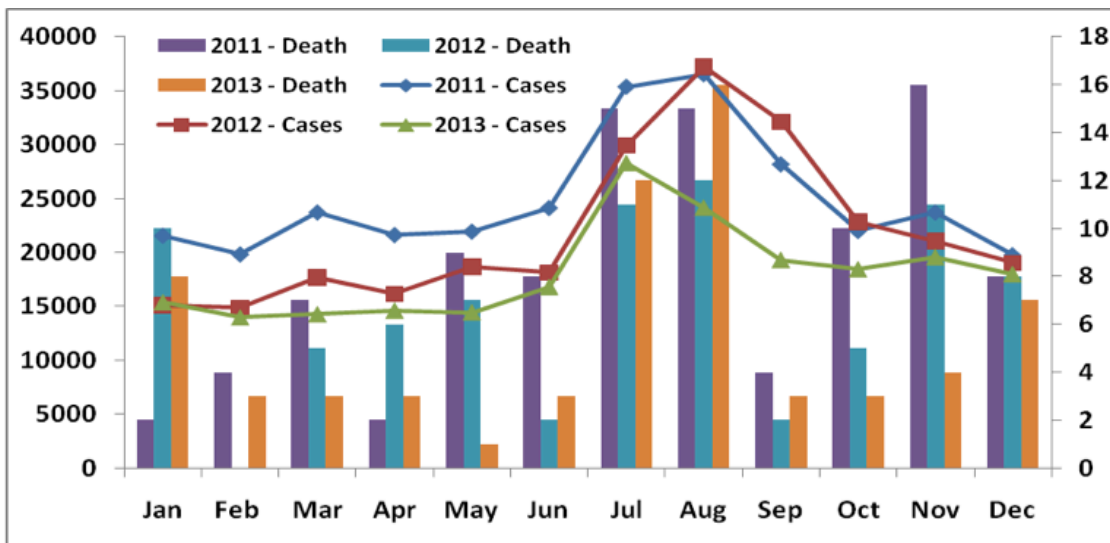
ODISHA TECHNICAL & MANAGEMENT SUPPORT TEAM: PHASE II

OCTOBER – 2014

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF ODISHA



PUBLIC HEALTH CADRE RESTRUCTURING AND CAPACITY BUILDING FURTHER DEVELOPED INCLUDING IN THE LIGHT OF FINDINGS AND RECOMMENDATIONS OF THE FACULTY OF PUBLIC HEALTH, UK

TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS 5

1. EXECUTIVE SUMMARY 10

2. BACKGROUND 12

2.1 Public Health Definitions 13

2.2 Public Health Functions 13

3. OVERVIEW OF THE PUBLIC HEALTH STRUCTURE IN ODISHA 15

3.1 Village level Sub Centres (SC) 16

3.2 Primary Health Centres (PHCs) 16

3.3 Block level-Community Health Centres (CHCs) 16

3.4 District and Sub-district level (District Headquarter Hospitals, Sub Divisional Hospitals, and Other Hospitals) 17

3.5 State level Directorate structure 17

3.6 Public Health Cadre Restructuring Process 18

3.7 Key weaknesses of the existing PH structure, which the new cadre strengthening and implementation plan is expected to address 18

4. PUBLIC HEALTH CADRE RESTUCTURING IN ODISHA 20

4.1 Proposed structure of the public health cadre 20

4.2 Key features of the PH Cadre: 20

4.3 Proposed Public Health Cadre Strength vis-à-vis Clinical Cadre (based on revision suggested by Finance Department in 2014) 22

4.4 Organization of the PH team at different levels 22

District level 22

Block level 23

Sector (PHC) level 23

Subcentre level 23

4.5 Financial implication of restructuring 23

4.6 Setting the priorities and taking them forward 23

5. STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS FROM THE SCOPING VISIT REPORT 25

5.1 Strengths 25

5.2 Weaknesses 25

5.3 Opportunities 26

5.4 Threats 27

6. WAY FORWARD: IMPLEMENTATION PLAN 28

6.1 Short Term 28

6.1.1 Strengthening the Structure of the state and district health administration 28

6.1.2 Dissemination and sharing of all the updated information with all the relevant stakeholders to get a common understanding on the PH system of the state 29

6.1.3 Defining and redefining job descriptions in consultation and agreed with PH Directorate and other key stakeholders 29

6.1.4 Development of database of the available PH workforce in the system with their qualifications, PH trainings and the competencies required for optimal delivery of their designated roles 30

6.2 Medium Term 30

6.2.1 Study the burden of disease of the state 30

6.2.2 Capacity Building /Training (Medium-Long term) 30

6.3 Long-Term 31

6.3.1 Development of PH Leadership Training Programmes 31

6.3.2 Strengthening of Existing training institutions under government 31

6.3.3 Strengthening the laboratory network in the state 31

6.3.4 Review of the PH Cadre in the state vis-a-vis the PH needs 31

6.3.5 PH Research 32

7. SUGGESTED WORK PLAN 33

8. CONCLUSION 42

9. ANNEXURES 43

ANNEXURE A: Detailed Structure of the Public Health cadre proposed in Odisha, September 2014 .. 43

ANNEXURE B: Concept note on strengthening public health cadre in Odisha through a partnership with Faculty of PH, UK 55

ANNEXURE C: Terms of Reference for an Public Health Consultant to Support Strengthening the Public Health Cadre in Odisha 61

ANNEXURE D: Report of the Scoping Visit to Bhubaneswar, Odisha 64

ANNEXURE E: Minutes of Meeting of Project Steering Committee of OHSNP, 23rd April 2014, with covering letter.. 74

ANNEXURE F: Minutes of the Annual review meeting of OHSNP, August 2014 75

10. BIBLIOGRAPHY 76

ABBREVIATIONS AND ACRONYMS

ADAPT	Area Development Approach for Poverty Termination
ADMO-FW	Assistant District Medical Officer - Family Welfare
ADMO-MED	Assistant District Medical Officer - Medical
ADMO-PH	Assistant District Medical Officer-Public Health
AIPH	Asian Institute Of Public Health
ANC	Antenatal Check Up
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BAM	Bachelor of Ayurvedic Medicine
BoD	Burden of Disease
BPHEO	Block Public Health Education Officer
BPHN	Block Public Health Nurse
CDMO	Chief District Medical Officer
CHC	Community Health Centre
CMAM	Community Based Management of Acute Malnutrition
CoE	Centre Of Excellence
CPD	Continuing Professional Development
CTM	Core Training Module
DFID	Department for International Development, Government of UK
DFW	Director of Family Welfare
DHH	District Headquarter Hospital

DHS	Director of Health Services
DLO	District Leprosy Officer
DMO	District Medical Officer
DOHFW	Department of Health and Family Welfare
DP	Delivery Point
DPH	Director Public Health
DPHO	District Public Health Officer
DPMSU	District Programme Management Support Unit
DSMO	Disease Surveillance Medical Officer
FD	Finance Department
FIMNCI	Facility based Integrated Management Of Neonatal and Childhood Illnesses
FPH	Faculty Of Public Health, UK
GDMOs	General Duty Medical Officer
GNM	General Nurse Midwife
GoO	Government Of Odisha
HEO	Health Education Officer
HFW	Health & Family Welfare
HO	Health Officer
HQ	Head Quarter
HR	Human Resources
HRMIS	Human Resource Management information System
HS-F	Health Supervisor-Female
HS-M	Health Supervisor- Male

ICMR	Indian Council Of Medical Research
IDSP	Integrated Disease Surveillance Programme
IIPHB	Indian Institute of Public Health Bhubaneswar
IIPHI	Indian Institute of Public Health India
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IPD	In Patient Department
IPHS	Indian Public Health Standards
JSSK	Janani Sishu Surakshya Karyakram
JSY	Janani Surakshya Yojana
LHV	Lady Health Visitor
MAE	Masters in Applied Epidemiology
MCTS	Maternal and Child Tracking System
MDR	Maternal Death Review
MHA	Master of Health Administration
MIS	Management Information System
MMR	Maternal Mortality rate
MO	Medical Officer
MO I/C	Medical Officer In charge
MoU	Memorandum of understanding
MPH	Masters in Public Health
MPHW-F	Multi Purpose Health Worker- Female
MPHW-M	Multi Purpose Health Worker- Male

NBC	Newborn Corner
NBSU	Newborn Stabilization Unit
NCD	Non Communicable Diseases
NHM	National Health Mission
NLEP	National Leprosy Eradication Programme
NPCB	National Programme for Control of Blindness
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NSS	National Sample Survey
NSSK	Navjat Sishu Surakhya Karyakram
NVBDCP	National Vector Borne Disease Control Programme
O & G	Obstetrics and Gynaecology
OH	Other Hospital
OHSNP	Odisha Health Sector and Nutrition Support Plan
OMS	Odisha Medical Services
OPD	Out Patient Department
PAHO	Pan American Health Organization
PGDPHM	Post Graduation Diploma In Public Health Management
PH	Public Health
PHC	Primary Health Centre
PHC-N	Primary Health Centre- New
PHFI	Public Health Foundation Of India
PNC	Postnatal Care

QA	Quality Assurance
RFP	Request For Proposal
RH	Rural Health
RMRC	Regional Medical Research Centre
RNTCP	Revised National Tuberculosis Control Programme
SC	Sub Centre
SDH	Sub Divisional Hospital
SHRMU	State Health Resource Management Unit
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute Of Health & Family Welfare
SNCU	Sick Newborn Care Unit
SRS	Sample Registration System
SWOT	Strengths, Weaknesses ,Opportunities, Threats
TA	Technical Assistance
TMST	Technical and Management Support Team
ToR	Terms of Reference
WHO	World Health Organization

1. EXECUTIVE SUMMARY

The Government of Odisha has undertaken a systematic approach to the reform of Human Resources for Health (HRH) in the State since 2007-8. Reform was needed to address the shortage of doctors, nurses and other health professionals, with doctor vacancies especially acute in remote areas. To accelerate improvement in key health indicators, which were much lower than the national average, and to meet expectations of service providers and users, the Department of Health and Family Welfare (DoHFW) has planned a number of changes to the structure and management of its human resources. They are supported in this through the DFID-funded Technical and Management Support Team (TMST) under Orissa Health Sector Plan (which later became the Odisha Health Sector and Nutrition Support Plan – OHSNP). The Logframe for OHSNP (2007-2015) has a 'Public Health Cadre Policy', as one of the milestones to be achieved.

The Public Health Cadre is envisaged to realise the State's public health goals and to help provide optimal primary health care to the community. A new approach to public health is needed to enable Odisha to meet the dual challenge of high burden of communicable diseases like malaria and tuberculosis plus an increasing incidence of non-communicable diseases such as diabetes and hypertension. Odisha is more than 80% rural, has a high proportion of vulnerable scheduled tribe and scheduled caste communities (22% and 16% respectively) and more than a third of the population is below poverty line.

Public health is primarily provided through the government health system. The public health service delivery system is doctor-centric and doctor-dependent, expecting doctors to do both clinical as well as managerial functions. However, a majority of doctors do not have adequate training, aptitude or experience in public health, and are promoted only of the basis of cadre seniority. The functional focus is on implementing various disease control programs, however, core PH functions such as surveillance, epidemic preparedness and response and convergent action action often do not get prioritised. Use of data and evidence for planning and management is poor and research is centrally driven and not necessarily linked to current public health needs. Diagnostic service availability is poor, particularly at levels till the district hospital

The concept of a dedicated public health (PH) cadre has been further developed following notification of the Public Health Directorate in 2009. Through a process of workshops, meetings, consultations and exposure visits to states which had a functional public health cadre, the Department of Health and Family Welfare has worked on a clear structure of its public health cadre. There is in-principle approval

for the Public Health Cadre from the highest decision making body, chaired by the Chief Secretary, and the final Cabinet approval is awaited.

Key features of the PH cadre as proposed include:

1. Creation of a dedicated Public Health Cadre for doctors and separation of Clinical streams from the Public Health stream, for postings at block level and above. Of the currently (September 2014) sanctioned posts of doctors at block level and above, 1354 doctors will be in the clinical cadre and 617 in the public health cadre, and 65 doctors will belong to the common cadre. Apart from these, 2769 positions will be below block level (base level), which will not be eligible for cadre separation.
2. Doctors to be inducted into public health cadre or clinical cadre will have to exercise their option for entering into concerned cadre.
3. Public health personnel will include doctors and paramedics as well as management persons with necessary diploma/degree/certificates.

The Department of Health and Family Welfare has articulated its' priorities, which are to strengthen the HR component of the public health delivery system at state and district levels, capacity building, PH management, better data management and surveillance, laboratory strengthening, and improved health sector emergency response.

In view of the imminent Public Health cadre notification, DFID and DoHFW, together with TMST, agreed a scoping visit by the Faculty of Public Health (FPH), UK would be useful to support next steps. Terms of Reference (ToRs) were developed for conduct of a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, leading to a roadmap and suggestions for the DoHFW to take forward. Dr Sushma Acquilla, International Faculty Adviser of FPH visited Odisha from 6th to 9th July 2014. The report from this visit is included in Annex D.

Subsequently, TMST has discussed with counterparts in the Department an implementation plan to be taken up during 2014-20. This incorporates components of the PH cadre restructuring document, and the road map developed during the FPH visit. The draft implementation plan is included in section 6 of this report. TMST will support this plan until March 2015 and further support from the FPH will be planned in agreement with the DoHFW and DFID. The DoHFW has indicated that it welcomes continuing technical support through DFID and other partners to roll out the implementation plan for Public Health in the State.

2. BACKGROUND

The Government of Odisha has already created a Public Health (PH) Directorate in the state through notification no. 149994/H dated 26.5.2009. Creation of a separate PH Directorate is a major step towards recognizing the importance of a public health perspective and acknowledging the disctinct skills and experience required for managing PH functions. At present, mid and senior level PH posts are filled by clinicians who do not have adequate training for those roles and until recently, had been reporting to the Directorate of Health Services, which focuses mainly on clinical service provision. Similarly, PH nurses reported to different management lines depending on whether they started as General Nurse Midwives (GNM) or Auxilliary Nurse Midwives (ANMs). The new Directorate brings together the functional responsibility for all cadres working in a designated PH position with focus on maximising potential of the existing personnel through an integrated approach.

The concept of a dedicated PH cadre has been proposed in Odisha, which would initially start with separation of PH doctors from clinical positions and over a period of time, include other PH professionals such as nurses, paramedics and PH managers to manage PH positions at different levels. Starting from late 2009, the state government's Department of Health and Family Welfare (DOHFW) has worked towards creating the PH cadre, with support from Department for International Development (DFID) supported Technical and Mangement Support Team (TMST). The PH cadre was envisaged by the state to realise its Public Health Goals and to help provide optimal primary health care to the community, using learnings from other states like Tamilnadu which have good, functional PH cadres resulting in better health indicators. The PH cadre will comprise of a dedicated group of PH professionals for optimal delivery of PH services at various levels in the government health services.

In a high level meeting chaired by the Chief Secretary of the State, it has already been decided to create a dedicated PH cadre in the State. Honourable Chief Minister of Odisha has also approved the creation of a separate PH cadre. The file awaits Cabinet approval as of October 2014.

Formation of a dedicated PH cadre is also one of the conditionalities of National Rural Health Mission (NRHM), linked to payment of a percentage of the NRHM funding allocated for the State – therefore the PH cadre in Odisha is a felt need of both the State and central governments. This has been one of the key recommendations of the National Task Force on PH (2009).

2.1 Public Health Definitions

The World Health Organisation (WHO) defines PH as “All organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.”

2.2 Public Health Functions

These are the fundamental set of actions that should be performed in order to achieve public health’s central objective of improving the health of populations.

The three main PH functions, according to WHO, are:

1. The *assessment and monitoring* of the health *of communities* and populations at risk to identify health problems and priorities.
2. The *formulation of public policies* designed to solve identified local and national health problems and priorities.
3. To assure that *all populations have access to appropriate and cost-effective care*, including health promotion and disease prevention services.

The Pan-American Health Organization (PAHO), through the Public Health in the Americas Initiative, defined the eleven Essential Public Health Functions necessary to strengthen PH practice, and developed a methodology that allows countries to evaluate their PH capacity. The Essential Public Health Functions are the following:

1. Monitoring, evaluation and analysis of heath status
2. Surveillance, research and control of the risks and threats to PH
3. Health promotion
4. Social participation in health
5. Development of policies and institutional capacity for PH planning and management.
6. Strengthening of PH regulation and enforcement capacity
7. Evaluation and promotion of equitable access to necessary health services

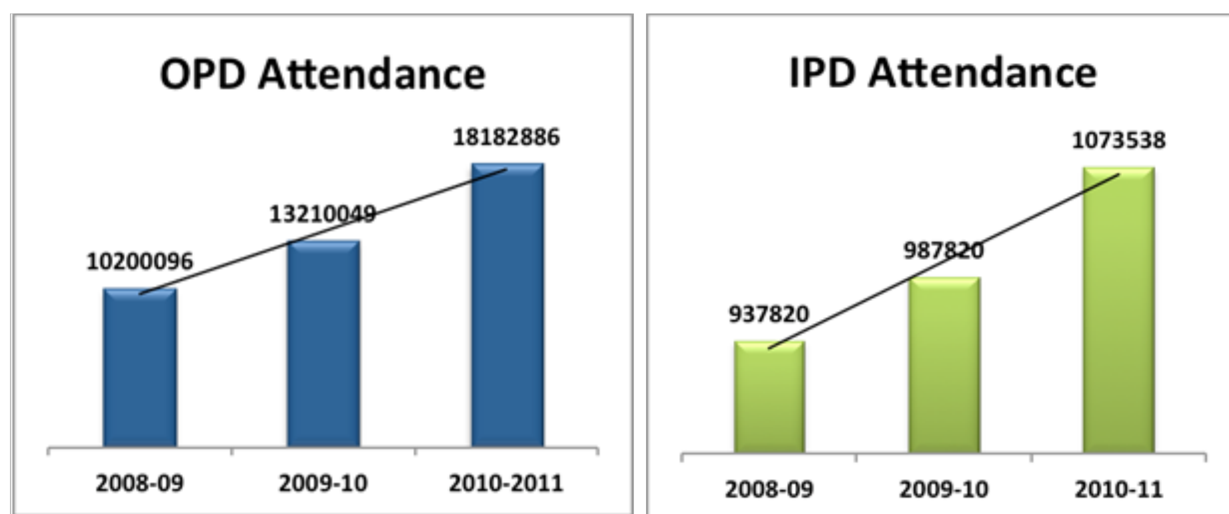
8. HR Development and training in PH
9. Quality Assurance in personal and population based health services
10. Research in PH
11. Reduction of the impact of emergencies and disasters on health

3. OVERVIEW OF THE PUBLIC HEALTH STRUCTURE IN ODISHA

Odisha faces many public health (PH) challenges today with disparities in health indices across the socio-economic classes, high cost of healthcare, an aging population, a large burden of communicable diseases, and an increasing burden of non-communicable diseases. The State has an Infant Mortality Rate (IMR) of 51 per 1000 live births (SRS 2013) and Maternal Mortality Rate (MMR) of 237 per 100,000 live births (SRS 2012), which is much higher than the national average (MMR of 178 and IMR of 40 respectively), despite recent progresses in mortality reduction.

Odisha has had a high dependence on the public sector system: approximately 80% of inpatient department (IPD) and 50% of outpatient department (OPD) services are accessed in Odisha through the public sector facilities (National Sample Survey (NSS) Round 60, Report No. 507: Morbidity, Health Care and the Condition of the Aged: January -June, 2004). Comparative figures for the country show that 40% of IPD services and 20% of OPD services are accessed from public sector facilities, which is half and less than half of the corresponding figures for Odisha! Comparison of NSS Reports of Rounds 52 (1995-96) and 60 (2004) show an increase in dependency on public sector health facilities in both urban and rural settings, as well as IPD and OPD services, in Odisha. More recent service statistics also show increasing demand for public sector IPD and OPD services (Fig 1). Thus, government sector health system continues to remain and is increasingly the principal means to deliver and contribute to policy goals in the State.

Fig. 1 Attendance at outpatient and inpatient services in Odisha (Source: HMIS reports, DoHFW)



In Odisha, government health services are provided through a set of organized Public Health Institutions and workforce (work force engaged at different levels starting from village to state level mostly through

the public (government) sector). Involvement of the private sector in public health is on a much lower scale, and mostly limited to civil society organisations (CSOs) and missionary health institutions.

The PH institutions in the government sector include 6,688 Sub Centers (SC), 1,226 Primary Health Centers (PHC), 79 "Other Hospitals" (single doctor), 377 Community Health Centers (CHC), 5 Public Health laboratories and 5 Public Health Training Institutions.

3.1 Village level Sub Centres (SC)

The SC provides basic minimum health services. There are 6,688 SCs with an average of 1 SC for 5,000 population in plain areas and 1 SC for 3,000 population in hilly and tribal areas. SC is the most peripheral unit of the health system. It has one male multipurpose health worker (MPHW-M) and one female multipurpose health worker (MPHW-F, also known as Auxiliary Nurse Midwife (ANM)). There is one additional ANM provided under National Rural Health Mission (NRHM) in 859 SCs. One lady health visitor/MPHS-F (LHV) supervises 4-6 SCs. In many SCs across the State, the MPHW-F is the only human resource available at SC level.

3.2 Primary Health Centres (PHCs)

There are 1,226 PHCs in Odisha (these were earlier designated as PHC (New), and have been re-designated as PHC) with an average of 1 PHC for 30,000 population in plain areas and 20,000 population in hilly/ tribal areas. 4-6 SCs are covered by one PHC. PHC is the first contact point between community and the medical officer and also the first referral point for the SCs. There are few (4-6) observation beds for patients in some of the PHC. Each PHC has two Medical officers (MO) – one from allopathic system and one from the Department of Ayurveda, Yogo & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) system provided under NRHM. Although different norms are provided under Indian Public Health Standards (IPHS), the PHCs in Odisha are have a pharmacist, a MPHW-F and few other support staff apart from the two MOs. The major activities of PHC involve basic curative (primary level of care), preventive, health promotion activities and family welfare services.

3.3 Block level-Community Health Centres (CHCs)

There are 377 CHCs in Odisha’s 314 administrative blocks with an average of 1 CHC for 120,000 population in plain areas and 80,000 population in hilly and tribal areas. Roughly 4-5 PHCs are covered by one CHC. CHCs are the first referral point between community and the Medical Institution with specialist facilities. As per IPHS, the CHC should have one each of the following specialists: general

medicine, surgery, obstretrics and gynaecology (O&G), paediatrics and PH. But in Odisha, the pattern of specialists in the CHCs is not uniform. 109 CHCs have all the four specialists, 114 CHCs have two specialists (O&G and paediatrics) and remaining CHCs have the post of one O&G specialist only. CHCs are responsible both for curative (secondary level of care) and PH functions along with health promotional activities.

3.4 District and Sub-district level (District Headquarter Hospitals, Sub Divisional Hospitals, and Other Hospitals)

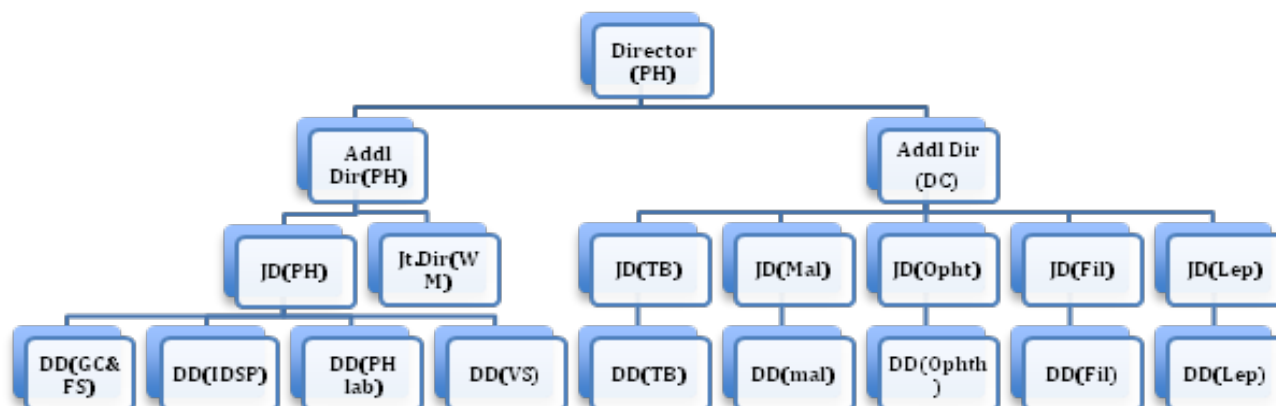
Apart from the above mentioned set of health institutions, which provide primary and secondary level of health care in rural areas, curative care is provided by another set of secondary and tertiary health units which include 3 Medical Colleges, 32 District Headquarter Hospitals (DHH), 27 Sub Divisional Hospitals (SDH), and other speciality hospitals (TB Hospitals, Leprosy Home and Hospitals and "other rural hospitals" (OH)).

At district level, the PH activities are performed under the leadership of the Assistant District Medical Officer - Public Health (ADMO-PH). All the PH wing officers of the district level, which are Disease Survelleince Medical Officers (DSMO), Disrtict Malaria Officers (DMO), District Leprosy Officers (DLO), etc report to this person. All districts have the same personnel structure under PH, irrespective of size.

3.5 State level Directorate structure

The structure at the level of Directorate of Public health is as follows:

Figure 2- PH Directorate at the State level



PH:	Public Health	Addl Dir:	Additional Director	DC:	Disease Control
JD:	Joint Director	DD:	Deputy Director	WM:	Waste Management
TB:	Tuberculosis	Mal:	Malaria	Opht:	Opthalmology
Fil:	Filariasis	Lep:	Leprosy	VS:	Vital Statistics
IDSP:	Integrated Disease Control Project			GC & FS:	Goitre Control and Food Safety

3.6 Public Health Cadre Restructuring Process

Key milestones

Year	Milestone/ Process	Documents Available
2009	Creation of Post of Director of Public Health (DPH)	Notification
2010	DPH Declared as Head of Office	Resolution
2011	Workshop on Public Health Phase-I	Workshop Report
2011	Work Shop on Public Health Phase-II	Workshop Report
2011	Work Shop on PH Phase-III	Workshop Report
2011	Exposure Visit to Tamilnadu	Visit Report
2011	Exposure Visit to Maharastra	Visit Report
2011	Stakeholder Consultation with Asian Institute of Public Health (AIPHB)	Consultation Report
2011	Draft Note on TOR of PH Functionaries	Note
2011	Formation of a Committee on Creation of PH Cadre	Government Order
2012	Draft Note on Creation of PH Cadre for DOHFW and Finance Department (FD)	Note
2013	Meetings Held with Chief Secretary, Honourable Chief Minister of Odisha and Revised Modalities Agreed Upon	Minutes of Meetings
July 2014	Draft Note on Cabinet Memorandum	DOHFW/ FD File
August 2014	Cabinet Memorandum moved with Finance Department	File Movement

3.7 Key weaknesses of the existing PH structure, which the new cadre strengthening and implementation plan is expected to address

In general, the whole PH service delivery system is doctor-centric; expecting doctors to do both clinical as well as managerial functions. Most of the doctors are not qualified in PH nor do they have relevant training. There are a few non-medical PH professionals in the system. The functional focus is on implementing the various disease control programs and not on the core PH functions like surveillance,

epidemic preparedness and response, inter-sectoral convergence and evidence based action. Research in PH is poor and laboratory services nearly non-existent in primary and secondary levels of care.

Focus on surveillance, inter-sectoral activities and other disease prevention activities is low. The whole issue of PH delivery in urban areas needs focused attention.

The Odisha Medical Services Cadre to which all the doctors of the peripheral cadre belong, continues to be a single cadre characterized by doctors with clinical and administrative experience. This holds true even for those holding the PH positions in the new PH Directorate. Most of them do not have a PH qualification and are promoted on the basis of seniority regardless of their background.

Other PH positions like entomologists, microbiologists and other non medical PH specialists need to be introduced into the system.

Doctors seconded to the bigger municipalities as health officers do not have any specific PH qualification nor any exposure to issues in urban health.

Mechanisms for inter-sectoral coordination with other departments are relatively poor and joint review opportunities not structured with clear-cut accountabilities.

The DOHFW seeks to establish a clear strategy and structure to deliver the essential PH functions through the formation and roll-out of a PH cadre. This would require setting the priorities within the system.

4. PUBLIC HEALTH CADRE RESTUCTURING IN ODISHA

4.1 Proposed structure of the public health cadre

Health workforce is central to advancing health. The health sector, more than any other sector, depends on people to carry out its functions. In any health care system, it is health workers— professionals, technicians, and auxiliaries—who determine what services will be offered; when, where, and to what extent they will be utilized and as a result, what impact the services will have on the health status of individuals. The success of health activities depends largely on the effectiveness and quality with which these resources are managed. Health personnel comprise not just individuals but integral parts of functioning health teams in which each member contributes different skills and performs different functions. Developing capable, motivated and supported health workers is essential for achievement of national and global health goals.

The PH cadre would comprise but not be limited to:

1. In service personnel from Odisha Medical Services (OMS) Cadre and select personnel responsible for PH activities from nursing and para-medical cadre. These health personnel will have to undergo PH training like certificate courses, diploma or degree in PH if not included in their current qualification.
2. NRHM and contractual personnel responsible currently for PH Management and administrative functions. They too will need to obtain a recognized PH qualification through full or part-time study or tailor-made courses.
3. PH Specialists- Doctor of Public Health (DPH), Master of Public Health (MPH), Masters in Applied Epidemiology (MAE), Post Graduate Diploma in Public Health Management (PGDPHM), Doctor of Medicine (MD) Community Medicine, Doctors with Diploma in PH and , fresh Bachelor Medicine, Bachelor of Surgery (MBBS) graduates with experience PH service delivery in field for minimum period of 5 years (at PHC or CHC) will be considered for lateral entry into PH cadre.

4.2 Key features of the PH Cadre:

Key Features of PH Cadre:

1. A dedicated PH Cadre is created and clinical streams is separated from the PH related activities. This will strengthen both clinical and PH services in the state at community level. (Annexure-A)

2. Separation of PH cadre is to be made at the Block level (CHC) institutions and downwards. These institutions will include,
    a. 377 CHCs (carry out both clinical and PH functions)
    b. 1,226 PHC-N,
    c. 79 OH (single doctor health institutions functioning as Hospitals) and
    d. 6,688 SCs doing exclusive PH work including treatment of minor ailments and activities under national and State programmes.
3. PH cadres/personnel should not necessarily include doctors and paramedics but also will include management persons with diploma/degree/certificate in PH or PH management (MPH, Master in Health Administration (MHA), Doctor of Public Health (DPH), PG DPH, Post Graduate Diploma in Epidemiology, Rural Health management etc.). Management professionals having requisite public health qualification (degree/diploma/certificate) already working in health sector under DOHFW will be preferred.
4. Doctors to be inducted into PH cadre or clinical cadre will have to exercise their option for entering into the concerned cadre.
5. Doctors opting for PH cadre must possess degree/diploma/certificate in PH as mentioned earlier. Doctors having experience of working in PH Institutions (CHC/PHC/PHC-N/ Municipality as Health Officer (HO) for a minimum period of 5 years may also be considered. Newly appointed Doctors opting for PH cadre without having requisite above mentioned PH qualification will have to do minimum a DPH within next 5 years or before promoting to next higher grade.
6. ADMO (PH) is re-designated as District Public Health Officer (DPHO) and will function as Head of Office for all PH Programmes at the district level and below. But for administrative point of view and better coordination s/he will report to Community District Medical Officer (CDMO) of the district.
7. CDMO will be preferably from PH back ground. CDMO will be responsible for effecting better coordination between PH and clinical stream at the district level and will report Director of PH for PH programmes and to all other directors as usual as per programme need.
8. ADMO (FW) will functionally report to DOHFW but will be included under PH cadre.

Details of the PH team structure at various levels is annexed (Annexure-A).

4.3 Proposed Public Health Cadre Strength vis-à-vis Clinical Cadre (based on revision suggested by Finance Department in 2014)

Sl. No	Grade	Total Number	Clinical Cadre	PH Cadre	Common cadre
	Super Time (SS)	1			1
1	SAG	5	0	0	5
2	SG (Floating)	28	0	0	28
3	Jr. Adm. Gr Lev-I	120	80	9	31
4	Lev-II	431	327	103	0
5	Sr. Class-I	1451	946	505	
	Total		1354	617	65
6	Jr. Class-I	2769			
	Grand Total	4805			

4.4 Organization of the PH team at different levels

District level

At the district level, other than the doctors, none of the other cadres are currently being divided into a PH cadre. However, all functionaries discharging PH activities at various levels in the district will form a PH team at that particular level.

The NRHM personnel at various levels, performing PH functions, like District Programme Manager, Block Programme Manager etc. will also be part of the district PH team.

The ADMO (PH) will be the nodal person at the district in charge of PH activities. He will have a team of District Tuberculosis Officers (DTO), DLOs, DMO and DSMO. The role of the DSMO is to be reoriented towards undertaking surveillance activities. The other officers will be in charge of their respective programs. All of these positions are planned to be be held by persons with PH qualifications.

Block level

At the block level, the facilities will be under the charge of a PH qualified/trained doctor. The clinical duties will be carried out by the General Duty Medical Officers (GDMOs) and Specialists. The Medical Officer Incharge (MO I/C) will be assisted in PH activities by the Health Supervisor- Male (HS-M), Health Supervisor- Female (HS-F, otherwise designated as the LHV), Block Public Health Education Officer (BPHEO), Block Public Health Nurse (BPHN), Laboratory Technician and Ophthalmic Assistant. The MO I/C at the block level will supervise the activities of all PHCs in that block.

Sector (PHC) level

At the PHC level, if the doctor incharge does not have a PH qualification, s/he will be trained to supervise PH activities through a short training course. The doctor will be assisted in PH functions by a team of HS-F and HS-M. The health supervisors will supervise the work of MPHW-M and MPHW-F.

Subcentre level

The SC will continue to have a MPHW-M and MPHW-F. The activities at the SC will be supervised by the MO I/C PHC.

The district teams will be primarily incharge of implementing the PH activities as planned. Their main activities will revolve around the four areas of health promotion, health protection, health service delivery and surveillance.

4.5 Financial implication of restructuring

The entire exercise in restructuring is leading to redesignating and redefining the job responsibilities with focus on PH (preventive, promotive) and clinical care. Hence no additional salary cost is involved at present. Expenses required for implementation can be expected to be met from NRHM funding pool (PH strengthening is within the mandate of NRHM) for the time being and later budgeted in regular budget after due concurrence from FD, Government of Odisha.

4.6 Setting the priorities and taking them forward

The government's priorities for strengthening of the PH delivery system are mentioned below and are proposed to be undertaken in a phased manner:

1. Strengthening the HR component of the PH delivery system at the state and district levels in order to respond to PH challenges
2. Training and skill development in PH for the PH personnel

3. Improving PH management including implementing annual planning to avert outbreaks, developing and refining protocols for outbreak response, control and investigations
4. Strengthening the state PH infrastructure including PH laboratories
5. Strengthening PH monitoring and surveillance through improved data collection and management
6. Improving disaster and emergency response in health sector

To take forward implementation of the PH cadre in the State, the DOHFW agreed to invite the FPH, UK, to conduct a SWOT analysis and roadmap for PH in the State. ToRs were developed, based on discussions between Government of Odisha, TMST, DFID and FPH, UK. This was followed by a scoping visit by Dr Sushma Acquilla, International Faculty Adviser of FPH from 6th to 9th July 2014. The Concept Note for the visit, ToRs and the Scoping Visit Report are annexed (Annexure B, C and D). Meetings were organized with key stakeholders, and a tentative roadmap developed, which was shared with all stakeholders.

5. STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS FROM THE SCOPING VISIT REPORT

5.1 Strengths

1. An initiative to establish the PH Cadre in the whole State of Odisha that has been approved and backed by the Government from the very senior level is a positive starting point.
2. Presence of a number of PH and related organizations in Odisha, that have wide variety of expertise and experienced workforce in them e.g. AIPH, Indian Institute of Public Health (IIPH), Bhubaneswar/ Public Health Foundation of India (PHFI), TMST funded by the DFID and the people working in the Unit.
3. In our meetings with all the organizations, we found that all expressed their desire to collaborate in the development and implementation of PH Cadre.
4. There is already established Directorate of Public Health and Mission Director National Health Mission (NHM), all giving their support to the initiative.
5. Sanction of necessary funding from the Government of Odisha to make it happen.

5.2 Weaknesses

1. The agreement to have a separate PH Cadre was initially floated in 2009 and decision taken to have public health cadre taken in principle, approved over two years back in 2011. The system is hierarchical and once approved at higher level, does not need further consultation or approval from those who have recently entered the system yet they may not be on-board.
2. The approval was with the FD for funding approval and has recently been put up as a Cabinet Memorandum. Implementation has been suggested, based on the approval of the cadre. No earlier study on the SWOT analysis has been carried out.
3. There is implicit understanding throughout that there is a shortage of trained medical and nursing staff in PH. Hence the required numbers could not be met from existing workforce within the system for immediate implementation of required PH Cadre.
4. Current PH workforce is medically led and any introduction of other professions entering to provide PH services could be initially resisted strongly by those already in the system.
5. Although various PH priorities have been identified in the meetings with different groups but I could not see the evidence of agreed priorities listed centrally. There is also some understanding on the service delivery at different levels but that may not be clearly visible to all concerned within the existing structure or organization.

6. Although there is information with the State Human Resource Management Unit (SHRMU) on those who are PH trained through government sponsorships and are currently in the system, who could possibly take on the senior positions or be role models, it is not widely available, and a comprehensive list of all personnel who have undergone training, including self-funded personnel is not available.
7. Current system of promotion that is linked to the seniority rather than level of training or expertise, in the system is so well established that any changes to it to develop one specialty cadre might get in the way.
8. In practice there is an implicit rule, followed by those in the State Government that they do not support recruitment from outside the state to build the required workforce. Hence this could hinder the progress in developing PH workforce in the State, at least in the short-term or interim. However, NHM does offer the opportunity of open recruitments, which could be worked favourably to resolve this shortage in the short-term.

5.3 Opportunities

1. The timing of this scoping study and the fact that it has been explicitly expressed clearly that the PH Cadre will be developed in Odisha, has been good for all those involved to get a confirmation from the top and also to bring in partnerships in the areas that need strengthening.
2. Opportunity to get explicit collaboration going between all the PH and related organizations present in the State at the back of this development of PH Cadre, is likely to be more acceptable.
3. Strengths of the organizations like IIPHB/PHFI and AIPH in provision of necessary courses and training has been expressed clearly in terms of developing the capacity that they have and are willing to offer.
4. Opportunity to systematically assess the functions required to be delivered by PH at different levels and the competencies that would be required for the workforce for delivery of such functions.
5. The Government of Odisha has currently increased the age of retirement of its employees by an additional two years, which gives a window of opportunity for training mid-level and senior personnel, who will mostly remain in the same positions for the next two years.
6. As there is an agreement to provide additional places by medical colleges to address the shortage of medical graduates to populate the required manpower, as it is proposed that up to five medical schools/institutions will be set up in the next few years. There is an opportunity to

help develop the PH in the undergraduate curriculum to help develop the recognized PH cadre. However, this would not deliver the numbers required in the interim phase.

5.4 Threats

1. There has been a lot of changes in the manpower with several new positions filled in the last one year. With recent elections, and new personnel in position, not all newly appointed personnel are fully aware of the developments made in last two years. There can be no assumptions, that it would all be accepted as given by all newcomers.
2. Plans for an implementation of the cadre on competency based criteria without working out the clear roadmap and getting a buy-in from the existing seniors in the system, might create dissatisfaction among seniors who are used to a seniority-based promotional avenue rather than competency based systems. This is particularly difficult as it would be moving away from currently accepted government rules and practice.
3. With the approval of funding coming through, there may be some urgency to demonstrate the progress in the implementation of PH Cadre so as not to lose the momentum and the right political climate for change.
4. Those already in the system have seen many consultative workshops and documents. Some have had recent exposure visits to other states to help those who may be in the similar position to share experience on development of structure and organization of the cadre and consultations within medical fraternity and policymakers. Combined with the in-principle approval from the Chief Minister of the State, is a systematically planned work. However, this needs to be backed with a detailed roadmap for successful implementation.

Based on the recommendations of the FPH scoping visit, the Implementation Plan has been developed with support from TMST.

6. WAY FORWARD: IMPLEMENTATION PLAN

Once the PH cadre is notified, the following activities will be taken up:

a. Finalisation of job descriptions for all positions in the PH cadre keeping in view the revised focus on PH.
b. Development of training and reorientation modules, and identification of institutions for collaboration on training; roll out of training courses
c. Finalisation of recruitment rules including qualifications, and criteria for recruitment
d. Development of posting, promotion and leave rules for the cadre
e. Framing rules for pursuing higher education

Implementation of the PH Cadre requires a huge amount of work to get the desired results. Since the present directorate needs substantive strengthening in terms of administrative and functional requirements, a very systematic and scientific approach is required to equip it to take up the challenges. The DOHFW acknowledges the need for good quality and sustained technical inputs and expertise, evidence from within and outside the country and linkages with national and international institutions and experts, in order to develop and support implementation of area specific strategies and workplans for PH. In the Project Steering Committee meeting of the Odisha Health Sector and Nutrition Support Plan (OHSNP) held on the 23rd of April 2014 (minutes at Annexure E) as well as the annual review of the OHSNP held in August 2014 (DoHFW minutes at Annexure F) and on many other occassions, the DOHFW has clearly asked for DFID technical assistance (TA) support to take forward work on the PH cadre beyond March 2015. DFID has been, and continues to be, one of the core partners supporting systems strengthening including PH cadre strengthening in the State of Odisha.

The proposed "Public Health Cadre" shall have the following implementation plan and key features (with indicative areas for external TA support) over the short, medium and long-term, based on which the detailed workplan is suggested later in the document.

6.1 Short Term

6.1.1 Strengthening the Structure of the state and district health administration

Block level CHC will be the base for bifurcation of clinical cadre and PH Cadre. PH Institutions will cover health facilities from block level and downwards and will include 377 CHCs, 1,226 PHC, 79 "Other

Hospitals", 6,688 SC as well as urban health centres. Post of doctors below CHC level shall not be covered under PH Cadre. These posts will be included in the common cadre. PH cadre and personnel will not necessarily include only doctors, nurses (public health) and paramedics but also will include management persons with diploma/degree/certificate in PH or PH management (MPH, MHA,DPH, PG DPH, PG Diploma in Epidemiology, Rural Health management etc.).

The key activities envisaged are:

I. Defining the structure of the PH workforce.
II. Exercise of options for PH or clinical cadre based on appropriate qualification criteria as a prerequisite to the corresponding cadre post.
III. Cadre Rules will be prepared for the PH cadre. Promotion and service conditions of PH cadre will be governed by these rules once it is notified by the government. This will be notified to avoid confusion**.**
IV. Management professionals having requisite PH qualification (degree/diploma/certificate) already working in NHM and through development partners under DOHFW are brought into the PH cadre fold.

6.1.2 Dissemination and sharing of all the updated information with all the relevant stakeholders to get a common understanding on the PH system of the state

I. Listing of all the steps chronologically (meetings/ workshops, exposure visits, discussions, Govt. Orders and Notifications regarding the consensus reached for PH cadre).
II. Dissemination workshop for sharing of updated information with all stakeholders for a common understanding and getting them on board on the outcomes, outputs, functions and activities on short-term, medim-term and long-term basis.
III. Getting a common agreement on the public priorities, functions and possible number of professionals/workers required to be involved at each level for effective and efficient PH service.

6.1.3 Defining and redefining job descriptions in consultation and agreed with PH Directorate and other key stakeholders

I. Listing, review and revision of the existing job descriptions.
II. Finalisation of the proposed job descriptions.

6.1.4 Development of database of the available PH workforce in the system with their qualifications, PH trainings and the competencies required for optimal delivery of their designated roles

I. Identification, listing and mapping of existing doctors with their training status in PH (with degree, diploma or certificate in PH), and regular updates of this database and linking it with Human Resources Management Information Systems (HRMIS).

II. Assessment of competencies required for optimal delivery of PH functions against designated positions, and identification of training needs for different competencies.

III. Identification, listing, and mapping of all Senior PH personnel (Programme Officers) who would provide leaderhip and mentorship to the programme.Training of the mentors and development of a mentoring support structure will be a key activity.

IV. Identification of the gaps in competencies needing further capacity building.

V. Assessment of training needs of different category of staff and training load for different levels of service delivery.

VI. Identification and selection of training institution based on need.

VII. Identification of the trainers/ resource persons and partnership with different state, national and international institutions for training of trainers.

6.2 Medium Term

6.2.1 Study the burden of disease of the state

I. Using secondary analysis of existing reported data (this will be a short term activity).

II. Doing a robust and structured Burden of Disease Study for the State.

6.2.2 Capacity Building /Training (Medium-Long term)

Doctors already in the cadre who opt for PH cadre must possess degree /diploma/certificate in PH as mentioned earlier. Doctors having experience of working in PH Institutions (CHC/PHC/PHC-N/OH and Municipality as HO for a minimum period of three-five years may also be considered. All newly appointed doctors opting for PH cadre without having minimum PH qualification will have to do at least a DPH incorporating all the areas of PH practice and competencies with in next 5 years or before promoting to next higher grade.

I. Development of Training Modules for different competencies.

II. Training of the PH Professionals including Senior and middle-level mangers at each level to meet their required competencies as per gap assessment.

III. Identification and recruitment of external resources for training and capacity building.

IV. Development of a mentorship module/format the existing PH personnel pairing with senior public professionals already trained in PH.

V. Development of short-term courses on key areas identified in competency assessment, and on key areas on PH practice, such as, but not limited to Epidemiology, Biostatitics, Research Methodology, Laboratory Quality Assurance etc. through locally competent training Institutions. (PHFI/IIPHB/AIPH or any other institution jointly running courses under aegis of Welcome Trust funded collaboration between UK Universities and PHFI, and agencies like the FPH, UK.)

6.3 Long-Term

6.3.1 Development of PH Leadership Training Programmes

I. Identification and listing of suitable training institutions.

II. Development of Core Training Modules (CTM) for Leadership Training in PH.

III. Development of Master Trainers by both Internal and External Resource persons.

IV. Continued Profesional Development by both Internal and External Resources (combinationof technical and leadership training – combining activities F and G).

6.3.2 Strengthening of Existing training institutions under government

I. Line listing of all the existing training intitutions.

II. Gap analysis with focus on infrastructure, human resources (HR), equipments, instruments, furnitures and fixtures.

III. Development of the action plan for addressing the gaps based on the gap analysis.

6.3.3 Strengthening the laboratory network in the state

I. Identification, line listing and gap analysis of all the PH laboartory network vis-a- vis the current need, collaborate with external and internal resources for strengthening.

6.3.4 Review of the PH Cadre in the state vis-a-vis the PH needs

I. There is a need to review the existing PH structure vis-a-vis the changing needs of current PH especially capacities to deal with emerging and reemerging communicable diseases such as Swine Flu, Dengue, Ebola etc, non communicable diseases such a Diabetes, Hypertension, Heart Disease, Cancer, Geriatric Health, and PH regulations and their enforcement.

II. Review of existing PH legislation and suggesting amendments in view of changing scenario and needs in PH.

6.3.5 PH Research

Research is currently a low focus area in the state. However, it is an essential component to generate evidence and help in propper planning. Hence it is necessary to conduct the following activities:

I. Linkage with industry and PH practice.
II. Identification research needs
III. Capacity building on operations research.
IV. Conduct operational research in priority problem areas.