraput & Sambalpur, new construction will be done.
- Similarly, new ANM school will be constructed in Sambalpur.

a-8 **Vehicle**

To monitor the field training activities by the BTT transport will be provided for DTUs.

a-9 State Training System & Child Survival Safe Motherhood

a-9.1 An attempt will be made to fit CSSM training into the State Model

i.e; DISTRICT → B.T.T → V.T.T → Interface (TBA/AWW) → MOTHERS

State Model of the 3 days on the job training at sectoral level once in 3 months provides scope for accommodating CSSM/ICDS/HSC Management.

a-9.2 CSSM district - wise coverage is given below for reference.

1992 - 93	1993 - 94	1994 - 95	1995 - 96	1996 - 97
Ganjam Keonjhar Sambalpur	Koraput Bolangir Sundargarh	Balasore Mayurbhanj	Phulbani Kalahandi	Puri Cuttack Dhenkanal

a-9.3 Since CSSM is a vertical programme and has to be done through the system identified by CSSM. ADP will concentrate on the other districts during 1992-93 & 1993-94 and take up the CSSM covered districts during 1994-95. The break-up is given for reference.

YEAR	C S S M	A D P
92 - 93	1. Ganjam 2. Keonjhar 3. Sambalpur	1. Puri 2. Cuttack 3. Dhenkanal
93 - 94	4. Koraput 5. Bolangir 6. Sundargarh	4. Phulbani 5. Kalahandi 6. Balasore 7. Mayurbhanj 8. Ganjam 9. Keonjhar 10. Sambalpur
94 - 95	7. Balasore 8. Mayurbhanj	11. Koraput 12. Bolangir 13. Sundargarh
95 - 96	9. Phulbani 10. Kalahandi	
96 - 97	11. Puri 12. Cuttack 13. Dhenkanal	

5.4.4 REGIONAL TRAINING CENTRES

5:4.4.1 Health & Family Welfare Training Centre (HFWTC)

There are 2 Health and Family Welfare Training Centres at :

- Sambalpur
- Cuttack

* HFWTC undertake :

- Basic Training for Health Workers (Male) - 1 year course.
- Inservice Training for :
- Medical officers
- Block Extension Educator
- Health Assistant

* HFWTC have good facilities for classrooms, library, hostel, dinning facilities.

* HFWTCs have been provided financial assistance by ADP in strengthening

- Learning Resource Materials
- Transport
- Renovation

Their linkages with the State Institute, the DTUs and BTTs will be clearly established, so that they do not train on issues which are not directly relevant to the State training concept.

* STAFF POSITION IN RFWTC

INSERVICE TRAINING

SL.NO	D E S I G N A T I O N
1.	Principal
2.	Medical Lecturer-cum- Demonstrator
3.	Health Education Instructor
4..	Health Education Extension Officer
5.	Senior Sanitarian
6.	Social Science Instructor
7.	Asst. Director of Statistics
8.	Senior Health Inspector
9.	Public Health Nursing Instructor
10.	Artist-cum-Draftsman
11.	Projectionist

BASIC TRAINING

SL.NO	D E S I G N A T I O N
1.	Epidemiologist
2.	Dist. Public Health Nursing Officer
3.	Sanitary Engineer
4.	Management Instructor
5.	Communication Officer

ESTABLISHMENT

SL.NO	D E S I G N A T I O N
1.	Head Clerk
2.	Computer
3.	Accountant-cum-Store Keeper
4.	Stenographer
5.	Clerk-cum-Typist
6.	Driver-cum-Mechanic
7.	Sr. Clerk (Basic Health Scheme
8.	Junior Clerk-cum-Typist (Basic Health Scheme)
9.	Cook
10.	Peon-cum-Daftary
11.	Aya
12.	Watchman-cum-Mali
13.	Peon
14.	Sweeper
15.	Peon (Basic Health Scheme)

5:4.4.2 RURAL HEALTH TRAINING CENTRES (RHTCS)

* RHTCs are attached with the Department of Social and Preventive Medicine of Medical Colleges. There are 3 RHTCs :

SL NO	MEDICAL COLLEGE	RHTC LOCATION
1.	CUTTACK	JAGATSINGHPUR
2.	BURLA (SAMBALPUR)	ATTABIRA
3.	BERHAMPUR	DIGAPHANDI

* Basically RHTCs are involved in :

  - Internee's (Medical) training
    (Rural posting for 3 months)

  - Staff Nurse Training
    (Community Health Nursing)

* RHTC Jagatsinghpur was upgradated during Phase I of ADP on par with HFWTC and conducts the same programmes as HFWTCs.

* RHTCs Attabira & Digaphandi will be upgraded during Phase II of ADP through inputs so that they could be upgraded as Regional Training Centres.

* Each HFWTC/RHTC Jagatsinghpur has their own geographical coverage for inservice programmes. Sooner all the RHTCS are upgraded, each institution will cater to a particular geographical area for inservice training activities.

a) **ROLE OF REGIONAL HEALTH TRAINING CENTRES**

a-1. **Training Programmes**

a-1.1 Training of Trainers of District Training Units.

a-1.2 Medical officers
|
Induction Course for 8 weeks
|
Inservice Course for 2 weeks
|
Peripheral Specialists Programme in coordination with the medical colleges.

a-1.3 Block Extension Educator - IEC management training

a-2 **Support to District Training Units**

RHTCs will provide technical support to DTUs in the

- Preparation of annual training plans
- Provision of learning resource materials
- Providing support in the training programmes organised at DTUs

5:4.5 STATE INSTITUTE OF HEALTH & FAMILY WELFARE

Health manpower has increased tremendously over the past 10 years. Many new programmes, projects and intervention programmes are introduced in the health care system. As discussed in the earlier chapters, it is very crucial that the demand generation created through health promotion and social mobilisation programmes should be adequately and appropriately met by Quality and Coverage of health services for which training plays a major role.

At present there is no definite system existing in Orissa in Manpower planning, Training and Development. Now Govt. of Orissa through ADP is keen to develop a systematic approach to the above mentioned issues. This document describes the entire process of training system development through bottom up approach. Therefore the need to establish an apex body at the State level becomes very crucial in the overall development of manpower planning, training and development.

a) JUSTIFICATION

Area Development Programme Phase I in Orissa provided very important lessons in the areas of training and IEC.

a-1. College of Nursing Berhampur

The College was constructed, furnished and equipped through ADP's financial assistance during Phase I. But the college is yet to take off even inspite of 6 year's existence because of lack of foresight on the availability of the trained manpower planned staff and institutional development. The college will face these problems in the coming years unless the faculty position is adequately strengthened to get the recognition from Indian Nursing Council and university of Berhampur.

a-2. Information Education Communication (IEC) Centre Bhubaneswar

IEC Centre was constructed, furnished and equipped through ADP's financial assistance during Phase I. The staff were trained in India and in the UK. But the performance of the centre is highly disappointing as the centre was reduced as an appendage to the Director of Family Welfare.

The State Government is planning some administrative changes in the IEC structure and reporting, in order to make the IEC effective in its role.

a-3. Therefore learning from the two experiences, one should be cautious in planning the SIHFW so that such slippages could be avoided and SIHFW becomes a viable and active apex body to a sustainable training system.

a-4. In India under World Bank assisted India Population Projects 11 States have been covered for Training & System Development Projects. They are:

- Andhra Pradesh
- Madhya Pradesh
- Uttar Pradesh
- Jammu &Kashmir
- Gujrat
- Punjab
- Karnataka
- Assam
- Himachal Pradesh
- Rajasthan
- Haryana

National Institute of Health and Family Welfare New Delhi is involved in developing the Training & System Development Project in these States. Orissa will be funded through ODA for the Training & system development through ADP. **Therefore there is an urgent need to set up the project as early as possible in order to be in confirmity to the National Health Policy and approach to develop the training systems in a more integrated fashion so that Orissa could provide adequate technical and managerial skills to the service providers at different level in health care system.**

a-5. Further Govt. of Orissa's 5 health priorities and the programmes addressing the 5 health priorities are in operation and being contemplated. Unless the systematic approach is developed to provide an integrated package to the service providers, all the efforts in addressing the 5 Health priorities will be a futile exercise.

a-6. Govt. of Orissa's new initiative of demand generation for health services through intensive and innovative health promotion and social mobilisation programmes is bound to create demands from the user's side. These demands should be adequately and appropriately met by Quality care and coverage which is possible through systematic development of health manpower through integrated packages of training programmes and through well define and organised training system.

Therefore the need to establish SIHFW is absolutely vital in the overall development of health human resources in Orissa.

b) **APPROACH**

b-1. The existing IEC Centre at Bhubaneswar could be upgraded as SIHFW. IEC Centre has classroom, library, documentation facilities. The additional requirements will be additional classrooms and hostel apart from renovation of the existing building.

b-2. GOO will identify the resources to provide financial assistance for furniture, equipment, learning resource materials to upscale the production capacity of the Institute for developing training as well as IEC materials.

GOO will identify the resources to provide full support in terms of technical and financial inputs to upgrade the IEC Centre as SIHFW.

c) **FUNCTIONS**

SIHFW will : aim to be a training institution rather than an academic body.

c-1. Assist the Government to evolve health promotion and human resource development policy.

c-2. Assist the Government to develop annual training and IEC plans.

c-3. Organise the training programmes for :

3.1 Training of Trainers of Regional/District units.

3.2 Management Development Programme for the District Health Teams.

c-4. Organise need based workshops/seminars in HRD/IEC.

c-5. Undertake monitoring and evaluation of the training courses.

c-6. Develop training resource materials with technical support from NIHFW.

c-7. Develop programme based, audience centered IEC materials for health promotion-designing, pretesting, printing, distribution.

c-8. Publish monthly/quarterly news letter on Health Services Development.

c-9. Laise with NIHFW in the consortium of training institution in India and publish the experiences from Orissa in National/International forum.

d. STRUCTURE

d-1. SIHFW should be an autonomous institution right from inception for sustainability and operational efficiency

d-2. SIHFW should be headed by (Preferable) medically qualified Public health expert

d-3. SIHFW should have the training cadres (Lecturers, Reader & Professor)

d-4. Following disciplines are absolutely essential :

d-4.1 Health Services and Administration

d-4.2 Epidemiology, Bio statistics and Demography

d-4.3 Behavioural Sciences and Communication

d-4.4 Management Sciences - Until the faculty strength is fully developed, the resources from Xavier Institute of Management could be drawn)

d-4.5 Education and Training with Administration, Finance, Library & Documentation and Computer support.

d-5. SIHFW should grow and develop. Therefore a 10 years institutional frame work is given on next page for reference.

TECHNICAL COMPETENCE REQUIRED IN 10 YEARS

	HEALTH SERVICES AND ADMINISTRATION
1.	Community Health Services & Admn +
2.	Hospital Administration
3.	Nursing Administration
4.	MCH
5.	Nutrition
6.	Environmental Sanitation
7.	Lab Technology
	EPIDEMIOLOGY, BIOSTATISTICS & DEMOGRAPHY
8.	Epidemiology
9.	Biostatistics +
10.	Demography
	BEHAVIOURAL SCIENCES & COMMUNICATION
11.	Sociology +
12.	Psychology
13.	Anthropology
14.	Electronic media +
15.	Health & Extension Educator +
	MANAGEMENT SCIENCES
16.	Health Planning
17.	**Quantitative Methods**
18.	System Analysis / OR +
	Health Economics
	Qualitative Methods
19.	Organisational Behavior +
20.	Evaluation Methods
	EDUCATION & TRAINING
21.	Curriculum Planning +
22.	Curriculum Evaluation
23.	Learning Methods +
24.	Training Methods

In practice it is very difficult to set up every thing required immediately. Therefore to start with SIHFW should have essentially 1-2 faculty members. The details are given below for reference.

Health Services and Administration

1. Community Health Services & Administration

   |---- Medical

   |---- Nursing

Epidemiology, Bio statistics and Demography

2. Bio Statistics

Behavioural Sciences and Communication

3. Sociology
4. Electronic media
5. Health & Extension Educator

Management Sciences

6. System Analyst
7. Organisational Behaviour

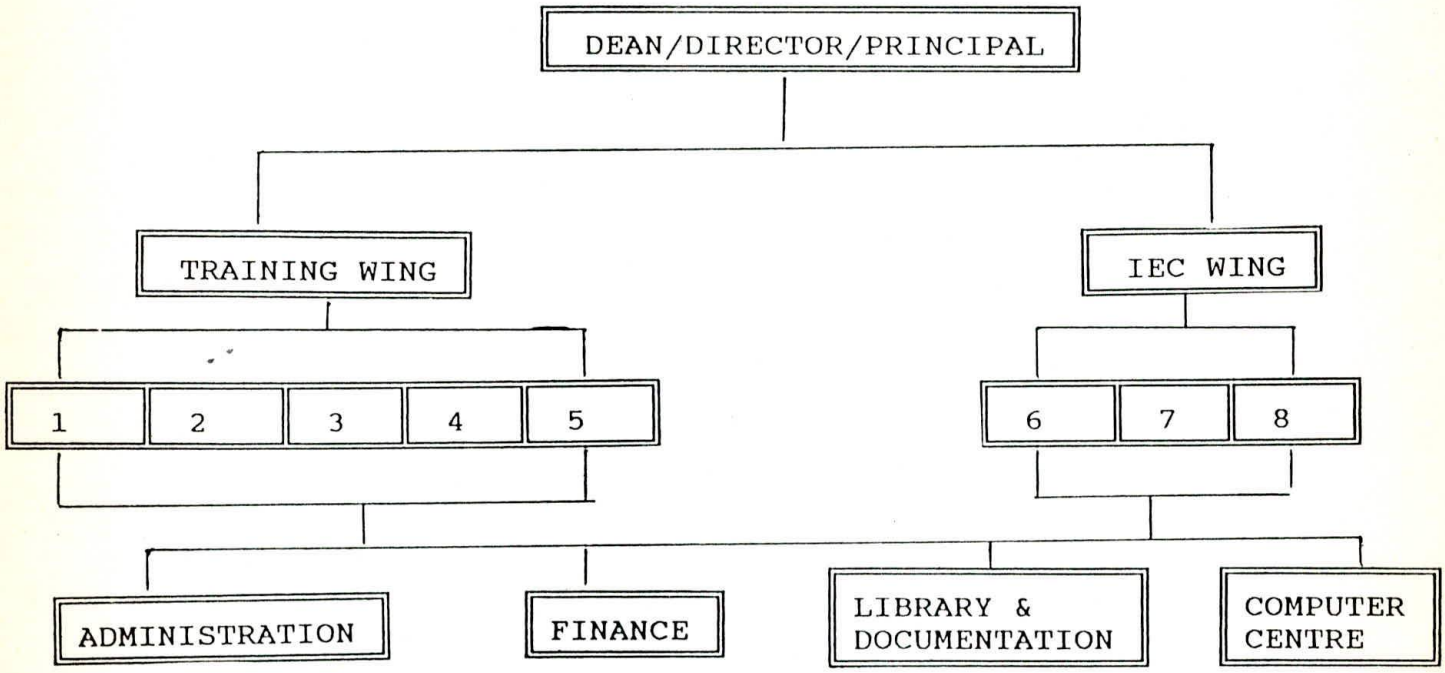
Education & Training

8. Curriculum Planning
9. Learning Methods

Administration, Finance, Library & Documentation and Computer Centre.

To initiate ADP could finance the staffing until the project period. As SIHFW guns depending on the needs, the other positions could be filled in future.

d-5. PROPOSED STRUCTURE



1. HEALTH SERVICES & ADMINISTRATION
2. EPIDEMIOLOGY BIO STATISTICS & DEMOGRAPHY
3. BEHAVIOURAL SCIENCES & COMMUNICATION
4. MANAGEMENT SCIENCES
5. EDUCATION & TRAINING
6. MATERIAL PRODUCTION
7. MATERIAL DISTRIBUTION
8. MONITORING & EVALUATION

d-6. COMMITTEES

d-6.1 GOVERNING BODY

Details are provided in the annexe I.

STRUCTURE

CHAIRMAN - Commissioner & Secretary, Dept. of Health & FW

VICE CHAIRMAN - Director Area Development Programme
Director Medical Education
Director Family Welfare
Director Health Services
Deputy Director IEC

MEMBER SECRETARY- Director SIHFW

MEMBER - Secretary Deptt. of Finance
Secretary Deptt. of Planning & Coordination
Secretary Deptt. of Education
Secretary Panchayat Raj
Secretary Public Works Deptt.
British Council Division
UNICEF
State Resource Centre
Xavier Institute of Management
Gopabandhu Academy of Administration
Joint Secretary(ADP) Ministry of H & FW
Director -NIHFW New Delhi
ICMR

d-5.2 **EXECUTIVE COMMITTEE**

ISSUES SANCTION

CHAIRMAN - Director SIHFW

MEMBER SECRETARY- Faculty member

MEMBER - Joint Secretary (training)
Director of Medical Education
Director of Family Welfare
Director of Health Services
Deputy Director (IEC)

d-5.3 **TECHNICAL ADVISORY COMMITTEE**

Advises on technical issues - contents, curriculum, methods & media courses and materials.

Chairman - Director SIHFW

Member Secretary - Senior faculty SIHFW
Members - Director of family welfare
Director of health services
Director of medical education
Director Area Development Programme
Director voluntary health Association
Director ICDS
Dy. Director IEC
NIHFW Delhi

d-5.4 **PAY STRUCTURE**

The pay scales of Department of health & FW, Medical colleges, University are enclosed in the Annexe III.

It is desirable to adopt the UGC pay scale. If not, atleast pay structure of medical colleges should be adopted.

e) **ROLE OF NATIONAL INSTITUTE OF HEALTH & FAMILY WELFARE (NIHFW) NEW DELHI**

NIHFW will be the consultant for developing the Health and family welfare training and systems development in Orissa. The terms of reference will include :

e-1. To provide technical and management support in developing the training & system development.

e-2. To provide technical and management support in the institutional development of SIHFW.

e-3. To provide support in the provision of learning resource materials (print & audio visual materials) and guidance in the local designing and production of learning resource materials.

e-4. To provide support for faculty identification, recruitment, pre placement training and continued guidance in faculty development.

e-5. To provide support in the preparation of byelaws and constitution of committees, body and working group and in the organisation of meetings of these committees until SIHFW is strong enough to do in their own.

e-6. To establish linkages for SIHFW with the other training institutions in the country (consortium) and provide support for exchange visits.

e-7. To establish linkages for SIHFW with institutions in the UK especially Nuffield Institute Leeds University and Liverpool School of Tropical Medicine institutes in S.E.Asian countries for specific inputs for faculty and institutional development.

e-8. To advise the consultancy requirement (local/India/UK) and channelise them in consultation with British Council Division/WHO etc.

e-9. To advise SIHFW/Government of Orissa and British Council Division on the Technical Cooperation Training Programmes.

e-10. To affiliate SIHFW in the event of NIHFW being declared as deemed University to commence post graduate diploma courses in Public Health & Health education. This is a long term requirement.

NIHFW will open a cell for Orissa in the Institute (Delhi) for effective Coordination, support and guidance.

f) **TECHNICAL COOPERATION AND TRAINING PROGRAMME**

It is absolutely essential to develop the potentials in the areas of :

- Public Health
- Management
- Planning
- Health Economics - utilising the TCTP slots.
- IEC

The following recommodations are suggested for building up a system for effective training and manpower development as long term measures.

MEDICAL PROFESSION

f-1. Govt. of Orissa should insist that the Jr. class I specialists to undertake Diploma in Public Health (Calcutta or Indian Institute of Health Management Research Jaipur) before they are promoted to Senior class I. This is very important to gain overall view of the National Health & Family Welfare Programmes and update the skills in management.

f-2. Those officials who have public health qualifications and background should be encouraged to take up master courses in Health Planning and Epidemiology in the UK.

f-3. Those officials who have public health qualification and background should be encouraged to take part time MBA at Xavier Institute of Management.

EXTENSION EDUCATION

f-4. Graduate BEES/LHVS/DY.MEIOS subject to their age limit should undertake Diploma in Health Education. Conditions should be imposed that only BEES with DHE Qualification should be considered for promotion as Dy. MEIO.

NURSING EDUCATION

f-5. Govt. of Orissa should depute minimum of 3 graduate nurses to undertake MSC courses within India.

f-6. Govt. of Orissa should insist that DPHNS should undertake Diploma in Health Education as a pre-condition for their promotion as Assistant Director.

PAY STRUCTURE IN DEPARTMENT OF HEALTH & FAMILY WELFARE, GOVT. OF ORISSA HEALTH SERVICES

1. **Assistant Surgeon/Specialist (class II)**

   Rs. 2000-60-2300-EB-75-3200-100-3500.
   Advancement scale of pay of assistant surgeons/specialist in rules 1985

   Rs. 1975-65-2040-70-2250-75-2700-EB-80-3100

2. **Junior class I**

   Rs. 2200-75-2800-EB-100-4000

3. **Senior class I**

   Rs. 2800-100-3600-EB-125-4350

4. **Joint Director level II**

   Rs. 3200-100-3700-125-4700

5. **Joint Director level I**

   Rs. 3700-125-4700-150-5000

6. **Director of Health Services/Family Welfare**

   Rs. 4800-150-5700-200-6300

MEDICAL EDUCATION

1. Lecturer - Rs. 700-40-1100-50-1300-EB 50-1800
2. Asst. Professor - Rs. 3700-125-4950-150-5700
3. Associate Professor - Rs. 3700-125-4950-150-5700
4. Professor Rs. 4500-150-5700-200-6300 (3 advance increments)
5. Director of Medical Education Rs. 4500-150-5100-200-6300 (2 advance increments)

UNIVERSITY GRANTS COMMISSION

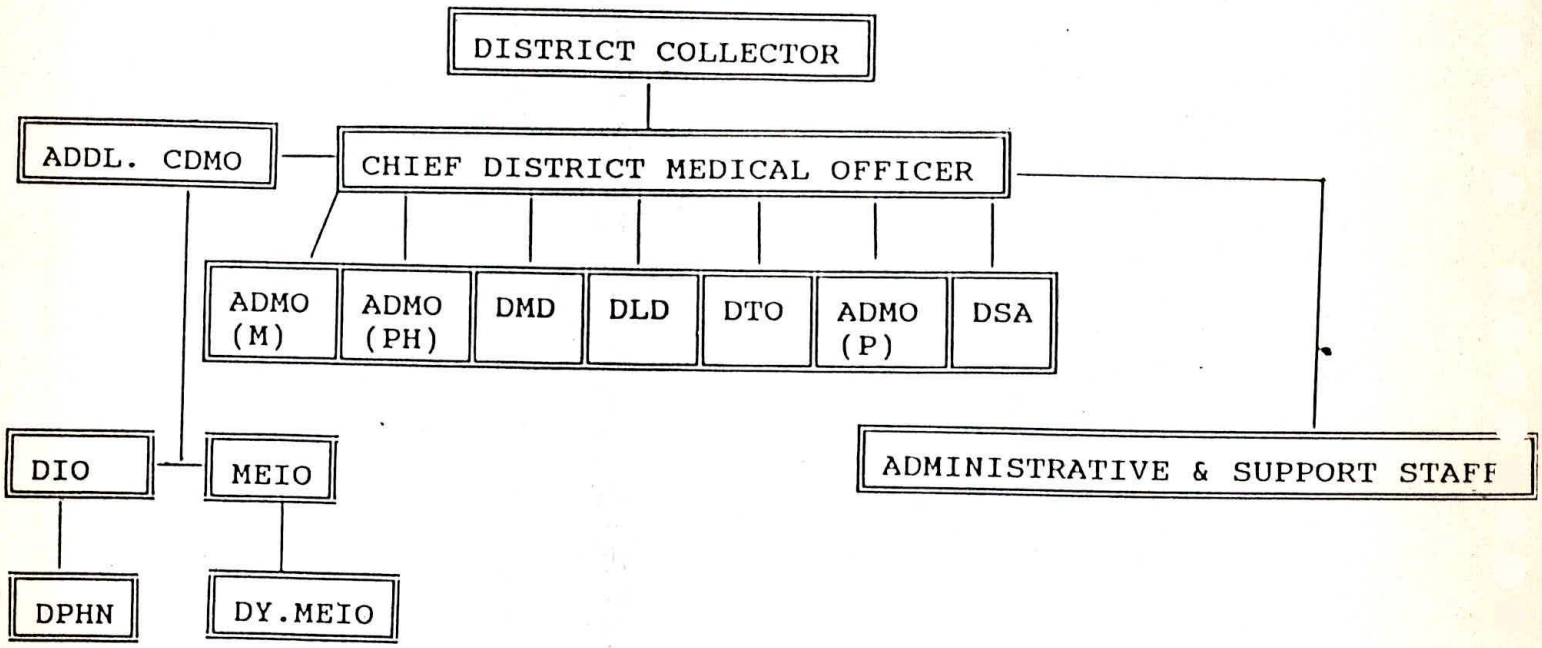
1. Lecturer - Rs. 2200-75-2800-100-4000
2. Senior Lecturer Rs. 3000-100-3500-125-5000
3. Lecturer Selection grade and Reader
   Rs. 3700-125-4950-150-5700
4. Professor Rs. 4500-150-5700-200-7300
5. Vice Chancellor - Rs. 7600 (Fixed)

CHAPTER - 6

DISTRICT HEALTH MANAGEMENT

District is the functional unit for all the activities of the Government. In health care system, the district assumes greater importance and plays a vital role in supporting and strengthening the delivery system at sub district, block, sub block and village levels. Therefore it is very important that special focus and attention should be given to the district health management. In order to ensure the coverage and quality of health care services.

STRUCTURE



DIO - DISTRICT IMMUNIZATION OFFICER
DPHN - DISTRICT PUBLIC HEALTH NURSE
MEIO - MASS EDUCATION & INFORMATION OFFICER
DSA - DISTRICT STATISTICAL ASSISTANT
ADMO - ASST. DIST. MEDICAL OFFICER
(M) - MEDICAL
(PH) - PUBLIC HEALTH
(P) - PROJECT
DMO - DISTRICT MALARIA OFFICER
DLO - DISTRICT LEPROSY OFFICER
DTO - DISTRICT TUBERCULOSIS OFFICER

6.1 SITUATION ANALYSIS

6:1.1 PLANNING

a) Over all planning is done at the State level and the districts are informed about the activities, targets and the budget provided from the state level to directorates:

- DIRECTOR OF HEALTH SERVICES (DHS)
- DIRECTOR OF FAMILY WELFARE (DFW)

b) DFW gets 100% central assistance for family welfare activities which include establishment, programmes (training), activities, vehicles, motivation, IEC activities. The State provides some additional incentives for sterilisation.

c) DHS gets some funds & material from GOI on Malaria and Filaria control, and assistance for :

- National Programme for Control of Blindness
- National Programme for Aids Prevention & Control
- National TB Control Programme
- National Leprosy Eradication Programme

All the remaining programmes of promotion of secondary health care, establishment, medical education etc. are met from the State funds.

At the present moment **there is little scope** for planning at the district level.

However, an exercise is on to decentralise planning. The first step being proposed in this direction is a district-wise reallocation of the 93-94 budget. The districts would be asked to plan for their respective needs within this financial ceiling and keeping in mind some policy guidelines.

Health care will form the part of the district plan.

6:1.2 **IMPLEMENTATION**

a) All the National Health & Population programmes and the regular curative care services are implemented by the district health officials. For each programme, there is a responsible official at the district level.

b) All these programmes are implemented through the CHC / PHC / HSC by the respective health and paramedical staff and monitored individually by the respective programme officers.

c) In short, the multipurpose workers scheme stops at the level of PHC / CHC and from there onwards only individual vertical programme implementation and monitoring commence and continue upto the State level which results in :

- Individual vertical programme - priority
- Multiplicity of Controls by Individual programme officers
- Confusion at the field level for programme priorities
- Dilution of the Concept of Comprehensive package of health care delivery
- Lack of Coordination between the programme officers at district/state level
- Least scope of developing proper plan of implementation for the comprehensive package of services

d) These deficiencies lead on to certain problems in the field level :

- Poor supervision and monitoring
- Poor Quality and Coverage of services
- Poor demand generation for health services

e) These problems lead on to the :

- Status Quo in the health status and parameters
- Growing unmet demands
- Wastage of human resources, materials and time

6:1.3 **Management - Adjustment**

a) **Additional CDMO**

His / Her job description extensively covers the :

- Materials and Child Health - child survival & safeguard
- Population
- Training
- I E C
- M I S (To a greater extent)

But in practice, majority of the Addl. CDMO'S time is spent on administration and not on programmes - even if one argues for programmes, again it is limited to :

- sterilisation target & achievement
- Immunization target & achievement

6:1.4 **Delays in transfer of information**

Extensive delays occur in transmitting the changes in the schedule (for eg. immunization) or technology from the State to district and district to the grassroot which result even in poor updating of IEC materials (locally produced) and skills.

6:1.5 **Confusions in the training programmes**

There is more confusion in the field level especially among workers and supervisors as they have been drawn to different training programmes by different programme agencies/officers at different points of time which results in poor coordination and wastage of human resources and time.

6:1.6 **Limited use of health information system**

Data and information collected from different resources are pooled at the district level and passed to state without proper analysis. There is no system at the district level for use of data and information for monitoring and planning purposes. The analysis done at the district level is the :

Review of Target against Achievement

6:2 STRENGTHENING HEALTH MANAGEMENT INFORMATION SYSTEM

a) ADP supported new HMIS provides for :

SC

- Introduction of family card system
- Withdrawal of individual programme registers
- Streamlining the information flow at fixed day in month
- Feed back from PHC / CHC on Performance & Quality Care

PHC/CHC/DISTRICT

- Development of support information system :
  - Mortality, Morbidity, inventory, etc.
- Development of Performance indicators on Quality Care indicators.
- Streamlining the flow of information and feed back system
- Using the data and information for monitoring & planning
- Installation of Computer facilities at the district level and linkage with national net work

b) **Conduct of Specific Surveys**

DHMS will organise specific surveys on :

- Infant mortality
- Coverage evaluation for UIP
- Utilisation of services at HSC

Cluster technique using WHO formats in one HSC in each block every year.

All the HWS (F) & (M) AND HS (F) & (M) about 30 of the health personnel will carry out the survey in one HSC every year.

(EG) Each HSC has 1000 house holds i.e; 5000 population. If the HWS are about 20, each one of them can survey 50 houses in 3-4 days under the supervisors guidance.

This survey should be linked during April-May when the updating of ELCO is done.

No extra cost and no additional manpower are required.
If the district has 20 blocks, then the DHMS will get the sample of 20 * 5000 = 100,000 population. All the required data and information collected for this sample size is statistically significant and all the morbidity, fertility and mortality rate could be calculated per district.

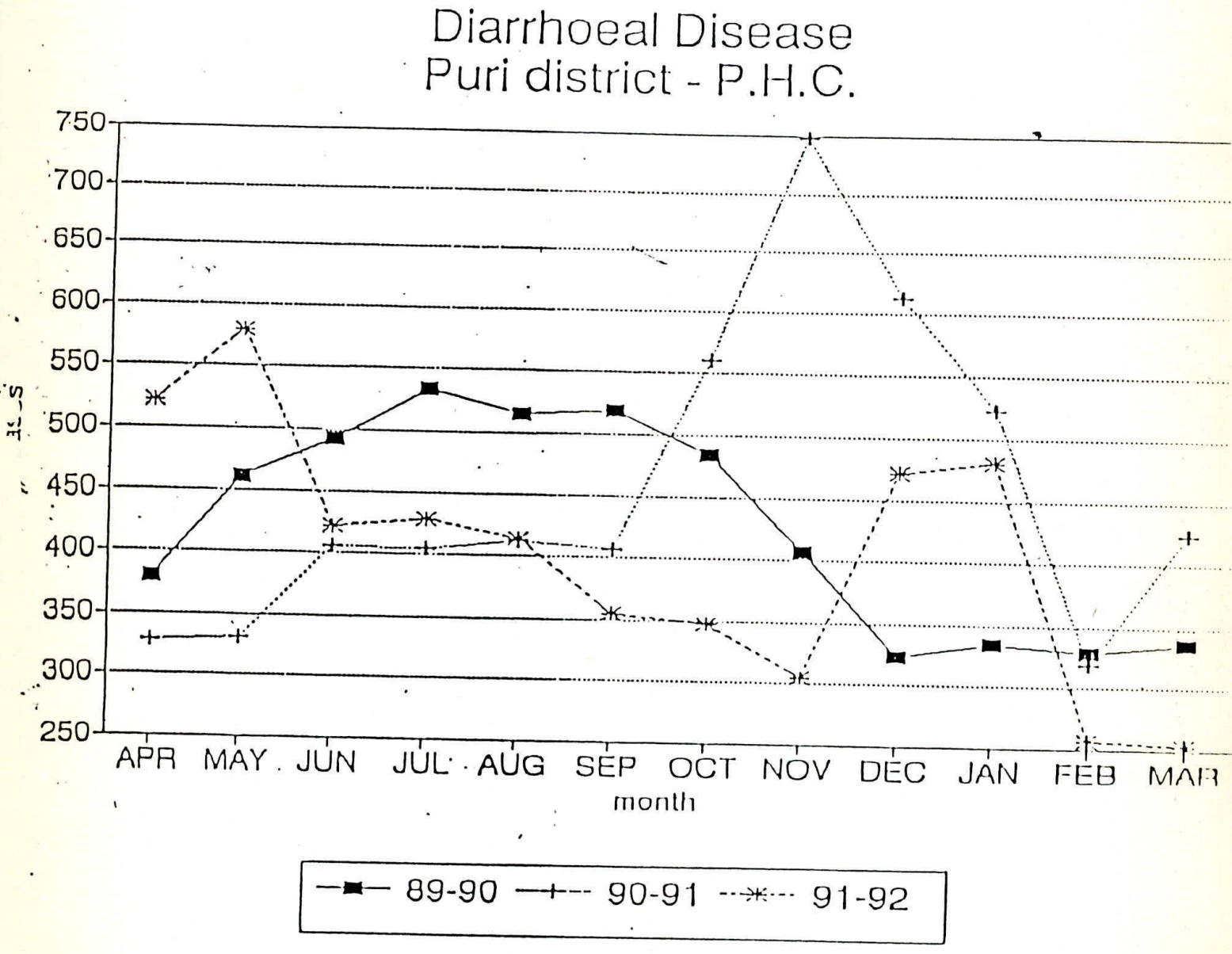
c) <u>Retrospective Study on Communicable Diseases</u>

Data on Communicable diseases like Diarrhoea, Malaria, T.B and Leprosy could be collected from the secondary data i.e; from the registers & records and they constitute the reported cases. The data collection should be for the past 3 years containing information on month wise, area wise, age & sex wise distribution.

Such exercise will give the information on :

- What is the problem ?
- Where is the Problem ?
- When is the problem ?
- Who are affected ?

An example is illustrated below for a PHC in Puri district.



With the installation of computer at the district, such type of information could be brought about. (Some more illustrations are given in the annexe)

The advantage of such exercise is manifold.

- Tells the epidemiological forecasting.
- Provides the planner the scope of mobilising the resources well in advance.
- Using the epimaps, with the planned programme the incidence & prevalence could be brought down considerably.

d) <u>District Data Bank</u>

With the Computer and trained manpower, district data bank could be established which will provide information :

- Manpower - (Unit wise)
- Inventory - Furniture, Equipment, Vehicle (Unit wise)
- Performance data ------
- Survey (special) data- | for comparison
- Epidemiological forecasting for control of epidemics
- Developing tools for monitoring the coverage and quality
- Planning the programmes.

6:3 <u>STRENGTHENING THE HUMAN RESOURCE DEVELOPMENT</u>

Discussed extensively in the chapter 5

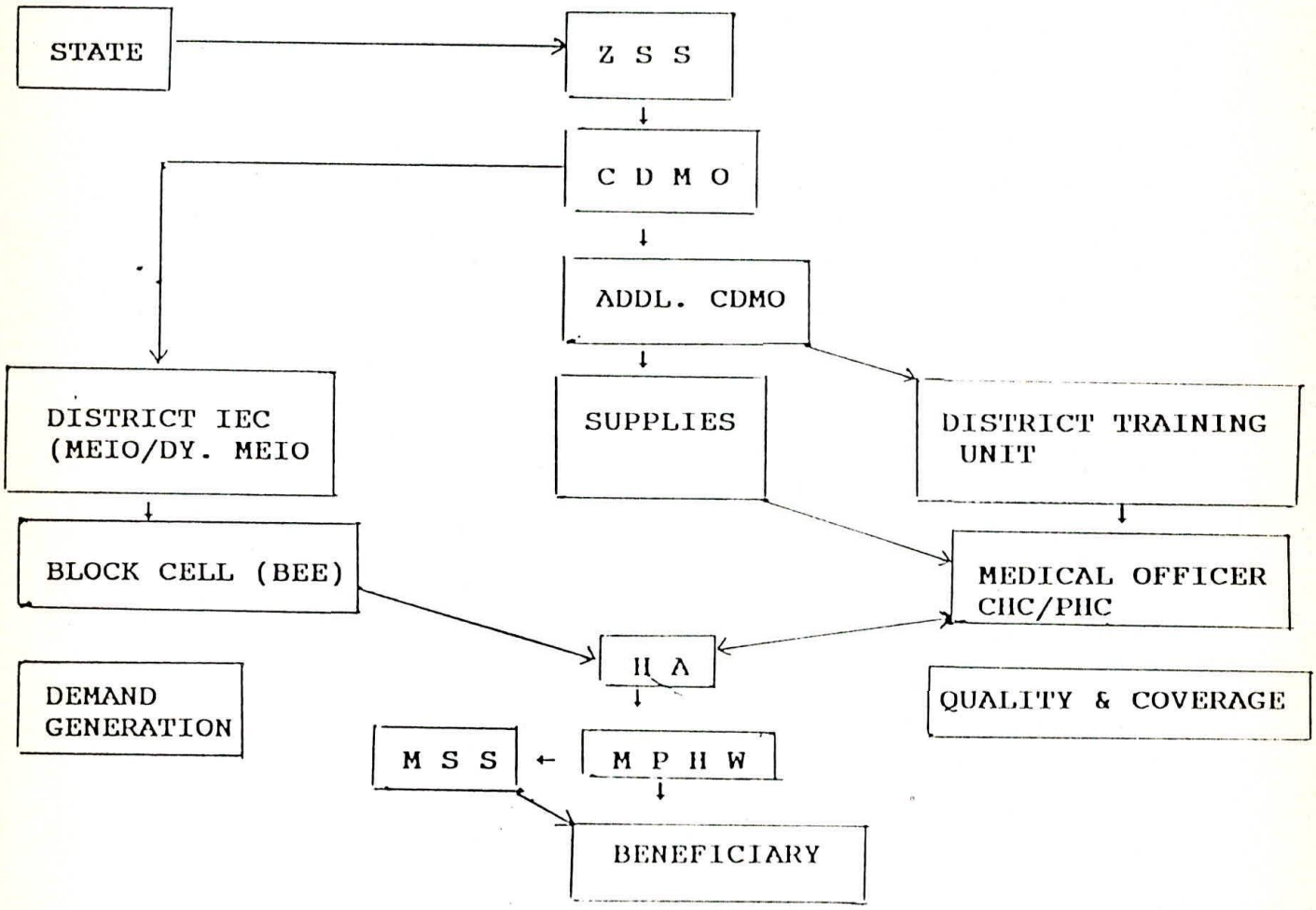
6:4 <u>STRENGTHENING THE HEALTH PROMOTION & SOCIAL MOBILISATION</u>

a) The strategies have been discussed extensively in the chapter 4. The most important aspect is the support and logistics required for the strengthening of Block Communication cells and District Communication unit.

b) ADP will provide financial, and technical support in strengthening the Block and the district in terms of :

* Equipment
* Furniture
* Transport
* Facilities for production of print materials
* Provision of Audio Visual materials

c) Both the block cell and the district unit will supplement the block teams and the district training teams.



6:5 DISTRICT HEALTH COMMITTEE/ZILLA SWASTHYA SAMITI

a) District should be made as the focal point of planning implementation & monitoring of all the health care services with support from the State. Govt. of Orissa realising the important role of the district health management system established District Health Committee called Zilla Swasthya Samiti under chairmanship of the district collector and CDMO/Addl. CDMO as the member secretary. The major objective of ZSS :

* **To obtain support of entire district level machinery for demand generation, quality & coverage of health care services, effective use of information in planning, implementation and monitoring of programmes and financial flexibility.**

- District level planning
- Decentralisation and delegation of administrative and financial powers
- Flexibility
- Effective use of information system

6:6 <u>CHANGES FOR PROPOSED MANAGERIAL EFFECTIVENESS</u>

1. It is proposed that CDMO will be overall in charge but his focus and attention will be specially on :

   - Hospital - Curative Care
   - Administration
   - Finance through ZSS
   - Public Health Matters

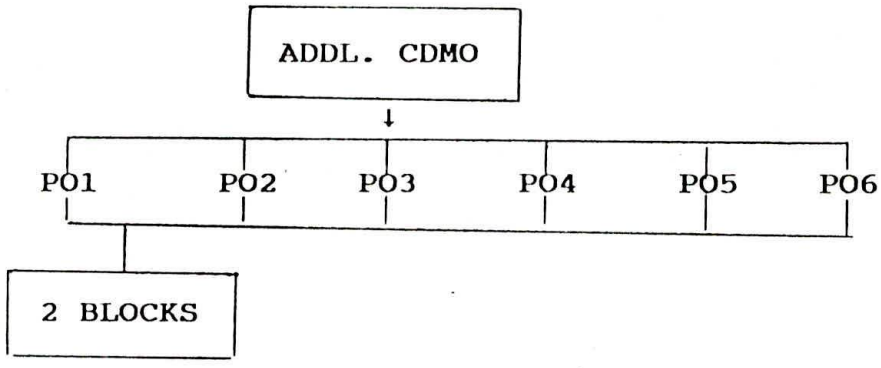
   The role of Addl. CDMO will be modified and he will be nominated to look after all the schemes which include the 5 health priorities of the State.

2. It is proposed that all the district level officers like DIO/DMO/DLO/DTO etc. will be instructed to review all the 5 health priority programmes of the State while they are on tour and keep Addl. CDMO and the respective programme officers informed.

3. It is proposed that the MEIOs will be entrusted with the responsibility for demand generation under the direct supervision of CDMO/Dy. Director (IEC). MEIOs will be directly responsible for establishing linkages with ICDS, education (literacy campaign) and MSS.

6:6.4 PILOT EXPERIMENT

All the individual programme officers will be redesignated as programme officer 1,2,3 etc. with definite area jurisdiction. They will be responsible for all the programmes under their jurisdiction under the direct supervision of Addl. CDMO.



The pilot experiment will be carried out in the district of Keonjhar for a period of one year. It is also preferable to take up one Phase-I and one non project district in this experiment. The experiment will be closely monitored for a period of one year and if successful it will be expanded through out the State.

6:6.5 SUBDIVISIONAL LEVEL

The present system of SDMO supervising the CHC/PHC will be restricted only to the referral system. The programme officers will directly supervise the CHC/PHC for all the programmes under the guidance of Addl. CDMO and overall supervision of the CDMO.

6:6.6 BLOCK LEVEL

a) At the block level, the BEE will be squarely responsible for all demand generation and coordination activities and with Medical officers service support, they will develop linkages with ICDS, adult literacy campaign, opinion leaders and MSS. They will work under the direct control and supervision of MEIOs.

b) MO of PHC/CHC will be responsible for services, logistic support for programmes.

c) BEE will be responsible in organising training programmes especially for MSS for demand generation where as MOs will be responsible for organising training programmes for services and support.

d) All the block level functionaries i.e; MO, BEE HA (F) & (M) will carry out their work and supervision as per the fixed day schedule (enclosed in annex II)

6:6.7 **VILLAGE LEVEL**

- HWS will strictly adhere to the fixed day schedule (enclosed in annex III)
- Training focus at this level will be more in skill development.
- The programmes at this level will be of a team approach. (HA, MPHWS, TBAS, VHG, MSS etc.)
- Village level workers will provide support to MSS/YC in each village.

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Draft

Activities of Health Supervisor-Female (LHV)

(a) TECHNICAL SUPERVISION

(1) Immunization:

- Sterilization of Needles and Syringes, Maintenance of Cold Chain and Immunization skill of Health Worker

(2) Maternal Care:

- Skill to conduct ante-natal check-up, weighing of the mother and babies, Care at birth, Post-natal visit of the previous week's delivery, Prophylatic anti-malarials to pregnant mothers (Keonjhar dist.)

(b) SUPPLIES AND EQUIPMENTS

- Physical verification of stock at Sub-centres and arranging replenishment of supplies

(c) TRAINING

(1) On the job training for health worker-female

(2) Supervising TBA training

(3) Mother's meeting

(d) SCRUTINY OF RECORDS

(1) Mother-Child Care Record

(2) Counterfoils of Mother-Infant Immunization Card

(3) Village-wise Coverage Register

(4) Eligible Couple/Acceptor Register

(5) Community Based Surveillance

(6) Ante-natal/Delivery/Post-natal Register

(7) Reporting Fee Disbursal Record

(e) *FAMILY PLANNING*

(1) *Follow up of IUD acceptors/Tubectomy*

(2) *Verification of IUD/Oral Contraceptives*

(f) *ORT/ARI*

- *Visiting any child of diarrhoea or ARI to assess home-practices of management and health workers skill to manage such cases*

(g) *ICDS*

- *Visit Anganwadis, monitor the progress of third and fourth degree malnutrition and follow up of referral cases*

(h) *SCHOOL HEALTH*

- *Health Education, promotion of personal hygiene and conducting school immunization.*

(i) *REPORTING*

- *Sector-level collation and compilation of reports*
- *Preparation of epidemic report*

(j) *AREA SPECIFIC ACTIVITY*

- *Supervision of malaria chemoprophylaxis (Keonjhar)*

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SAMPLE MONTHLY WORK PLAN[13] MPHW (F)

Week	Monday	Tuesday[14]	Wednesday	Thursday	Friday	Saturday[15]
First	Home Visit Village 1	FP services	SC (MCH) clinic	*Immun. Session Village 3	Home visit Village 5	Open
Second	Home Visit Village 2	FP	SC(MCH) Immun. clinic	*Immun. Session Village 4	Immun. session in hamlet(s) left out	Open HOL
Third	Home visit Village 3	FP	SC(MCH) Clinic	*Immun. Session Village 1	Home visit to hamlets	Open
Fourth	Home visit Village 4	FP	SC(MCH) Clinic	*Immun. Session Village 2	Immun. Session Village 5	Open
Fifth	For missed work on any day of above day due to leave or holiday and meetings					

* **Fixed immunization day as per state guidelines - not to be changed, wide publicity to be given.**

Must be done :

Updation of data
- Under 1
- Under 5
- ELCO
- Pregnant mothers
- Fever cases
- IUD insertion
- CC/OP distribution
- Immunization

Motivation for FP, MCH, Safe delivery, ORT & Chloroquin for fever.

[13] This is only a model workplan. This may be changed to suit local conditions. Mothers' meetings, contact with informants for community based surveillance and supervision of ORS/Chloroquine/Condom depot holders will be held as a part of the home visit or Immunization/MCH session at the village level

[14] This may be changed to some other day depending on the pattern followed in individual PHC areas. The activities of the corresponding day may accordingly be exchanged

[15] Open - state or district concerned may identifiy specific activities which can include, mothers' meetings, sectoral/PHC meeting, sessions in hamlets not covered on other days;

MONTHLY WORKPLAN OF HEALTH SUPERVISORS FEMALE (LHV)

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
First	Sub-Centre-6 Field Visits	Sub-Centre-5 Field Visits	Sub-Centre-1 MCH/ Immunization	Sub-Centre-4 Field Visits	Sub-Centre-2 Field Visits	Sector Meeting
Second	Sub-Centre-1 Field Visits	Family Planning Camps at PHC/ Sector	Sub-Centre-2 MCH	Sub-Centre-3 Field Visits	Sub-Centre-5 MCH/ Immunization	HOL
Third	Sub-Centre-4 Field Visits	Sub-Centre-3 Field Visits	Sub-Centre-3 MCH/ Immunization	Sub-Centre-6 Field Visits	Sub-Centre-1 Field Visits	Sector Meeting
Fourth	Sub-Centre-2 Field Visits	Family Planning Camps at PHC/ Sector	Sub-Centre-4 MCH/ Immunization	Sub-Centre-5 Field Visits	Sub-Centre-6 MCH/ Immunization	Sector Meeting
Fifth	Any missed activities on scheduled day. 1 mother's meeting per month			Last Working day PHC meeting		

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Male Supervisors' Activity Schedule

(1) Cross checking blood smears collected on the day or previous day.

(2) Check radical treatment being given/completed.

(3) Supervise the insecticidal spray during the spray period.

(4) Health education on environmental sanitation, personal protection against mosquito bites.

(5) Verify drug position in DDC/FTD and ensure replenishment

(6) Support vaccine transportation to SC in grey areas

(7) Supervise and update service/education skill of Health worker

(8) Verify maternal deaths, Neo-natal deaths and polio cases and seek Medical Officers help.

(9) Investigate Measles out-break and take up containment measures.

(10) Organize and supervise containment immunization for polio in his sector.

(11) Verify quality of ante-natal care given to all pregnant women, which includes education on nutrition, tetanus toxoid coverage, IFA coverage and referral if required.

(12) a) Group meetings for promoting vasectomies and condom use.

b) Regularity of use of condoms.

c) Ensure supply of Nirodh and oral pills.

d) Verify updating of Eligible Couple registers.

(13) Verify all diarrhoeal/ARI episodes of 24 hours duration.

(14) Supportive supervision for case assessment and management of the above and conducting of mothers meeting etc.

(15) During epidemics case management and containment measures for diarrhoea.

(16) Assess village level ORS availability and ensure ORS availability in each village through workers/volunteers.

(17) Verification of supply logistics as per the needs and ensure reallocation.

(18) Scrutinize record maintenance, local analysis and initiate necessary actions.

(19) Check drinking water sources, promote use of water from safe sources and educate personal and food hygiene.

(20) School health - personal health, provision of safe water and environmental sanitation.

(21) General sanitation -- Promote sanitary latrine, safe disposal of refuse (composting) and waste water (soakage pit)

(22) Verify all births and deaths and investigate cause of death.

(23) Investigate area specific health problems and initiate remedial action.

MONTHLY WORKPLAN FOR MALE SUPERVISOR

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
First	Visit to PHC	Field Visit Sub-Centre-3	Supervision MCH/ Immunization Family Planning Clinic Sub-Centre-5	* Sub-Centre-4	* NSS YSS Sub-Centre-2	Sector Meetings
Second	"	Family Planning Camp	" Sub-Centre-6	* Sub-Centre-3	Field Visit Sub-Centre-1	Sector Meetings
Third	"	Field Visit Sub-Centre-1	" Sub-Centre-5	* Sub-Centre-6	* Sub-Centre-1	Sector Meetings
Fourth	"	Family Planning Camp	" Sub-Centre-2	* Sub-Centre-5	Field Visit Sub-Centre-4	Sector Meetings
Fifth	Any missed activities on scheduled day . Collection and analysis of data					Meeting at PHC Last Working Day

* Community Day - Touring by Units

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WORKPLAN FOR BEE

WEEK	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
I	@ SC-1/13	RB/V Motivation	@ SC-5/17	* Sector I Support to MSS/YS Meeting	@ SC-9/21	Sectoral Meeting S-1
II	@ SC-2/14	FP Camp	@ SC-6/18	* Sector 2 Support to MSS/YS Meeting	@ SC-10/22	S-2
III	@ SC-3/15	RB/V Motivation	@ SC-7/19	* Sector 3 Support to MSS/YS Meeting	@ SC-11/23	S-3
IV	@ SC-4/16	FP Camp	@ SC-8/20	* Sector 4 Support to MSS/YS Meeting	@ SC-12/24	S-4
V	Review Health Education efforts and plan for next meeting		PHC meeting	--> Update Staff on 1 priority issue & essential communication points (1 hour)		

* *BEE will support 1 sub-centre in one sector/each week by rotation. One sub-centre in each sector will get his support, wherein he will use audio-visuals and conduct mass meetings.*

- *RB/V Motivation :*
  Resistant beneficiaries/village direct motivation

- *Sectoral meeting: To plan and implement problem/intervention specific publicity/demand generation efforts.*

Here numbering is given assuming that there are four sectors and each sector has got 6 sub-centres.

@ i) *Direct support to health workers, to improve their communication skills*

ii) *Contact Local influences (leaders) for FW/MCH/Insecticidal Spray*

iii) *Each sub-centre will be visited alternate months, and in the sub-centre all villages will be visited in each year.*

<u>Assumptions</u>: *1 BEE per Block PHC*
No. of sub-centres to be supervised = 24 = 4 sectors.

- <u>Tasks</u>: a) *Supporting to improve interpersonal communication skills of HWs.*
  b) *Demand generation for services*
  c) *Promoting utilization of services*
  d) *Mass Media activities*
  e) *Preparing area specific*
  f) *Ensuring of reaching of communication materials*

MONTHLY WORKPLAN OF MEDICAL OFFICER

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
First	OP/IP OP and Review with Male Supervisor	Field Supervision Sub-Centre-1 OP	OP/Immunization MCH Clinic	OP/IP Sub-Centre * Clinic 6	OP/IP Sub-Centre * Clinic 5	OP/IP Sectoral Review Sub-Centre* Clinic-4
Second	"do"	Family Planning Camp	"do"	OP/IP Sub-Centre Clinic 6	OP/IP Sub-Centre Clinic 5	OP/IP, SR Sub-Centre Clinic-4
Third	"do"	Field Supervision Sub-Centre-2 OP	"do"	OP/IP Sub-Centre Clinic 6	OP/IP Sub-Centre Clinic 5	OP/IP, SR Sub-Centre Clinic-4
Fourth	"do"	Family Planning Camp	"do"	OP/IP Sub-Centre Clinic 6	OP/IP Sub-Centre Clinic 5	OP/IP, SR Sub-Centre Clinic-4
Fifth	Last Working Day - PHC Meeting					

* Sub-centre clinics once a week in 2-3 farthest sub-centres.

CHILDREN BY CHOICE NOT CHANCE