

FAST TRACK CAPACITY BUILDING PROGRAMME

09TH August 2010 – 14TH August 2010



SECOND ROUND

**VENUE: IPH, NAMKUM, RANCHI,
JHARKHAND.**

DAY 1

The Fast Track Capacity Building Programme, Round 2 for the last batch commenced on the 9th August 2010 at Institute of Public Health, Namkum with participants and full team from 4 districts of Jharkhand (Bokaro, Palamau, Simdega, and Lohardaga) and DPMS from 6 districts namely Garhwa, Godda, Hazaribag, Ramgarh, West Singhbhum and Koderma. The team from Deogarh district could not attend the capacity building programme due to their involvement in month long Shravani Mela going on in their district.

After registration, the sessions began with a welcome note by Mr.Haldhar Mahto, Senior Coordinator PHRN and a round of introduction by the participants.

Resource Persons - Dr. Dinesh Jagtap (NHSRC), V R Raman, Balram and Haldhar Mahto

Session1: Inaugural Session

The **training curriculum** for the Fast track programme was briefed by Shampa Roy. It covers review of

- DHAP planning process in the state and suggestive framework.
- Planning for the vulnerable groups and vulnerable area.
- Workshop on Training Plan and Workforce Management.
- Overview of RKS & District Health Society, ROP & Fund Management and Epidemic Control and IDSP.
- Information about RSBY, TB, Maternal Health, Child Health and Process of HMIS
- Understanding of Community participation in DHAP and VHC and Sahiyya support.
- Intensive post training follow up and support to the application of these skills.

Pre-session questionnaire about the understanding about the District Health Programme by the participants.

The first session began by Mr.Haldhar Mahto who shared the objectives of the Fast Track Training Programme. The main objective of the programme was to refresh and evaluate the depth of understanding of the last training by the participants. Decentralised health planning is one of the five approaches of NRHM. The training was to be organised in 3 rounds altogether of which this was the 2nd round. And this round was to focus on post training skill assignment.

The training is expected to groom the participants to imbibe with **skills** to :-

- Draw up a district, block or village health plan and facilitate the implementation of the plan.
- Draw up a facility development annual plan given the resources made available to the Rogi Kalyan Samiti/Hospital development committee so as to provide quality care in IPHS defined services.

The immediate **institutions** to help the participants achieve this at the district level is by forming a

- A district planning unit acting in coordination with the district training team, link data and by having convergence with other departments.
- A state health resource center with the institutional capacity to support decentralized planning.
- A network of public health practitioners and public health professionals who are able to mutually enrich each others' learning and lead to a more relevant growth of this discipline.

Issues related to DHAP planning (2010-2011)

- The process did not focus on Team work and DPM's were only assigned to prepare DHAP.
- The format has to be revised (HSC population data was not correct).
- The team in the District (members of the team were from different PHC/ blocks) should be consulted.
- Support from the state should be provided to District Team.
- RCHO & ACO should have key roles in the team.
- Unit costs not mentioned so formulating the training budget was extremely difficult.
- Letter to DC and ICDS and other Departments

Session 2: DHAP Planning

Resource Person: Dr. Dinesh Jagtap

The session on Review of the DHAP Planning Process in the District by Dr. Dinesh Jagtap (NHSRC). He also presented and discussed about the details of DHAP Report preparation.

Five components of NRHM

1. RCH
2. NRHM Additionalities
3. Immunisation

4. National Disease Control Programme
5. Convergence

Preparation of DHAP:-

The DHAP would focus on the chapters acknowledgement, abbreviations, reference materials, planning, mapping of Health Services (Public and Private), donors in the District (Civil Societies and NGO), concerns, situation analysis, NHRM Goals and Analysis and discussion was held in detail on the framework of DHAP and each and every topic mentioned here. Many of the participants had been involved in the planning process and therefore had practical understanding of the problems and also suggested solutions.

Session 3: Planning for the Vulnerable Groups and Vulnerable Area

Resource Persons: V R Raman and Mr. Balram

Discussion was conducted by V R Raman about the vulnerable group and identifying their health needs. The vulnerable group consists on women, physically challenged, and mentally challenged, transsexuals and the old people. The importance of addressing vulnerability, marginalisation and exclusion of these groups was highlighted during the discussion.

Mr Balram discussed about identifying the vulnerable areas. To focus on vulnerable group the health worker should focus on specific planning rather than general planning. Jharkhand needs focused planning for Kalazar, Malaria, malnutrition in forest and hilly areas and the Tribal communities on the verge of extinct.

DAY 2

Session 1: Managing District Health Systems and Services (PHRN Book No. 11)

Resource Person: V R Raman

Mr. Raman started the session on the basics of Management. Management was defined as Input => Management => Output. He discussed about the difference between Management and Administration. Process of Management requires 6 M's (Men, Material, Machines, Methods, Money and Markets). Managing these resources with Planning/organising and Staffing and directing will give the desired output. He explained different aspects of management like Traditional method of management, human relations model, human resource model, DHS Management, CS/CMHO Office: Functions and skill sets, DPMU: Roles and Skill sets and Interface with PRI. Later Mr. Raman discussed about Work Force Planning, Work allocation, Environment that influences HRH Behavior, Health Worker's Motivation, Appreciative Inquiry, Meetings: Critical Issues and Knowing the Workforce. He

highlighted the importance of CHCs and PHCs as Institution to manage, ANMs: the key workforce and Sahiyyas: the dignified Community Volunteers.

Before Lunch break the participants were divided in three groups and each group was given a topic to discuss and complete the assignment. Assignment 1: Job Description for BPM & Hospital Managers, Assignment 2: ANMs Meeting Streamlining

After the presentation of group 2 some feedback came from the panel which was follows:

- Less discussion was there about systematic meeting .
- Start meeting with greeting of every participants and achievements of the month
- Penalty should be good practice for achieving the target
- Other motivation element should be cultural activity, intensive, appreciation.

Assignment 3: Rationalisation of Human Resource

After the presentation of group 3 feedback and suggestion given by the panel were follows:

- Presentation was not prepared on the given LFA framework
- Priority of rationalization was not clear

Session 2: ROP and Fund Management

Resource Person: Mr Tapan Chakraborty

Mr Tapan Chakraborty from CINI had done a study on Untied Fund and he shared his experiences and what he had seen in Tamil Nadu. Quoting examples from Tamil Nadu. He shared his study findings which was regarding fund utilization status, the study was done on the financial data studied of Orissa, Tamil Nadu, Rajasthan and Jharkhand state. Major finding of study was following:

- Fund not reached at time till February and March may state have not received the fund.
- Fund flow in draft to block and community eg Sahiyya leads to problem in encashing the amount.
- Opening of bank A/C of VHC is still a problem .
- In Tamil Nadu fund was released in two times once at March and another in October.
- In Tamil Nadu fund is transferred to ANM through by bank account.
- In Tamil Nadu,RKS fund released in June and November months. In PHC they installed solar light.

Some recommendation to utilize untied fund:

- Every year till May month fund should reach the PHC.
- Required lot of supportive supervision, more concentration on audit so that mistake can identified as soon as possible.
- Community participation should be increase.

Session 3

Resource person: Sudhir Kr. Jha

In this session resource person discussed the RSBY scheme with the participants. Some of the major points discussed were follows:

The objective of RSBY is to provide the insurance cover to below poverty line (BPL) households from major health shocks that involve hospitalization.

About 75%, is provided by the Government of India (GOI), while the remaining is paid by the state government. State governments engage in a competitive bidding process and select a public or private insurance company licensed to provide health insurance by the Insurance Regulatory Development Authority (IRDA).

In case of death of a family member, he can be replaced by another member who was not originally listed in the card. However, the name of this additional member should have been there in the BPL database available at the time of enrollment.

The registration fee of Rs.30 would be collected from the beneficiary by the insurance company and adjusted against the payment of premium to be made to the insurance company by the State Government.

Coverage under the scheme is being provided for BPL workers and their families (up to a unit of five). A family would comprise the household head, spouse and up to three dependents. The dependents would include such children and parents of the head of the family as are listed as part of the family in the BPL database.

If the family size is more than five, the head of the family would decide as to whom all should be left out. However, in case the name of the spouse is listed as part of the family in the database, the second member would necessarily be the spouse and the selection would be for the remaining three slots.

He also discussed the bottleneck for low patients under RSBY scheme were following:

- Backlog of JSY scheme
- Schedule of health camp are not well planned
- Incentive of sahiya for RSBY is not clear
- Food for patient provision is not clear
- Scheme is independent and no other scheme is attached with it

- Till date in Jharkhand only 35 patient have got benefit from RSBY

DAY 3

Session 1: Child Health Planning

Resource Person: Baruni Majumdar (IMNCI)

Ms. Baruni Majumdar discussed about the Child health planning, determinants of Child Health, and problems of Rural/Urban child health. She gave guidance for result based Planning, capacity building of the Health Workers close to the children, training them to recognize early signs of identifying child health problems. She highlighted the need for gap analysis. It's the gap between what was planned and the output. On working methodology she stressed that one should be S.M.A.R.T (specific, measureable, achievable, relevant and time bound) worker rather than simple worker.

Strengthening Comprehensive Newborn Care in National Rural Health Mission is the main objective of Integrated Management of Neonatal and Childhood Illnesses (IMNCI). Hence our planning should be Indicators and Survey based, it should have a target and timeline and budget should be made to get the desired output.

Special Newborn Care Unit (SNCU) Gatshila has been completed and three more SNCUs are being constructed in Jharkhand. These are RIMS Ranchi, Hazaribagh and Dhanbad Medical College.

Session 2: Exercise: Cluster Survey

Resource Person: Dr. Dinesh Jagtap

The objective of the Assignment was explained to the participants . Cluster Survey was introduced to them . It's a quantitative analysis. To get primary data with 95% confidence we need Cluster Survey. The goal of the Cluster Survey is to design a sampling method to estimate the objective with ± 10 percentage points of the true proportion, with 95% confidence. Each cluster should be a small scale representation of the total population. Dr. Dinesh explained how Cluster Survey is done. Where to collect data from? Why Cluster Survey should be preferred over NHFS and DLHS data. NHFS give state level data and DLHS gives District Level data. Here we don't have the clarity about Block Level and Panchayat Level data.

The method of village and cluster selection, preparation of questionnaire was explained and taught and then exercise was given to the participants which was to prepare questionnaire on Child Health , Maternal Health and Family Planning. The groups prepared the questionnaire and realized the importance of such studies in the field.

Day 4

Resource person- Dr. P. Baskey, Deputy Director (Malaria)

Topic- Epidemic control and IDSP

In the beginning of the session the resource person emphasised on the importance of IDSP programme, among all the public health diseases half of them were catered by the IDSP. Diarrhoea and Malaria like common diseases surveillance were done by syndromic survey and is done by health worker. There are 13 diseases of which surveillance was done by the district IDSP team. For district IDSP there are 4 member team headed by any health official and syndrome survey were done at the HSC level by the health workers of any fever, nausea with fever, polio were major surveillance programme. Rapid response team is online unit and directly send their report to district and then to state and from state to centre. IDSP have two major branch one is **data centre** whose task is to collect information, compilation of data then analysis and feedback on data. The second unit is **training centre**, and there are 800 sites for training.

Then RP discussed on the surveillance form for syndromic reporting. There are three type of forms which are following:

1. Form S- reporting format for syndromic surveillance
2. Form P- form for probability case
3. Form L- laboratory confirmed diagnosis form for Malaria, T.B and H1N1 cases

Then RP shared the reporting pattern for H1N1 done by the state IDSP team. Then he presents the power point presentation of IDSP reporting pattern.

Apart from district level health team community level surveillance and Sahiyya reporting system is also important. Community can report by dialing – 1075 (toll free No.) can be report any kind of community related problem.

He also mention about the rumors register, every HSC should maintain a rumors register and health worker visit the place of rumors and verified the site and entry on this register.

Then Dr. Baskey discussed the investigation of an outbreak situation in this presentation he discussed on unusual health event, etiology source and transmission source. Then he discussed the summary of outbreak investigation and response its syndrome trigger event and action taken. What is role of medical officer level investigation and probable diagnosis trigger event and action taken?

Session II

Resource person: Dr. Neelima Tirkey

Topic: Malaria control

To commence the session the district wise malaria endemicity in India through the map of India was shared. The general aspects of the programme was focused ie- introduction of RDTs which has enabled early diagnosis of falciparum cases and complete treatment by trained health workers and volunteers in the most remote areas of the country. This has resulted in availability of effective treatment in all parts of the country, thereby facilitating prevention of severe malaria and also breaking the chain of transmission. Emergence of chloroquine resistance in falciparum malaria has led to rolling out of ACT as the first line treatment. Indoor Residual Spray (IRS) had been the mainstay of vector control in the programme. Use of ITNs: Long Lasting Insecticidal Nets (LLINs) which are more effective have now been introduced by the programme.

The malarial indices were discussed with the participants .

After the presentation the group was given assignment of malaria with following objectives:

- To assess the understanding of the participants regarding the Indices used in Malaria Control Programme.
- To update, orient and refresh the participants on the strategies of Malaria Control.
- Understand the need and scope of district level planning on Malaria.
- To be able to integrate planning in their specific district and blocks.
- Enable them to supervise and monitor the activities related to Malaria Control.
- To be able to conduct Epidemic Investigation whenever need arises.

The participants were divided into small district wise groups assignments were given.

Lohardaga district worked on looking at the Pf proportion and the ABER and API in the different blocks and the reasons behind it.

Palamu district had to define the challenges faced for malaria control in the district. They had to state the steps they would undertake and what did they propose to do? The house gave them the feedback that they would have to work out their surveillance strategy more clearly, role of frontline workers need to be stated and active supervision strategies and challenges had to be defined.

Bokaro district had to develop a Capacity Building Programme for the Sahiyya's. The background information was provided to them for preparing the module. The feedback of the house was that objective of training should be clear, outcome of training also be clear like – what sahiyya is expected to do after training, method of calculation of training cost must be specified, national level training guideline should be referred to develop training content.

Simdega district - Case study was given to group and assignment on what treatment would be given to the patient. There was a lot of discussion on the National Drug Policy and the house was of the opinion that if you differ from the National Drug Policy Guideline you should have evidence based case history and data should be support your evidence.

West Singhbhum, Hazaribag, Godda, Garhwa etc distict – They had to do a the situation analysis of the given data and situation given to them and then had to prepare the interventions and determine the strategy for EDCT. In the feedback from the participants infrastructure and HR issues were highlighted but the plan lacked clear cut EDCT. Operational issues were not discussed too - medicine, trained staff, surveillance etc.

Day 5

Session I

Resource Person: Dr. Dinesh Jagtap, NHSRC

Topic: Guidelines on Maternal Health

In India 235 districts have been identified for high focus and it is relevant to mention that 8 districts have been identified in Jharkhand which are Sahebganj, Dumka , Godda, Deoghar, Jamtara, Latehar, Giridih, Chatra.

He specified that it is important to ensure that there is parity in resource allocation to the most backward regions of our country. There is a need of fast track improvements in health outcomes especially in reproductive and child health indicators.

To make difference in the district especially those with geographic, social and economic constraints but having the same technical and human resources is difficult and therefore there is a need of more resources and investment.

Then RP shared the major findings of JSY study done in 24 district of Jharkhand. During last few years Institutional deliveries have increased but the impact on maternal mortality uncertain/not optimized, because management of complications in public systems has been very limited. Management of complications in private sector not covered for costs no JSY or inadequate JSY.

Then he asked the participants about the % of delivery –

Complications are unpredictable and there are 15% complication case out of total delivery and 10 to 5% needed minimum cesarean. If in your district there is no facility to manage complication then the MMR will be high and there are some unreported cases too.

Then he shared the eight principles of the district plan and 3 delay during delivery. First delay is in recognizing the problem, second delay is in reaching the health facility and third delay is in receiving adequate treatment.

There are three level of care **Level 3:** Institutional Delivery – Comprehensive Level: Management of all complications – **OR** Comprehensive Emergency Obstetric & Newborn Care (CEmONC) / FRU

- C-section
- Blood Transfusion
- SNCU / NSU (Neonatal Stabilization Unit)

Level 2:- Basic Emergency Obstetric & Newborn Care BEmONC

- 24x7 services
- Delivery conducted by SBA – Skilled Birth attendant
- Newborn Stabilization Unit / Newborn corner

Level 1: Deliveries conducted by skilled birth attendant in all HSCs or in some PHCs which have not reached the level of 24x7 PHC.

- Newborn corner
- Home deliveries assisted by SBA

Session 2

Resource person: Dr. Suranjeen Prasad

Topic: Facility Readiness

The session started with the case study of :-

Post Lunch Session

Case 1 - Cardiac Emergency that last month a friend called me up at 9:30 in the night. He had severe Chest Pain. He was 40 years old. He wanted advice. I thought it was best to refer him for an ECG and other tests rather than suggest any medicines.

So I suggested he go immediately to..... RP asked the participants. The group response as follows:

- Continue with old medicine
- Take treatment within half an hour
- Go to nearest hospital with cardiology specialisation

Then RP summarise the answers that people gave suggested that he should be taken to the hospital on the basis of facility, C- section availability, ICU facility and emergency facility availability.

Case 2 - Then RP again shared a case study of road accident and asked the participants to what to do, where to refer these patient?

The participants gave their opinion to visit district hospital, X ray clinic first, near by hospital where every facility will available.

- Worried – because you are not sure if you have enough drugs and supplies
- Not worried – because you know the stock position and have already trained your staff to handle such emergencies.

It was discussed and understood that in emergency one will have to play the role of a doctor and manager.

Facility readiness – why, what to do and how are the major concerns. Why should my Health Centre be always ready?

- Community trusts Health Centre who are always ready?
- Able to provide timely help and save lives.
- Able to provide quality emergency services
- Able to plan and prepare early, rather than on-the-spot.

What to do?- Decide which health issue you want to be ready for.

- Decide by understanding local pattern of disease- Decide by local availability of staff, skills and resources-trauma, pregnancy and newborn related issues, severe malaria, safe abortion.
- Prepare Standard Operating Protocol for each of the conditions decided-The protocol is placed at the hospital, all staff are taught and revised on the protocols.eg- protocol for pregnancy and newborn (IMNCI), trauma, severe malaria
- Ensure that every day / week a review of supplies - essential drugs – misoprostol, IV fluids, etc, essential equipment's – functional, essential staff – always present, create a record book that will maintain this data. Seeing the case load , the reorder should be placed .
- Review every month- List all cases that have come to the health Centre, discuss quality of care, any problems faced, Make rules for what needs to be done for the new cases coming, if the cases are rare and no case reported, conduct mock drill.

At the end of the presentation RP told the participants to follow the leading ways to become leader and manager.

1. Develop knowledge and skills lacking for district health management.
2. Take initiatives at your own level to create a role model, it not essential that you are in leadership role.
3. Create environment for acting, working environment, quoted an example of Sarikela PHC where staff member prepare lunch for all staff.

Then RP shared the vision and mission of PHRN and motivated all to join the network for good cause.

Community Participation

Resources Person: Gurjeet Singh, Anup Hore

This session started with a **Before Session Opinion Poll**. All participants were given questions to give their opinion on the role of Sahiyya's and community participation(VHC) The main objective of conducting this opinion poll was to record the changes in views and opinions of the participants after the session.

Mr. Gurjeet briefed the participants on the understanding of the community. The concept of community in terms of caste, tribe, village was discussed. Levels of community participation in baseline study, programme activities, implementation, monitoring and evaluation and planning and design making were discussed in detail. He defined ASHA as a link worker, change agent, social activist and a community mobilizer. He explained, what is community, community participation and levels of community participation. He also informed them about Community Health Worker (WHO Study Group), guidelines of CHW. He shared the NGO experiences about Community Health Worker ie – SEWA , Jamkhed etc. Situation in Jharkhand was also discussed. He narrated about the Union Governments study and experience which was of very large scale but with poor outcome about CHW. The Mitanin Experience of Chattisgarh was shared. The roles and responsibilities of Sahiyya as per NRHM guidelines were discussed. Facilitator is the key to ASHAs success.

In an interactive session the participants discussed on different queries and there was also a debate on whether the ASHA should be paid ? The participants gave their views on different queries put up by Mr. Gurjeet. There was healthy debate about salary of the ASHA. He concluded the topic by saying that our society needs CHW, she is the first referral point, has more knowledge about health than other community members and is answerable to community.

Mr. Anup then facilitated the Assignments which were on :-

- Designing the Capacity Building Module for the VHCs and Sahiyya's terms batches, calendar, monitoring, and tools to be used for quality assurance, with budget allocations.
- What would be the mechanism to establish coordination among the ANM, AWW and Sahiyyas in order to improve the immunization coverage and consumption of IFA tablets? What could be the role of VHCs in strengthening this?

- How to regularize the incentive payment mechanism. Do you agree to make fixed honorariums for Sahiyyas instead of incentives? Give reasons and also suggest a mechanism
- Mechanisms to ensure opening of savings account for all the VHCs? What should be done so that the VHCs use the fund without any apprehensions and block level officials are demystified about the fund?
- Suggest a mechanism in detail, along with list of tools and processes, to implement the community based monitoring across the district. Draft the Monitoring and Supportive Supervision strategy of the

Post opinion poll was conducted, where comparatively it was seen that there was a paradigm shift in the opinion of the participants regarding the Concept of Community participation and role of Sahiyya .

Day 6

The day started with feedback of the previous day's session.

Process of HMIS

Resource person : Ekta Saroha, NHSRC

Dr Ekta Saroha started the session with the Essential Components of HMIS, importance of reporting as it reflects work done in state, performance of a block/district/state/country, future decision making, fund sanctioning and recommending to GoI. The single most important principle of an HMIS reform is to make HMIS geared towards supporting local planning and action – a tool of decentralisation. She presented the key features of HMIS, definition, format, data guidelines(HSC, PHC, CHC/SDH/DH) and indicator manual:

- Process of PODC-(Planning, Organizing, Directing & Controlling)
- Components of HMIS
- Data Sources
- Information Flow Guidelines
- Web-based data capturing system
- Key indicators to be generated for local level use
- Intelligent analysis for use at all levels
- Standard and Custom Reports- National, State and District Fact Sheets
- Integration of health related information across programmes

MIES Reporting Formats: HMIS Formats has three components:

- Monthly(Sub centre, PHC, CHC,SDH & DH)
- Quarterly
- Annual

Implementation

- Districts-Already implemented
- Block Level-Awaiting Training

Then she discussed the new formats of reporting at each level- state, district and block.

After that she presented how reports are generated and also discussed data outline and common errors- validation error and percentage error.

The training was concluded after presentation of the performance of pre and post session, general feedback . The resource materials was also shared with all the participants. Therefore the teams departed taking back the task of preparation of DHAP in their own districts.
