Training Module

For

Medical Officers & NHM Staff

VOLUME - I

Compiled & Developed by:

State Institute of Health & Family Welfare, Jaipur

Supported By:

NHM - Rajasthan

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About Module

This module is intended to provide guide and directions to the trainers to be involved in the training Medical officers of different cadres during their service to understand the planning, executing and monitoring supervision the public health program under NHM in the state of Rajasthan. This module will be the helping guide to the prospective trainers with the essential understanding of the conceptual background of the process of training in general and Training MO/SMO in particular. The fruitfulness of the use of this module, however, depends on the use of some of the 'tips' that may optimize the effectiveness of the trainers. While using this manual, the basic consideration to be kept in mind is that training is not dominantly dependent on the use of lectures, which are not only monotonous in nature but also less productive in terms of transmission of knowledge to the trainees. In fact, training can be a rewarding experience to both the trainer and the trainees if its major thrust is on the promotion of participatory learning, through the use of methods which make the training process more interesting and also ensure the training's more productive results. Accordingly, some of the methods which are recommended for use in the Trainers itself are:

- Brain storming
- Interactive talk
- Illustrative talk
- Group discussion
- Panel discussion
- Role play exercise
- Case studies
- Simulations
- Videos and films
- Hands on practices
- Field practical

(i) **Brain Storming-** The use of this method is generally made as a first step to generate initial interest and essential involvement of the trainees in the training activity. For this, the trainer asks the trainees to think of any ideas without evaluation or judgment. The quantity, not the quality, is what matters. Ideas can be discussed later for practical consideration. Sometimes 'unwanted' or seemingly ridiculous ideas lead to a more practical idea, which would otherwise not have been considered.

(ii) **Interactive Talk-** This method is marked by encouraging the trainees to be quite active and analytical in their learning approach. They are also motivated to be inquisitive and anxious to know new things by asking questions and exploring alternatives.

(iii) **Illustrative Talk-** This is a lecture method supplemented by the use of proper illustration using training materials, including audio-visual aids. Presentation of success stories and case studies is also one of the essential elements of this method.

(iv) **Group Discussion-** Use of this method is based on the principle of the trainer taking on the role of a group promoter. This method is also an effective instrument of participatory learning, whereby the trainer acts as a group adviser, a group facilitator and a group torch bearer.

(v) **Panel Discussion-** The use of this method is marked by greater involvement of trainees in promoting participatory learning. In this situation the trainer's role is limited to be that of coordinator and moderator of the discussion, in which the trainees as panelists act as catalyst agents of the learning process.

(vi) **Role Play Exercise-** This is one of the most effective training methods of participatory learning, in which the trainees are provided an opportunity to put into action the skills learnt through the training. For this, an artificial situation is created, whereby every individual trainee is assigned a role which he/she enacts to demonstrate the skills learnt through the process of training. In ToT these assigned roles may be such as the trainer, the trainee, the operator of audio-visual equipment, etc. While using this method, the role of the facilitator of training is that of a 'guide' or director' of the enacted play

(vii) **Classroom Practical-** This method is generally used to reinforce the learning experience through classroom practice. In case of ToT this method may be used as a supplement to the knowledge input given to the trainees through the lecture method, to cover a particular topic of the training session. One such example may be that of developing a tool of Training Needs Assessment (TNA) or designing a plan of action for a training programme.

(viii) **Case studies-** This method is used to understand the real situation of the field. Participants can involved himself with the situation and analise the cause and consequences of any events. In case of child health or maternal any incidents happened what are the factors involved inthis incident who is responsible and what are the roles and responsibility of any individual to avoide such incident can be understand through case studies.

(ix) Simulations- A training simulation is a virtual medium through which various types of skills can be acquired. Training simulations can be used in a wide variety of genres; however they are most commonly used in corporate situations to improve business awareness and management skills. They are also common in academic environments as an integrated part of a business or management course. Simulation is an exercise to be conducted to understand the practical aspects of the theory. During simulation participants are to be involved and played the role of particular actors who is supposed to responsible for such

situation take appropriate action decisions and performe the particular skills with expected attitudes. .

(x) **Videos and films-**To understand the situation live shows can be presented through videos and films. Training films are very use in developing attitude and behavior change of particular person. Use of videos and films in training is to

- Reinforces reading and lecture material
- Aids in the development of a common base of knowledge among students
- Enhances student comprehension and discussion
- Provides greater accommodation of diverse learning styles
- Increases student motivation and enthusiasm
- Promotes teacher effectiveness

(xi) Hands on practices

Purpose of any training is to provide skill upgradation for which hands on practice most important method of trainings. This can be done only at hospital sites or skill labs.

(xii) Field practical

The overall goal of the Field practical is to get the field experience, to deepen theoretical knowledge, to bring the theory to life (apply the knowledge, concepts and skills in a real working environment). Like during RI training for MO visit of MCHN day.

TEN COMMANDMENTS for Trainers

1. Share learning with the trainees, rather than imparting knowledge to them.

2. Be creative yourself and also encourage the trainees to be creative.

3. Supplement your talk by suitable illustrations with a view to make your presentations more interesting by using different types of visuals like pictures, drawings, a flannel board, flash cards, models, samples.

4. Start the talk by inculcating in the trainees an interest in the subject matter being covered and end up by creating a curiosity to learn more about the topic in future.

5. Make maximum use of two-way communication by inviting comments and queries from the trainees and sharing your views with them.

6. Remember, the job of a trainer in ToT is not only to build a potential cadre of trainers for preparing functionaries for different development activities, but also to inspire, encourage and enthuse them to be the facilitators of a self-sustaining growth process through participatory approach.

7. Assess the impact of your role as a committed and competent trainer and do it as objectively as you can. This can be done by constant monitoring of the extent to which the trainees have been receptive, responsive and reinforced by the information input provided to them.

8. Equip yourself with knowledge of recent developments in the materials and methods of training skills. This can be done by keeping yourself in touch with the latest literature and widening your knowledge by frequent interactions with those who have earned a 'status' of a successful professional in the field of training.

9. Inculcate a sense of ideal role performance while facilitating ToT. The success of such efforts can be judged in terms of someone of your trainees following your example while himself/herself practicing the same principle as a trainer.

10. Finally, continue to think and act on developing new tools and techniques which may further enrich the exciting area of training. For this one needs not necessarily be highly educated or enormously resourceful, as some of the most valuable inventions have been made by persons and professionals of a very modest background. By doing this you will not only share an experience of excitement and achievement, but also a feeling of pride and privilege.

THE TRAINER AND HIS/HER ROLE

The Trainer and his/her Tasks

The trainer occupies a pivotal place in the whole process of training. He/she has multifarious roles to play during various phases of a training programme. The success of a trainer depends on his/her versatility in taking on a number of roles. Some of the Basic Requirements for a Successful Trainer

- A Desire to take up the Job
- Knowledge of the Subject Matter
- Basic Understanding of Human Behaviour
- Knowing the Learners, their Background and Training Needs
- Knowing Psychological Traits of the Learners
- Positive and Productive Learning Experience
- Creating Trainee Readiness to Learn
- Linking Training and Extension Activities at the Field Level
- Seeking Co-ordination from Related Agencies
- Multi-dimensional Skills

Supplementary Role of Trainers

- Initiative
- Organizational Ability
- Problem Solving Ability
- Judgments
- Self-improvement
- Reliability
- Public speaking

Health Care Delivery System

Session- Health Care Delivery System

Session Objective-

- To acquaint the participants about Health Care Delivery System of India and Rajasthan
- Explain about Health care infrastructure and norms for health facilities

Contents-

- **Evolution of** Health Care System in India,
- Health Care delivery infrastructure, norms, functions and services,
- Role of NHM in improving Health Care Delivery
- Mechanism and functions of Delivery Points
- Key service indicators

Methodology- Quiz, PPT Presentation, Brainstorming, Discussions

Duration of Session – 1 Hour 30 Minutes

Note for Trainers

Activity-1

- Facilitator should initiate the session by conducting a quiz...
- Facilitator should develop a questioner from the contents of session to be covered. Each of the participants need to involve in this quiz. Some incentives may be announced for the best performing participants in the form of appreciation or some chocolates or toffees

Activity -2

Participants may be divided into three groups

TOR for group work is to be given to each group.

Group-1 Functions of primary care facilities and their norms and infrastructure

Group-2 Functions of secondary level care facilities and their norms and infrastructure

Group-3 Functions of tertiary level care facilities and their norms and infrastructure

Each group is to discuss their Roles and responsibilities in improving functioning of facilities and health care delivery system.

After 20 minutes of group discussion each grop is to presents its discussion points and issues.

Activity -3

- With help of PPT facilitator need to elaborate key aspects of health care delivery system norms, functions.

Resource for reference –

- Recommendations of health committees constituted in India
- Public Health –PSM- Park and Park
- National Health Policy
- Program Guidelines
- NHM Website-MOHFW

Health care delivery System

Health care delivery system in India

Milestones in Health services development in India

1. **1947**
    a. Bhore committee appointed.
    b. India became independent country
    c. Establishment of Ministries of Health and Director General Of Health Services
    d. Became the member of WHO
    e. Development of Primary Health Centers as the nodal centers for providing health services
    f. Integrated approach with referral system
    g. Health as a state subject
    h. Launching of national programs on malaria, small fox, Filaria, TB etc.

2. **1948**
    a. Establishment of dental council of India
    b. Health subcommittee of the National Planning Committee
    c. Committee suggested preventive approach to Primary health care
    d. Preservation and maintenance of the health of the people should be the responsibility of the state

3. **1949:** Establishment of Pharmacy council of India, Family Planning Association of India.

4. **1952:** Appointed population policy committee Creation of Family Planning Cell in the DGHS.

5. **1951-56: First five year plan** launched
    a. Million rupees allocated to family planning.
    b. Launching of Malaria Eradication Program in 1953,
    c. Leprosy control program in 1954
    d. Filaria control program in 1955,
    e. National TB sample survey 1955
    f. Establishment of institutions like AIMS, CPHEO
    g. Only 725 PHC are opened with limited staff

1. **1956-61: Second Five year plan** was launched –143 Crores for health sector out of 4672
    a. Establishment of Indian medical council and Central Health education Bureau
    b. Mudaliar committee was appointed to review the first and second five year health plans.
    c. Malaria Control program was renamed as National Malaria eradication program
    d. National TB survey completed and national TB institute was established
    e. Total 1840 new PHC were opened

2. **1961-66: Third Five-year plan** was launched.
    a. Mudaliar committee report published. Allocated 342 Crores for health sector.
    b. Central Bureau of health intelligence was established
    c. Small pox eradication program,
    d. Goiter control program,
    e. District TB program were launched.
    f. National institute of communicable diseases,

g. National institute of health administration and education were created.
h. Family welfare given priority.
i. Malaria program became successful and other progress with the other programs.
j. Family welfare became an independent department.
k. Target approach to Family Planning evolved. Sterilization approach.
l. Promotion of nutrition education.

3. 1966-69

a. Jungalwala committee (small family committee) submitted report.
b. National Nutrition Monitoring Bureau was started.
c. Progress on many indicators like death and birth rate.
d. 315 new PHCs were established.
e. Sample registration system was launched to generate health data.

4. 1969-74

a. Emphasis on training facilities for different cadres of personnel.
b. Medical termination of pregnancy bill passed.
c. Post Partum scheme started.
d. 364 new PHC were opened.
e. Marginal improvements in indicators.
f. Integration of Family Planning services with MCH services and increased acceptance of contraceptive methods.
g. Proposed increased nutrition plan.
h. Midday meals program to cover 14 million children.

5. 1974-79 : Fifth Five year plan was launched

a. National minimum needs program was launched and health services, drinking water supply, environment improvement of slums were included as components.
b. Srivastava committee recommendation and Community Health worker scheme was launched. Part time and honorarium to be paid to them. Principle thrust was to accelerate the Family planning targets in birth rate.
c. Compulsive approach in national emergency 1977 through camps, and increased funding.
d. Government change and new policy on Immunization, woman's education, and emphasis on family welfare.
e. National rural health scheme was launched and also NIHFW.
f. WHO adopted **Health for All by 2000 AD** (Alma-Ata Declaration, 1978)
g. Improved attention on nutrition status of woman.
h. **Integrated Child Development Services (ICDS**) was launched.
i. National population policy was introduced. (Raising of age of marriage for men and woman from 15 to 18 years for females and 18 to 21 for males, Freezing of Peoples representation in legislatures and parliament on the basis of 1971 census till 2001. more central assistance to state on family planning.

6. 1980-85: a. National Health Policy formulated, 1983
b. Universal Immunization Program 1985

7. **1985-90**

    a. National AIDS Control Program, 1987
    b. Emphasis on consolidation and operationalization of PHCs and CHCs.

8. **1992-97:** VIII Five year plan launched

    a. Convergence of various schemes provided by different sectors, decentralized planning, urban health centers development.
    b. Draft population policy- suggestion of social development committees at different levels.
    c. Adoption of National Nutrition Policy.
    d. Launching of major projects by states to develop secondary level health infrastructure. Andhra Pradesh, Maharashtra, Orissa, Punjab and West Bengal.
    e. ICDS renamed Integrated Mother and Child Development (IMCD)
    f. National Pulse polio program
    g. IX Five year plan launched (1997-2002)
    h. RCH phase- I, 1997 October
    i. NSPCD-1997
    j. 2000 National population Policy
    k. 2002 National Health Policy (revised)
    l. 2004 RCH- Phase-II, integration of Japanese Encephalitis, Kalazar, Dengue, Filaria and Malaria into *National Vector Borne Disease Control Program*
    m. 2005 National Rural Health Mission launched.

9. **1997-2002:** IX Five year plan launched
10. **2002-2007:** X Five year plan launched
11. **2007-2012:** XI Five year plan launched
12. **2012-**17-XII Five year plan Launched
13. **2013-** RMNCH+A Launched
14. **2013-** Introduction of NUHM & Constitution of NHM
15. **2015-**Draft National Health policy

Health Care Systems in India

Health- The widely accepted definition of Health is given by world Health Organization (1948) in the preamble to its constitution which is as follows

"Health is a State of complete physical, mental, social and spiritual wellbeing and not merely an absence of disease or infirmity "

WHO has defined a **health system** as consisting of "all organizations, people and actions whose primary intent is to promote, restore or maintain health." It includes the full range of stakeholders in a health sector, for example, private for-profit and not-for-profit service providers, health insurance organizations, public safety legislation, community outreach workers, patients, and consumers as well as caregivers.

1. **Public Sector**
    a. Rural Health Scheme
        i. Primary Health Centers
        ii. Sub-Health Centers
    b. Hospitals/Health Centers
        i. Community Health Centers
        ii. District Hospitals
        iii. Apex Hospitals
        iv. Teaching Hospitals
    c. Health Insurance Schemes
        i. Employees State Insurance
        ii. Central Government Health Scheme
    d. Other Agencies
        i. Defense Medical and Health Services
        ii. Railways Medical and Health Services
2. **Private Sector**
    a. Hospitals and Nursing Homes
    b. General Practitioners
    c. Medical Insurance

Health system operating in India

The systems in operation in India are classified based on Nature/ Philosophy or Services as follows-

Philosophy of Services:

1. **Allopathic**
2. **Indigenous/Traditional**
    a. Ayurvedic
    b. Unani
    c. Homeopathy
    d. Naturopathy
    e. Siddha
    f. Chinese
    g. Tibetan
    h. Yoga & Meditation
    i. Hypnosis
    j. Divination & Exorcism
    k. Individual therapies like

Health care delivery System under NHM:3-tier Structure
Primary Care –PHC and Sub-center
Secondary care – CHC and DH

Tertiary care- Apex Hospitals and Teaching Hospitals

Rural health infrastructure: Norms

S. No.	Facility	Population Covered		Staff	Services to be Provided
1		General	Tribal/Hilly/Desert		
	Sub Centre	5000	**3000**	**2 ANMs + 1 MPW**	**Maternal Health** 1. Treatment of minor ailments First aid 2. Antenatal care 3. Intranatal care 4. Post natal Care 5. Child care including immunization 6. Family Planning and contraception 7. Adolescent health care 8. Assistance to school health services
	Primary Health Centre (PHC)	**30000**	**20000**	2 (1 MO + 1 AYUSH) Pharmacist-1 Nurse - 3 (for 24 hour PHCs; Mid wifes 2 may be contractual) LHV-1 Clerk-2 LT-1 IV class-4	• MCH Care including Family Planning • OPD • IPD Nutrition services School Health programmes • Promotion of safe water supply and basic sanitation • Prevention and control of locally endemic diseases Disease surveillance and control of epidemics • Collection and reporting of vital statistics • Education about health / behaviour change communication • National Health Programmes including HIV/AIDS control programs AYUSH local preference • Rehabilitation services • **Monitoring and Supervision**
	Community Health Centre (CHC)	**120000**	**80000**	4 Specialists ❖ Surgery ❖ OBG ❖ Pediatrics ❖ Anesthetics ❖ 10 SNs	❖ National Health Programmes (Specify) ❖ Emergency services (24 Hours) ❖ 24 - hour delivery services including normal and assisted deliveries ❖ Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions ❖ New-born care ❖ Emergency care of sick children Full range of family planning services including Laproscopic Services ❖ Safe abortion services ❖ Treatment of STI / RTI ❖ Essential Laboratory Services (Specify the type of lab tests conducted) ❖ Blood storage facility ❖ Referral transport service

National Health Mission an overview

Session- National Health Mission an overview

Session Objective- To orient the participants about NHM, its Goal and objectives, Key components, Institutional mechanism, structure

Contents- NHM, Objectives, Key indicators of progress and targets to be achieved by 2017, Components-NRHM, NUHM, RMNCH+A, NHM Additionalties, National Health Programs, Immunization, National Vector Born Diseases Control Program, Program Structures support system, Financial Mechanism, Fund allocation based Program Implementation Plan (PIP)

Methodology- PPT Presentation, Brainstorming, Discussions

Duration of Session – 1 Hour 30 Minutes

Note for Trainers

- Facilitator should initiate the session with two –three questions.
- Ask the participants-
    1. What do you know about NHM how it is different from NRHM?
    2. What are the key targets of NHM and How you can contribute in achieving these targets ?
    3. What are the Roles and responsibilities of SPMU, DPMU, and BPMU staff?
- With help of PPT facilitator need to elaborate key aspects of NHM includes goal and objectives Institutional Mechanism, key components support structure, expected out comes
- There should scope of question answer at the end of the session. So 10 -15 minutes should be given to the participants for discussions.

Key resource for reference –

- National Frame Work for Implementation of NHM
- Program Guidelines
- State PIP

National Health Mission (NHM)

The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission. Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision.

Vision

"Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health".

Core Values

- Safeguard the health of the poor, vulnerable and disadvantaged, and move towards a right based approach to health through entitlements and service guarantees ‹ Strengthen public health systems as a basis for universal access and social protection against the rising costs of health care.
- Build environment of trust between people and providers of health services.
- Empower community to become active participants in the process of attainment of highest possible levels of health. ‹ Institutionalize transparency and accountability in all processes and mechanisms.
- Improve efficiency to optimize use of available resources.

Guiding Principles

- Build an integrated network of all institutions for the Primary Health Care.
- Ensure coordinated inter-sectoral action to address issues of Health and health determinants,
- Promotion of health sector reforms for greater efficiency and equity in health care delivery.
- Ensure prioritization of services and reduce out of pocket expenditure on health care,
- Ensure to provide assured quality of health care services.
- Ensure increased access and utilization of quality health services
- Strengthen state level implementation capacity to progress towards achievement of universal health.
- Incentivize good performance of both facilities and providers.
- Address shortages of skilled workers in remote, rural areas, and other under-served pockets through appropriate monetary and non-monetary incentives.

- Promote partnerships with private, for profit, and not for profit agencies including civil society organizations to achieve health outcomes.
- Facilitate knowledge networks and create effective public health institutions.
- Encourage and enable the involvement of Panchayati Raj Institutions (PRIs) /Urban Local Bodies (ULBs) representatives
- Establish an accountability and governance and promote community based monitoring and an effective mechanism of concurrent evaluation.
- Mainstream AYUSH, so as to enhance choice of services for users and to learn from and revitalize local health care traditions.
- Expand focus beyond maternal and child survival to ensuring quality of life for women, children and adolescents.

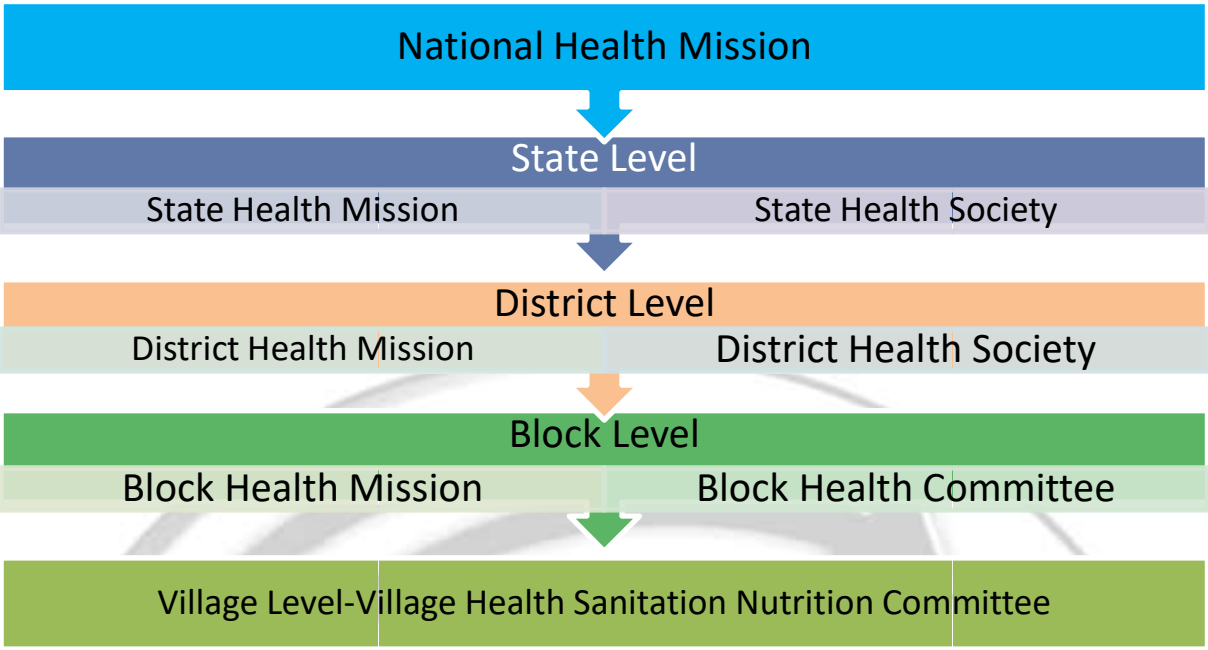
Objectives of the National Health Mission (NHM)

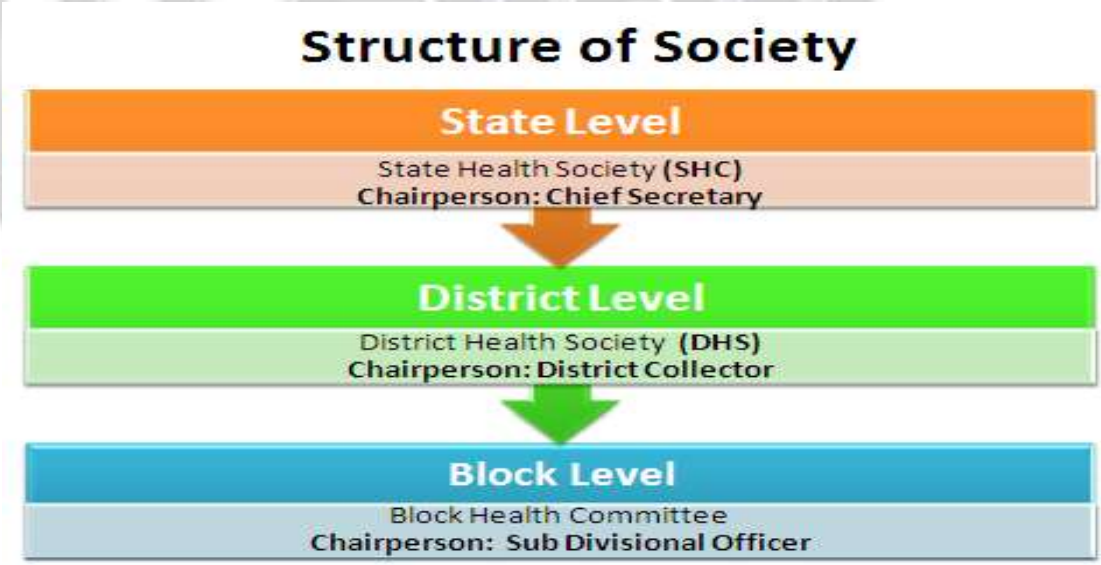
- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Population stabilization, gender and demographic balance.
- Mainstreaming of AYUSH
- Promotion of healthy life styles.

Targets

- Reduce MMR to 1/1000 live births
- Reduce IMR to 25/1000 live births
- Reduce TFR to 2.1
- Prevention and reduction of anemia in women aged 15–49 years
- Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
- Reduce household out-of-pocket expenditure on total health care expenditure
- Reduce annual incidence and mortality from Tuberculosis by half
- Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
- Annual Malaria Incidence to be <1/1000
- 10.Less than 1 per cent microfilaria prevalence in all districts
- 11.Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Structure of National Health Mission





The various components of NHM are described in the table below.

Table 1: Components of NHM

Component	Sub-Components
National Health Mission Financing	i. NRHM-RCH Flexipool ii. NUHM Flexipool iii. Flexipool for Communicable Diseases iv. Infrastructure Maintenance v. Flexipool for Non-communicable Diseases including Injury and Trauma vi. Family Welfare Central Sector component
Health system strengthening	i. MMUs ii. EMRI / Patient Transport Service iii. Infrastructure iv. Human Resources v. Drugs & Logistics vi. Telemedicine
RMNCH + A	i. Maternal Health ii. Family Planning iii. Adolescent Health iv. Newborn Child Health and Immunisation
National Disease Control Programme	i. National Iodine Deficiency Disease Control Programme ii. National Vector Borne Disease Control Programme iii. Revised National tuberculosis Control Programme iv. National Programme for Control of Blondness v. National Leprosy Eradication Programme vi. Integrated Disease Surveillance Programme

Reproductive, Maternal, Newborn, Child Health and Adolescent

- **(RMNCH+A) Services-** All schemes and programmes that constituted RCH-II have been absorbed into the NHM. The NHM provides an opportunity to build on past work and renew the emphasis on strategies for improving maternal and child health through a continuum of care and the life cycle approach. The inextricable linkages between adolescent health, family planning, maternal health and child survival have been recognized. There is additional focus on adolescence as a distinct „life stage" and the strategy is to increase knowledge and access to reproductive health services and information for adolescents and to address nutritional anemia.

- **Reproductive Health**
  - Meeting unmet needs for contraception through provisioning of a range of family planning methods
  - Reduce fertility to replacement levels and states which have achieved replacement levels will sustain it.
  - Family planning services would be utilized as a key strategy to reduce maternal and child morbidities and mortalities in addition to stabilizing population.
  - Post-partum and post abortion contraception would be a priority.

- Promoting IUCD and PPIUCD
- Quality Family Planning services based on demand
- Promoting CAC
- Involvement of private sector in family planning

- **Maternal Health**

  Key strategies include

  - Improved access to skilled obstetric care through facility development,
  - Increased coverage and quality of ante-natal and post natal care,
  - increased access to skilled birth attendance, institutional delivery;
  - Basic and comprehensive emergency obstetric care
  - Access to comprehensive abortion care, including post abortion contraceptive counseling and services,
  - Prevention and Management of Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI):
  - Gender Based Violence

- **Newborn and Child Health:**

  This will be through a continuum of care from the community to facility level and include
  - The provision of home based newborn and child care through ASHAs and ANMs, supplemented by AWW,
  - Community level care for acute respiratory infections, diarrhea, and fevers, including home remedies, first contact curative care, or referral as appropriate.
  - Essential newborn care and resuscitation at all delivery points through establishment of Newborn Care Corners and skilled personnel will be ensured.
  - Facility Based Care for sick newborns
  - Establishment of Newborn Stabilization Units and Special Newborn Care Units.

- **Universal Immunization:**
  - Sustaining Pulse polio campaigns and achieving over 80% routine immunization in all districts.
  - Introduction of new and underutilized vaccines based on recommendations of the National Technical Advisory Group on Immunization (NTAGI).
  - Improved cold chain management and adequate densities of Ice Lined Refrigerators (ILRs) and deep freezers.
  - Adequate number of vaccination sessions and sites, and logistics arrangements to reach all such sites especially in remote areas
  - Surveillance of vaccine preventable diseases
  - Intergradations with IDSP and name based monitoring of children done through the MCTS system.

- **Child Health**

  - The purpose is to improve the overall quality of life of children 0-18 years through early detection of birth defects, diseases, deficiencies, development delays including disability and provide comprehensive care at appropriate levels of health facilities.

  - These services will be delivered through the Rashtriya Bal Swasthya Karyakram (RBSK). RBSK will cover at least 30 identified health conditions for early

detection, free treatment and management through dedicated mobile health teams placed in every block in the country.

- District Early Intervention Centers (DEIC) will be set up to provide further screening and management support to children detected with health conditions and make appropriate referrals.

- **Adolescent Health:** Adolescent Health programmes include the following priority interventions:
  - Iron and Folic Acid (IFA) supplementation,
  - Facility-based adolescent health services,
  - Community based health promotion activities,
  - Information and counseling on sexual and reproductive health (including menstrual hygiene), substance abuse, mental health, non-communicable diseases, injuries and violence including domestic violence.
  - Operationalize various platforms including Adolescent Friendly Health Clinics (AFHC), VHNDs, Schools, Anganwadi Centers and Nehru Yuva Kendra Sangathan (NYKS), Teen Clubs and a dedicated Adolescent Health Day.
  - Outreach activities through Peer educators and mentors.

National Urban Health Mission (NUHM): NUHM seeks to improve the health status of the urban population particularly slum dwellers and other vulnerable sections by facilitating their access to quality primary health care.

- NUHM would cover all state capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner.

- Cities and towns with population below 50,000 will be covered under NRHM. Flexible Pool for Control of Communicable Diseases:

- The NHM will continue to focus on communicable disease control programmes and disease surveillance. The Flexipool for Communicable Diseases will facilitate the states in preparing state, district and city specific PIPs.

National Vector Borne Diseases Control Programme (NVBDCP): The NVBDCP is an umbrella programme for prevention and control of vector borne diseases viz.

- Malaria,
- Japanese Encephalitis (JE),
- Dengue,
- Chikungunya,
- Kalaazar and
- Lymphatic Filariasis.
- Kala-azar and Lymphatic Filariasis (targeted for elimination by 2015.)

Revised National Tuberculosis Control Programme (RNTCP):The goal is to decrease mortality and morbidity due to TB and reduce transmission of infection until TB ceases to be a major public health problem in India.

National Leprosy Control Programme (NLEP): Key activities include diagnosis and treatment of leprosy.

Integrated Disease Surveillance Programme (IDSP): IDSP is being implemented in all the States for surveillance of out-break of communicable diseases.

Communicable diseases need a special focus in urban areas, where disease transmission is facilitated by high population density. Poor urban management, lack of implementation of construction/ building laws, issues relating to water supply, poor waste disposal practices etc have a direct bearing on vector breeding. Diseases like TB which are transmitted through droplets have a higher incidence in crowded habitats. The NUHM, with a focus on urban areas, will enable heightened attention on prevention and control activities of communicable diseases

Flexible Pool for Non Communicable Diseases (NCD) NCDs account for 53% of the total deaths (10.3 million) and 44% (291• million) of disability adjusted life years (DALYs) lost in India. By 2030, NCDs are projected to cause up to 67% of all deaths in India. Most NCDs have common risk factors such as tobacco use, unhealthy diet, physical inactivity, alcohol use and require integrated interventions targeting these risk factors. The schemes and interventions under the non-communicable diseases that would be implemented upto the district hospital would be financed through a Flexible Pool for non-communicable diseases under NHM.

- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS):
- National Programme for the Control of Blindness (NPCB)
- National Mental Health Programme (NMHP)
- National Programme for the Healthcare of the Elderly (NPHCE)
- National programme for the Prevention and Control of Deafness (NPPCD)
- National Tobacco Control Programme (NTCP)
- National Programme for Palliative Care (NPPC)
- National Programme for the Prevention and Management of Burn Injuries (NPPMBI
- National Programme for Prevention and Control of Fluorosis (NPPCF)

NRHM-RCH Flexipool: This flexipool would address the needs of health systems strengthening and Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) of the States.
Critical Areas for Concerted Action towards Health Systems Strengthening are

- Decentralized Health Planning
- Facility Based Service Delivery
- Outreach Services
- Community Processes, Behaviour Change Communication, and Addressing Social Determinants
    - ASHA
    - The Village, Health, Sanitation and Nutrition Committee (VHSNC)
    - Behaviour Change Communication (BCC)
    - Addressing Social Determinants Action
    - Social Protection Function of Public Health Services \

- Partnerships with the NGOs, Civil Society, and the For Profit private sector
- Human Resource Development
- Public Health Management
- Pilots for Universal Health Coverage
- Health Management Information Systems (HMIS)
- *Governance and Accountability Framework*

Session- Rajasthan Health sytems

Session Objective- To orient the participants about on Rajasthan health Systems

Contents- Health Scenerio of Rajasthan (Helath Indicators), Public Healthcare Delivery System in Rajasthan, Infrastructure, Concept of Delivery Points, Job Responsibility of PHC - MO

Methodology- PPT Presentation, Brainstorming, Discussions

Duration of Session – 1 Hour 30 Minutes

Note for Trainers

- Facilitator should initiate the session with two –three questions.
- Ask the participants-
    1. What do you know about prevailing Public Healthcare Delivery System in Rajasthan?
    2. What are the current key health indicators and targets ?
    3. Infrastructure and responsibilities of a MO at PHC?
- With help of PPT facilitator need to elaborate key aspects Public Healthcare Delivery System in Rajasthan, Infrastructure, Concept of Delivery Points, Job Responsibility of PHC – MO and Health indicators of Rajasthan
- There should scope of question answer at the end of the session. So 10 -15 minutes should be given to the participants for discussions.

Rajasthan Health Systems

State Demography

Area (in lac sq. kilometers) – 3.42

Zonal Head quarters -07(Ajmer, Bharatpur, Bikaner, Kota,jaipur , Jodhpur ,Udaipur)

- **High Priority Districts – 10**
- **Tribal Districts – 06 (03 under HPD)**
- **Desert Districts – 11**

No of Districts (Census -2011)

	No. Of Districts	No of Sub Districts	Number of Towns	Number of Villages
India	640	5924	7933	640930
Rajasthan	33	244	297	44672

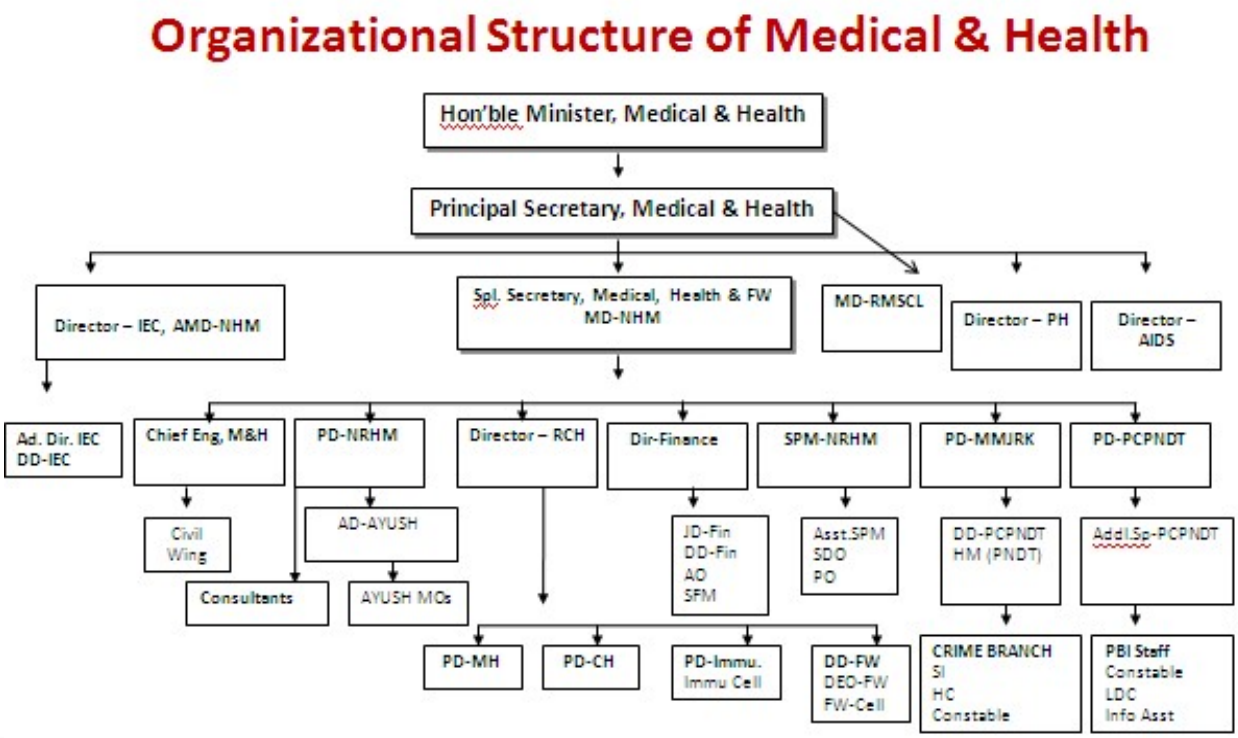
Health Facilities	Number of functioning facilities as on date
Delivery Points	2065 (1665 +400)
Sub-centres	14405
PHC	2092

CHC level hospitals	565
District Hospitals	34
Medical colleges	07 (6+1)

Demographic, Socio-economic and Health profile of Rajasthan State as compared to India figures

Item	**Rajasthan**	**India**
Total Population (Census 2011) (In Crore)	6.86	121.01
Decadal Growth (%) (Census 2011)	21.44	17.64
Crude Birth Rate (SRS 2013)	25.6	21.4
Crude Death Rate (SRS 2013)	6.5	7
Natural Growth Rate (SRS 2013)	19.3	14.5
Infant Mortality Rate (SRS 2013)	47	40
Maternal Mortality Ratio (SRS 2011-13)	244	167
Total Fertility Rate (SRS 2013)	2.8	2.3
Sex Ratio (Census 2011)	928	943
Child Sex Ratio (Census 2011)	888	914
Schedule Caste population (in crore) (Census 2011)	16.6	17.8
Schedule Tribe population (in crore) (Census 2011)	8.6	13.5
Total Literacy Rate (%) (Census 2011)	66.02	73
Male Literacy Rate (%) (Census 2011)	79.2	80.9
Female Literacy Rate (%) (Census 2011)	52.1	64.6

Organogram Department of Medical, Health and Family Welfare Rajasthan



Concept of Delivery Points : Functional Facilities to Provide Institutional Delivery

Public Health facilities like (DH)/ (SDH)/ (CHC)/ (PHC) are categorized depending on the levels (1, 2 and 3) of maternal and child health care and service delivery.

Among these levels, some have been categorized as delivery points based on their performance and case load.

According to GoI mandate, these functional facilities should be the first to be strengthened for providing comprehensive reproductive maternal newborn and child health (RMNCH) services.

Level 1

Institutional Delivery (Comprehensive Level-FRU): All complications managed including C-Section and blood transfusion, i.e. Comprehensive Emergency Obstetric and Newborn Care **(CEmONC)** provided at equipped public and private hospitals. The public and private hospitals would also be equippedwith Neonatal Stabilisation Unit and Sick Newborn Care Unit (SNCU).

Level 2

Institutional Delivery (Basic Level): Delivery conducted by a skilled birth attendant in a 24x7PHC level (PHC or CHC with Basic Emergency Obstetric and Newborn Care **(BEmONC)** or in a private nursing home with equivalent facilities) having Newborn Corner and Stabilization Unit.

Level 3

Skilled Birth Attendance: This refers to a delivery conducted by skilled birth attendant in all Sub-Centresand in some Primary Health Centres (PHCs) which have not yet reached the next level of "24 x 7 PHC".Newborn Corner in all facilities. Home deliveries assisted by a skilled birth attendant would also be included under safe deliveries at this level.

Delivery Points: Bench Marks

Health facility	For all other states
Sub-centers	>3 deliveries per month
Primary Health Centres	>10 deliveries per month
Non-First Referral Units(FRU)/ Community Health Centres(CHC)	>10 deliveries per month
FRU-CHC/Sub District Hospital(SDH)	>20 deliveries per month
District Hospital/ District Women Hospital	>50 deliveries per month
Medical colleges	>50 deliveries per month
Accredited PHF	>10 deliveries per month

Job –Responsibilities

Job Responsibilities of Medical Officers, PHC

General

MOI/c PHC under overall supervision and control of Block CMHO is responsible for implementing all activities grouped under Health and Family Welfare delivery system, in his PHC area.

He is responsible in his individual capacity, as well as, as over all incharge of PHC. He will be solely responsible for the proper functioning of the PHC. *He may assign any job to any health functionary in his team, which is deemed essential towards achieving National Health goals*.

On taking charge of PHC; MO will acquaint himself with his area which include (Geographical boundaries & terrain with detail route maps to reach each village, with the community its Socio cultural & behavioral patterns, community influencers, community organizations eg. PRI, MSS, NYM, other agencies like AWC and NGOs working in the area and with his staff, their expectations, their possible motivational forces and problems they are facing in delivering health care. He will take stock of the existing situation of stores, accounts, equipment, etc.

He will develop good networking within the system (from SCs , CHC/ DH) as well as outside system (with PWD, ICDS, PRI, NGOs etc.).

Broadly his responsibilities can be summarized as follows.

1. **Curative Work**

MO (by fixing priorities, delegating job responsibilities, and using all available resources) will organize health care delivery system, in PHC in such a way that :--

- OPD services are regularly and routinely available at PHC (he will arrange that somebody e.g. compounder / LHV who will take this responsibility in his absence)
- Dispensary at PHC is functioning smoothly and effectively.
- Emergency services - round the clock and to refer patients to right place; with due notes and first aid; if they require more sophisticated treatment.
- Laboratory services are available routinely and regularly.
- Referred cases are attended timely and sent back to the referring agency (SC) with detail note of care given and what is now required to be done at SC. Patient needing more sophisticated care are referred to the right place with detail note on patient's condition and care given so far; with telephonic communication to receiving institution if possible.
- Medical officer will visit each sub center in his area at least once in a fortnight for fixed day supervisory visit. He will check the work of the staff, provide on the spot training/ skill to health worker, *as well as impart curative care to the community.*

2 Implementation /Execution of National Health Programs

i) RCH: (including immunization)

- ❖ He will provide leadership and guidance to create conducive environment, get community participation/ involvement in planning and execution of health plans.

- ❖ He will ensure early registration of pregnancy and at least three ANC visits (spread out in three trimesters).

- ❖ He will ensure proper history taking, recording of weight and blood pressure, TT vaccination and provision of prophylactic IFA tablets to all pregnant and lactating mothers. He will also ensure that birth preparedness is being done in the last trimester of pregnancy.

- ❖ He will ensure safe delivery practices in community, SC and at PHC. Health workers are working for birth preparedness in last trimester and distributing dai kits to Dais working in that are and pregnant women in third trimester.

- ❖ Ensure availability of at least one skilled person for delivery, round the clock at PHC/SC area and timely referrals for emergency obstetric care.

- ❖ Ensure at least four PNC Visit (0/1, 4,7 & 40 days), to control infection; ensuring early initiation of right breast feeding practices and promotion of spacing methods.

- ❖ He will ensure 100% completely immunized children below 1 yr for that he will ensure:
    - Adequate supply and storage of vaccine
    - Maintenance of cold chain.
    - All planned sessions are regularly held at planned sites; which are well known and acceptable to the community.
    - Tracking of immunization cards for reducing dropouts for effective coverage.

- ❖ He will ensure safe new born care - cleaning of airways, Prevention of hypothermia, Kangaroo care; not giving bath immediately after birth (prevention of bath for at least 7 days; but keeping child clean by mopping), Initiation of breast feeding within 1/2 hr of birth, recording of birth weight.

- ❖ He will ensure early detection of diarrhea and dehydration and use of more fluid and/ or ORS in the community through his team and will arrange for correction of moderate and severe dehydration through appropriate treatment.

- ❖ He will ensure early detection of Pneumonia and its treatment as per protocol at SCs and will provide for early treatment to all patients coming to him directly or referred.

- ❖ He will be responsible for proper and successful implementation of Family Planning Programme in PHC area, including assessment of unmet need and providing services based on unmet needs. He will counsel all eligible couples and patients he sees in the OPD and ensure quality services as per demand.

- He will organize *out reach camps* for RCH and FW services. He will refer clients requiring MTP to CHC/ DH

- He will get himself trained in tubectomy, (minilap) and vasectomy and NSV. He will organize IUD insertion/ tubectomy and vasectomy (NSV as well as conventional) camps in his area with the help of Dy. CMHO FW. He will provide supportive supervision and leadership to all his health workers in this regard.

- He will make community aware of RTI/ STI and HIV/ AIDS and the methods of their prevention, importance of early diagnosis and treatment including importance of contact tracing.

- He will arrange for Family Life Education to all adolescents (boys and girls in schools or out of school). NGO partnership can be sought for this.

- He will ensure adequate and timely supplies of equipment, drugs, educational material and contraceptives required at all level(PHC and SCs) for the services/ program.

- He will ensure proper record keeping, timely reporting and use of data for planning it services at all level under his supervision and control.

- He will assess training needs of his staff and arrange through Dy. CMHO for their specific training needs.

ii) National Anti Malaria Program and Vector Control

- He will be responsible for all NMCP operations in his area. (all administrative and technical matters) .

- He will maintain liaison with Dy CHMO for spray operations in his area. He will verify the authenticity and adequacy of spray operations even if done on contract.

- He should be completely acquainted with all problems and difficulties regarding surveillance in his PHC area and be responsible for immediate action whenever the necessity arises.

- The Medical Officer will guide the Health Workers on all treatment schedules, especially radical treatment with Primaquine.

- Ensure investigation of all malaria cases in the area less than API 5 regarding their nature and origin, and institute necessary measures in this connection. He should ensure that the prompt remedial measures are carried.

- He will check the microscopic work of the Laboratory Technician and dispatch prescribed percentage of such sides to the Zonal Organization/ Regional Office for Health and Family Welfare (Government of India) and State - Headquarters for cross checking as laid down from time to time.

- He should during his monthly meetings, ensure proper accounts of slides and anti - malarial drugs issued to the Health Workers.

- The Publicity material and mass media equipment received from time to time will be properly distributed or affixed as per the instructions from the district organization.

- He should consult the Booklet on ' Management and Treatment of Cerebral Malaria' and treat cerebral malaria cases as when required.

- He should ensure that all categories of staff in the periphery are administering radical treatment to the positive cases. He should observe the instructions laid down under NMCP on the subject and in case toxic effects are observed in a patient who is receiving primaquine the drug is stopped by the peripheral worker and such cases are brought to his notice for follow up action/ advice, if any.

iii) Leprosy

- He will provide for voluntary reporting for leprosy through effective IEC & counseling.

- He will provide facilities for early detection of cases of Leprosy and confirmation of their diagnosis and treatment.

- He will ensure that all cases of Leprosy take regular and complete MDT treatment.

Iv)- Tuberculosis

- He is responsible for case - finding, categorization and treatment of TB Patients to achieve the objectives of the NTCP/ RNTCP and the laid down performance indicators.

- Diagnosis of TB patients, classification and prescription of adequate and correct treatment regimen. Careful history - taking is required, particularly to determine if patients have been treated previously for tuberculosis.

- Discuss with new patients the most convenient location for Directly Observed Treatment (DOT), to ensure regularity and completion of treatment, and educate them about the importance of completing therapy.

- Monitoring of progress, management of complications and discharge from treatment, according to guidelines.

- Ensuring correct registration of patient data in the Treatment Card and that the patient undergoes the necessary bacteriological examinations at the stipulated period and continues regular medication until cured.

- Evaluate patients with drug reactions, treatment failure and cases not converting to sputum-negative status in the initial intensive phase of treatment. Personal attention should be paid to all patients who refuse to take drugs in the prescribed manner to ensure an operationally viable procedure convenient to the patients and the staff.

- ❖ Ensuring that sufficient stock of drugs and other logistics is available and regular supply is maintained.

- ❖ Identifying and assigning responsibility for DOTS, reviewing it on a quarterly basis and discussing problems with the MPWs during routine/ regular meetings.

- ❖ Ensuring that all the peripheral health functionaries understand and carry out their job responsibilities.

v) National Program for Prevention of Visual Impairment and Control of Blindness

- ❖ He will extend support to mobile eye care units for cataract operations and correction of vision.

- ❖ He will ensure Initiation of breast-feeding with in 1/2 hr of delivery, exclusive breast feeding for six months and complementary feeding with right quantity and quality of foods at six months of age.

- ❖ He will ensure Vit. A supplementation with measles vaccine at 9 month (1 lac units) and ensure complete 5 of Vit-A doses supplementation till three years of life.

- ❖ He will refer cases to the appropriate institute for specialized eye treatment.

vi) Diarrhea Disease Control Program.

- ❖ He will ensure awareness in the community regarding use of extra fluids/ ORS and continuation of food during diarrhea.

- ❖ Proper management of the case of diarrhea and referral of complicated cases to appropriate hospitals with maintenance of hydration.

- ❖ Adequate stocks of ORS to ensure availability of ORS packets throughout the year at ORS depots in the villages.

- ❖ Monitor all cases of diarrhea especially for children between 0 -5 years.

- ❖ Recording and reporting of all deaths due to diarrhea especially for children between 0 -5 yeas.

- ❖ Organize wells to be chlorinated and coordination with Sewage agency for sanitation.
- ❖ Training of all health personnel like Anaganwadi Worker, Dais and others who are involved in health care regarding ORT Program.

- ❖ Control of Communicable Diseases

- He will ensure that all the steps are being taken for the control of communicable diseases and for the proper maintenance of sanitation in the village.

- He will scrutinize reports weekly and monthly to identify any out of proportion occurrence and take immediate action for containment.

- He will take the necessary action in case of any outbreak of epidemic in his area.

- He will ensure on going disease surveillance activities in his area.

vii) School Health

- He will develop regular fixed schedule for school health checkups. Teachers with the help of Health Worker (ANM, LHV or BHS) will conduct a pre check up to find out cases to be seen by MOIC PHC. He will examine such cases on his visit to SC, which is duly informed to ANM, so those children can be brought to him.

- He will visit school in the PHC area at regular intervals and arrange for medical check ups, immunization and treatment with proper follow up of those students found to have defects.

- He will visit schools in PHC area at regular interval and arrange for checkups, immunization and treatment with proper follow up and referral as and when needed.

viii) Training

- He will organize training programs including continuing education under the guidance of the district health authorities and Health & FW Training Centers as per the district training plan.

- He will also make arrangements/ provide assistance to the Health Assistant Female and Health Worker Female in organising training programs for indigenous Dais practicing in the area.

- He will ensure at least one-hour deliberation on topics of seasonal health relevance. In SikhoSikhaoSabha during monthly meetings.

ix) Administrative Work

- He will ensure that all HWFs have village route maps of their area and will keep a copy of the same with him.

- He will be responsible for general cleanliness of inside and outside the premises of PHC; maintenance electricity, water, building & equipment maintenance.

- He will organize to display his visit to each sub centre and availability hours on this visit.(Day & date of visit sub center wise) Displayed on PHC board and community places.

- He will allocate responsibilities according to capacity of staff.

- He will provide supportive supervision to all his staff (on his fortnightly visits to sub centre and during monthly meeting)

- He will hold monthly staff meetings with his own staff and AWW to evaluate their work, suggest actions/ steps to be taken to correct or guide for further improvement. He will scrutinize each workers program of activities to chalk out his next months tour program in perfect harmony with each worker and his own tour programme.

- He will send his tour programme to Dy CMHO and get it noted by each worker in monthly meetings.

- He will ensure timely collection of reports from periphery - (BHS at CHC should help ANM prepare monthly report), maintenance of records at PHC, compile and send report to Dy CMHO timely every month.

- He will critically analyze report of each subcentre and provide them feedback (appreciate if good - correct in case of short comings).

- He will send his tour report and appraisal of his health staff timely to Dy. CMHO.

Session- Planning Process under NHM

Session Objective- To orient the participants about on Planning Process under NHM

Contents- PIP, DHP, VHP, Supportive Supervision and Community Monitoring

Methodology- PPT Presentation, Brainstorming, Discussions

Duration of Session – 1 Hour 30 Minutes

Note for Trainers

- Facilitator should initiate the session with two –three questions.
- Ask the participants-
    1. What do you know about PIP, DHP and VHP preparation?
    2. What do they understand from term Supportive Supervision ?
    3. Role of Community in monitoring?
- With help of PPT facilitator need to elaborate key components of PIP, DHP, VHP, Supportive Supervision and Community Monitoring
- There should scope of question answer at the end of the session. So 10 -15 minutes should be given to the participants for discussions.

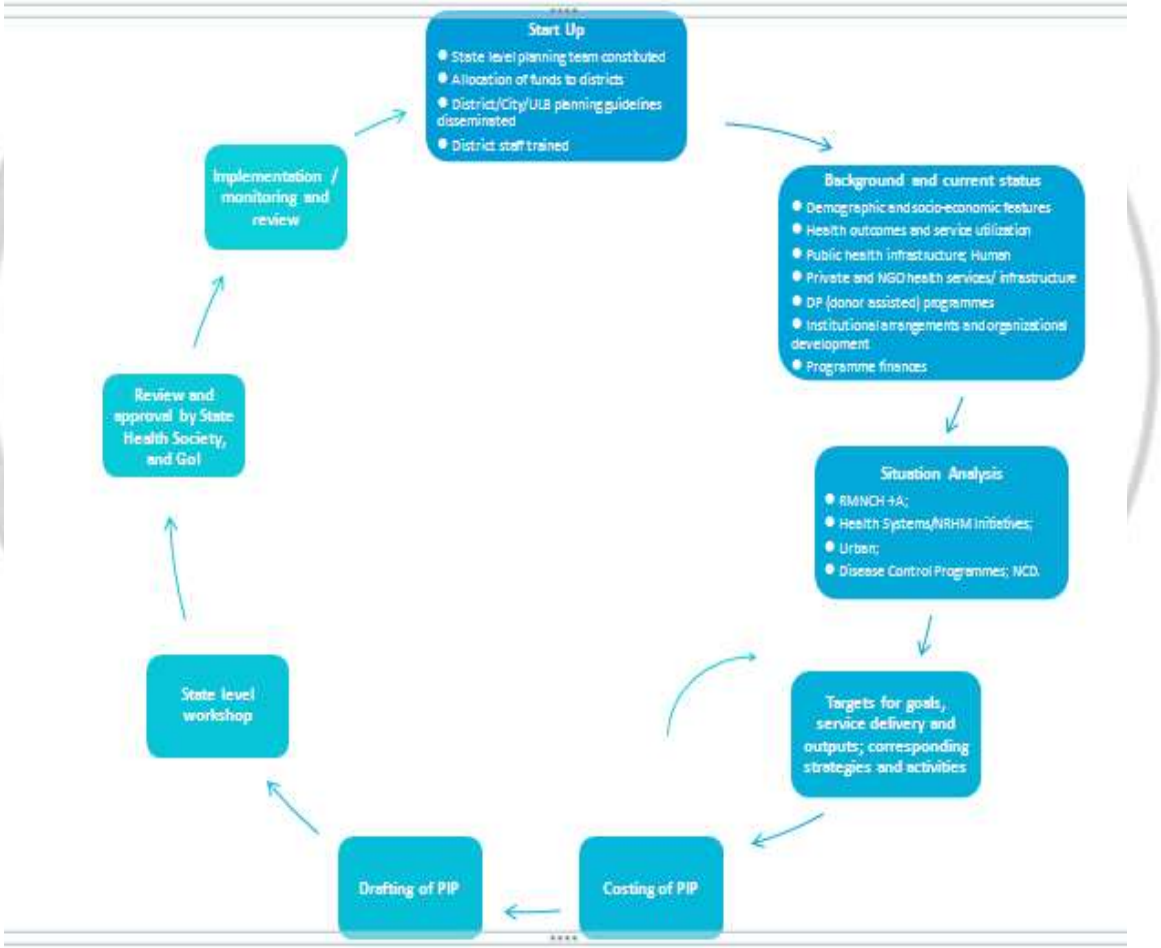
Planning Process under NHM

PIP, DHP, VHP

Program Implementation Plan

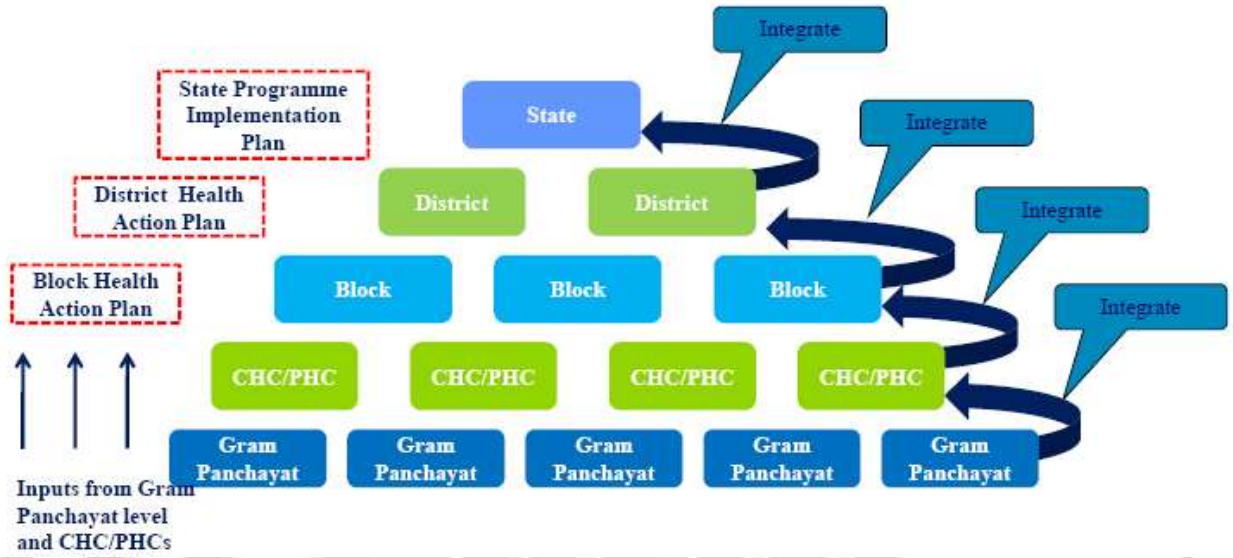
State Programme Implementation Plan is a document to be prepared by States annually which helps them in identifying and quantifying their targets required for programme implementation for the proposed year. The documents are then finalized in the NPCC (National Programme Coordination Committed) meeting for Administrative approval; Resource envelope is created and accordingly conveyed to the state. On finalization of the budget in the NPCC Meeting, it becomes an Official document available in the Ministry's site for general viewing.

OVERVIEW OF STATE NHM PIP PLANNING PROCESS

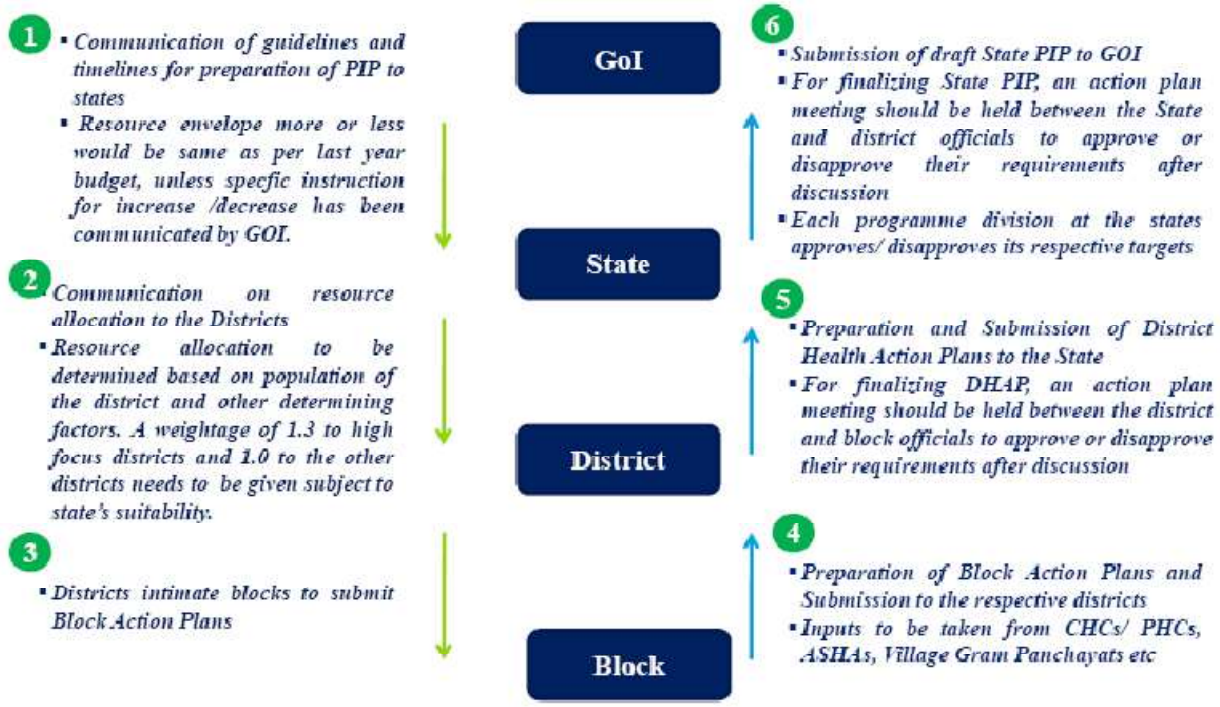


Bottom Up Approach

A bottom up approach is followed for preparing the State PIP wherein the inputs are taken from block, CHC/PHC and Village level to prepare a District Health Action Plan(DHAP). These DHAPs are then consolidated to prepare a State PIP.



PIP preparation- Key Steps



Key Timelines- Preparation & Approval of PIPs

Activity	*Timeline*
Communication of Resource envelope to Districts by the State	10th December
Submission of District Plans based on Village/Gram Panchayats/ Block Panchayat Samiti Plans	31st December
First Draft PIP to be submitted to State Health Mission	15th January
Receiving of PIP in MOH&FW, GOI	Third week of January
Pre-appraisal/ sub-group meetings at Center	Last week of January up to Mid February
Discussion at NPCC meetings	Mid February to Mid March
Submission of RoPs to AS&MD by the Group Leaders of the Sub- Groups	
Approved RoPs sent to the states after ASMDs approval	

District Action Plan and PIP at District Level

Planning can be put as “an act or process of choosing between alternatives to accomplish preset goals”.

Plan denotes a blue print of action.

The planning process involves a number of steps which are essential to identify, look into alternatives, and decide priorities and evaluation of impact.

The entire planning process is punctuated and complimented by constraints & considerations related to Finances, Manpower, Legal issues and expectations of people, which put together forms the Planning Environment.

Planning helps in assessing and forecasting demands and requirements, assessing resources available and matching resources with requirements in view of competing priorities

The planning prerequisites are-

1. Base line of standards and performance
2. Additional resources
3. Reallocation of resources.

Planning steps-

1. Situational analysis
2. Deciding objectives
3. Defining strategies
4. Laying an Operational Plan
5. Implementation
6. Evaluation-
    a. criteria,
    b. frequency and
    c. process

Further, specific to Health care, the planning process is cyclical & repetitive involving the following steps-

1. Measurement or assessment of burden of illness
2. Identification of cause of illness
3. Measurement of effectiveness of different community interventions
4. Assessment of efficiency of interventions in terms of resources used
5. Implementation of interventions
6. Monitoring of activities
7. Reassessment of burden of Disease to see if there is any change

Planning as such need to be tailor made in view of the varied geo geographical situation , burden of diseases, the infrastructure and manpower available and the resources based on these. Under this context it was envisaged under NRHM to develop District specific plans taking a cognizance of morbidity, mortality, resources, infrastructure and objectives in consonance to the overall goals of NRHM and National Health Policy.

Why district action plans?

1. Mechanism to partner with community
2. Planning based on local evidence and needs
3. Area specific strategies to achieve NRHM goals
4. Cost effective and practical solutions
5. Move from budget based plans to outcome oriented plans
6. Requirement of GOI – no funds if no plans

Why emphasis on participatory planning?

The very basis of District Action Plan is to have all the stake holders involved into the planning process so that everyone in rank and file feels involved and has a feel of ownership. The participatory planning shall help in:

1. Promote community ownership
2. Greater ownership of health functionaries
3. Harness benefits of community action
4. Bring accountability of health functionaries to community members
5. Draw together elements that are determinants of health
6. Share resources and opportunities with partnering departments – convergent action

District Plan Components

1. Introduction: - The Setting:

2. Situational Analysis
3. Goals and Objectives
4. Strategies
5. Activities
6. Work Plan/Schedule
7. Monitoring and Evaluation
8. Budget

What a district plan ought to have

1. Background
2. Planning Process
3. Priorities as per the background and planning process
4. Annual Plan for each of the Health Institutions based on facility surveys
5. Community Action Plan
6. Financing of Health Care Management
7. Structure to deliver the program
8. Partnerships for convergent action
9. Capacity Building Plan
10. Human Resource Plan
11. Procurement and Logistics Plan
12. Non-governmental Partnerships
13. Community Monitoring and evaluation Framework
14. Action Plan for Demand generation
15. Sector specific plan for maternal health, child health, adolescent health, disease control, Geriatric care disease, Surveillance, family welfare
16. Program Management Structure
17. Budget

The entire planning process has to be dealt under different heads wherein the activities will go simultaneously. For a better understanding the levels of planning have been identified as-

The Levels of Planning-

1. Goals
2. Objectives
3. Strategies
4. Activities/ Processes
5. Inputs indicators
6. Impact indicators
7. Outcome indicators
8. Output indicators
9. Process indicators

Steps for planning

1. Objectives (what is being planned?)
2. Approach or strategies for reaching the objectives (how shall the objectives be achieved?)
3. Activities required to achieve the objectives (which? enlistment)
4. The obstacles that may hamper the activities (why?)
5. Resources to be used (who?)

6. Cost of activities (money?)
7. Detailed scheduling

What is being planned?

1. Looking at the situation
    a. Information from the community
    b. Information from records
        i. Morbidity and mortality profile
        ii. Health care institutions (PPP)
        iii. ICDS
        iv. Social and cultural background
        v. PRI structure
        vi. Geographical area

District planning-situation analysis

1. Identify the problems
2. Identify the causes
3. Do resource analysis to handle the causes---man, money, material &time
4. Map the problem geographically, groups& vulnerability and the resources
5. Identify the strategies to improve.

District planning

a. Preparatory Activities -Orient District Collectors and CMO & train District Planning teams**.**

b. Desk Review
    1. Compare District with State average and NRHM objectives
    2. Mapping- facilities / services /staffing, infrastructure, population served /Patient load & utilization (PHCs &CHCs)
    3. Review performance of National Programs in the last year
    4. Map performance of ANM/ MPW
    5. Mapping of TBA- AWW-ANM- LHV
    6. Listing of NGOs –reach and focus of work
    7. CBOs in the district – block and activity- wise
    8. Last year's budget and expenditure analysis

c. Community Assessment
    1. Resource Mapping
    2. Understanding health problems
    3. Assess BOD
    4. Health expenditure
    5. Problems- referral/ transport/FP
    6. Role of PRI
    7. Understanding health seeking behavior and practices – Pregnancy/illnesses
    8. Understanding Community Participation and Ownership: Meeting VHSC
    9. Perception and the role of PRI
    10. Additional Information
    11. Studies
    12. NGO's- activities/achievement and willingness
    13. Other CBO's / SHG's federation

d. Recognizing important problems
    1. Health problems

a. Malaria
b. Malnutrition

2. Health service problems
    a. Insufficient drugs
    b. Lack of qualified person
    c. Difficult terrain
3. Community problems
    a. Inadequate water supply
    b. No primary education
    c. Inaccessibility of health care-socio cultural barriers

e. Setting objective

1. Expected outcomes
2. Relevance(related to the problem or policy)
3. Feasibility (it can be achieved)
4. Observable (its achievement can be clearly seen)
5. Measurable (outcome can be stated in number)

f. Reviewing punctuations

1. Types
    a. Manpower
    b. Materials
    c. Money
    d. Minutes
    e. Environment
    f. Technical
    g. Social
2. Analyzing punctuations
    a. Removable
    b. Modifiable
    c. Stubborn

g. Defining strategies

How do we aim to achieve objectives?

h. Choosing Alternatives

a. Technically sound
b. Feasible
    i. Manpower
    ii. Finances
    iii. Manageability of constraints

i. Scheduling the activities

1. Consider the alternative strategies
2. List out the resources
3. Select the best strategy
4. Mobilize the community resources
5. Detail activities
6. Log frame approach

j. Monitoring Efficiency tells you that the input into the work is appropriate in terms of the output. This could be put in terms of money, time, staff, equipment and so on.

k. Evaluation

1. Measure of the extent of achievement of specific objectives.
2. Whether or not the specific objectives made any difference to the main goals

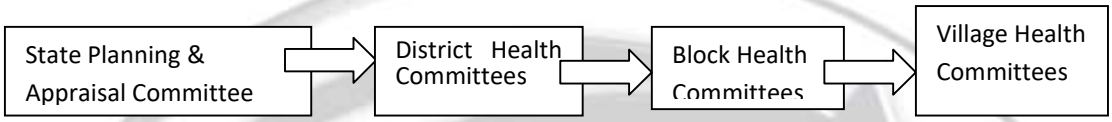
The PIP is

1. Essentially a statement of intent
2. A description of implementation with estimation of cost
3. Implementation likely to lead to desired results
4. The MOU between C&S should include plans, budget and log frames

Planning Process

The entire DAP should have a bottom up approach where village is the key focus and all

Village plans get converged to Block plans which subsequently are dovetailed into one District Plan. These DAPs then are consolidated into a State Plan.



Additional provisions and norms under NRHM

Village Health Water & Sanitation Committee	10,000
Gram Panchayat Health Committee	10,000
PHC Level Rogi Kalyan Samiti	50,000
Block Untied Fund	50,000
ASHA Workers per 1000 population – Gram Panchayat level revolving advance	5,000
CHC Rogi Kalyan Samiti	1,00,000
DH/SDH Rogi Kalyan Samiti	5,00,000

Additional provisions and norms under NRHM

1 ASHA Sahyogini /1000 population
2 ANMs/Sub Centre
2 Medical Officers/ PHC (1 AYUSH) –Mainstreaming AYUSH
3 Staff Nurses/PHC
7 Specialists/CHC
9 Staff Nurses/CHC
Rs. 20 lakhs for Staff Quarters as per IPHS standards
1 Mobile Medical Unit in each district

Sources of data

1. DLHS
2. NFHS
3. SRS
4. NSSO
5. UNICEF
6. Special surveys by Medical colleges
7. CBHI
8. District data
9. Household surveys
10. Facility surveys
11. Eligible couple register

12. State annual reports
13. Disease surveillance system
14. Routine reports

Institutional Framework for Convergent Action

1. State Health Mission/Society
2. District Health Mission/Society
3. Block Water & Health Sanitation Committee
4. Village Water & Health Sanitation Committee

Partners and Members in above mentioned Societies and Committees are DWCD; PRI/RD; Education; PHED and AYUSH

NRHM Support to Convergence

1. Planning process and Joint Action Plan
2. Sharing of Information
3. Regular Joint Reviews
4. Funds for Gap filling - Untied Funds at various levels

Key Enabling Actions

Constitution of State Health Mission	✓
Constitution of State Planning & Appraisal Committee	
Constitution of District Planning Teams & their training	
Constitution of Block Planning Teams & their training	
Forming of Village Health, Water and Sanitation Committees	✓
Nominating selected functionaries to the State, District and Block Planning Committees/Teams for leading the planning process	
Preparing clear guidelines on core NRHM strategies for planning teams at District and Block	
Communicating fund availability, allocations and the flow of funds to the Districts and other levels as per NRHM guidelines	

Level of planning and the key functionaries:

1. **Village Level**
   a. ASHA
   b. Anganwadi
   c. Panchayat Representative
   d. SHG Leader
   e. PTA/ MTA Secretary
   f. Local CBO Representative
   g. Data Source-Village Health Register
2. **Gram Panchayat Level**
   a. The Gram Panchayat Pradhan
   b. ANM
   c. MPW
   d. Village Health & Sanitation Committee
   e. Village Health Plan
3. **District Level**
   a. NGO Representatives
   b. Few professionals recruited to meet planning and implementation needs.
   c. Zila Parishad Chairman

d. District Medical Officer
e. District Magistrate

Conducting situational analysis

1. **District Profile**
   a. Public Health Infrastructure in the District e.g. at Government/rented
   b. Human Resources in the District

Functionality of District Hospitals, CHCs, PHCs &SC

1. District: - Availability of Staff needed for service Guarantees.
2. CHC: - Ob & Gy. Specialists, Pediatrician Anesthetist at identified FRUs. Indicate blocks where more than 20 % posts are vacant.
3. PHC: - Availability of an ANM at SC. Indicate PHCs with more than 10 % vacant.
4. Sub-Centre:- Availability of an ANM at sub-centre.

Status of Logistics

1. Availability of a dedicated District warehouse for health department.
2. Stock outs of any vital supplies in last year.
3. Indenting Systems (from peripheral facilities of districts).

Existence of a functional system for assessing Quality of Vaccine

1. Status of Logistics
   a. Physical Infrastructures
   b. Indicate the trainings conducted for all categories of health personnel's.
   c. Training load.
   d. Personnel's trained each training or topic wise
2. Locally Endemic Diseases in the District.
3. New Interventions under NRHM

Importance of Facility surveys

1. No routine allocation of resources under NRHM.
2. Every health facility will have to develop a baseline and an annual plan.
3. Funds will be released only after outcomes are guaranteed by additional funds
4. Every health facility need will be **specifically** asked for in the annual district action plan and budget.
5. Facility survey should focus on:
   a. Main building
   b. Staff quarters
   c. Equipment
   d. Furniture and fixtures
   e. Cleanliness and sanitation
   f. Human resources
   g. Needs for medicines and supplies

Indicators- Some of the variables which should be measured in the District Action Plan

S. No.	**Objectives to be achieved by the district**	Current year	Next year
1	Universal coverage of all pregnant women with package of quality ANC services as per national guidelines		
2	Increase in deliveries with skilled attendance at birth including institutional deliveries		
3	FRUs (including DHs, CHCs/PHCs) made functional as defined in the National RCH 2 PIP		
4	Universal coverage of all eligible pregnant women under JSY scheme		
5	Increase in percentage of new born babies given colostrums		
6	Increase in prevalence of exclusive breast feeding		
7	Increase in percentage of fully protected children in 12-23 months as per national immunization schedule		
8	Universal coverage with Vitamin A prophylaxis in 9-36 months children		
9	Percentage of severely malnourished children below 6 yrs referred to medical institutions		
10	Unmet demand for contraception -Spacing -Limiting A. Number of Govt. Health Institutions providing: i) Female sterilization services DH/ SDH / CHC / PHC ii) Male sterilization services iii) IUD insertion services --------- CHC / PHC / SC B. Number of accredited private institutions providing: i) Female sterilization services ii) Male sterilization services iii) IUD insertion services		
11	Number of health institutions in PHCs/CHCs offering ARSH services		
12	Number of health institutions providing services for management of STIs and RTIs		
13	Percentage (as planned) of ASHAs functional in the district (received induction training)		
14	Number of RKS registered /established		
15	Number of Health care delivery institutions upgraded - SHCs - PHCs - CHCs to FRUs fulfilling the 4 basic criteria in FRU guidelines Upgrading to IPHS will come later (these institutions should be in conformity with IPHS)		
16	Performance indicator for NVBDCP -API for MP -Annual blood examination rate for MP increased (over 10 % of all OPD cases) -Slide Postivity Rate -Number of deaths due to malaria		
17	Performance indicator for RNTCP -Percentage of TB suspects examined out of the total outpatients -Annualized New Smear Positive (NSP) case detection rate per 100,000 populations -Annualized Total Case detection rate per 100,000 populations -Treatment success rate		
18	Village health and sanitation committeesConstituted - Grants given		

19	Number of SCs strengthened - Additional ANMs hired - Annual maintenance grants given		
20	No. of PHCs strengthened to provide 24x7 - 3 staff Nurses hired - Annual maintenance grants given		
21	National Blindness Control Program - Cataract surgery rate (450/100,000 population) -% surgery with IOL - School Eye Screening in the age group of 10-14 years should be screened for refractive errors - Oral Health Screening for: Community School Children		
22	National Leprosy Eradication Program - PR – Leprosy cases per 10,000 population - ANCDR – New leprosy cases per 1,00,000 population - Proportion of MB, Female, Child, ST, SC cases among the new cases detected - Proportion of Patients completed treatment (RFT)		
23	Integrated Disease Surveillance Program - Number of labs to be upgraded (L1 and L2) - Number of staff to be trained in surveillance activities		
24	Staff for mobile medical units in place		
25	Number of facilities to be covered for facility survey - SHCs - PHCs - CHCs		
26	No. of villages to be covered for HH survey		
27	No. of Community hearings planned		
28	District training plan developed and implemented		
29	District BCCC plan developed and implemented		
30	District procurement and Logistics plan developed		
31	No. of PHC/CHC's where AYUSH physicians posted		

Role of DPM

1. Review of secondary data, consultations with Department officials to prepare common guidelines and resource material
2. Facilitate the planning exercise and support the State Planning cell
3. Orientation of Dist. Officials
4. Development and management of Monitoring System for Dist. Planning
5. Field level support to staff
6. Monitoring and review of the field level activities
7. District & Block Level Plan Appraisal
8. Orientation of District Health Missions and Societies
9. Training of District Planning and Appraisal Core Groups (DCGs)
10. Training of Block Planning and Appraisal Core Groups
11. Training of NGOs in the Districts allocated to them
12. Support to multi-stakeholder consultation workshops at block level

13. Support to NGOs for conducting village level participatory planning
14. Assist health facility surveys
15. Assist consolidation of Block Action Plans (BAPs)
16. Assist appraisal and approval of block action plans by the DCGs
17. Assist in preparation of District Action Plan based on BAPs
18. Assist in approval and state level appraisal of DAPs

Role of Block functionaries

1. Review RCH-I lessons & existing program strategies.
2. Compiling the information, data, reports and evidence from existing records at various levels, as the basis for planning
3. Reviewing the existing management systems and identifying gaps
4. Development of locally relevant strategies and suggesting changes
5. Provide lead to the consultation and participatory planning processes
6. Carry out assessment of strengthening needs of health facilities as per prescribed GoI norms
7. Consolidate Block Action Plans (BAPs)
8. Prepare District Action Plans based on Block level plans

Role of NGOs

1. Orientation of Village Health Water and Sanitation Committees
2. Involvement of women's groups and community based organizations
3. Support to multi-stakeholder consultation workshops at block level
4. Assist health facility surveys
5. Assist consolidation of Block Action Plans (BAPs)
6. Participate in the functioning of Block Core Group/Health Committee for planning, program implementation and monitoring support to the Block Health Plan

Role of PRI's

1. **Village Level**
   a. Select Panchayats for participatory planning.
   b. All Gram Panchayats to be included.
2. **Block Level**
   a. PS and Pradhans to lead planning process in Block core groups.
3. **District Level**
   a. Health and Nutrition Committees of District Panchayats lead the planning process as part of the District Core Groups.
   b. Support implementation of Village Health Plans.
   c. Organize monthly review meetings.
   d. Report progress to Block Health Planning and Appraisal Committees.
   e. Draw attention of emerging needs and call for support from the Health, WCD, IPH, RD Departments.

Supportive Supervision

Background

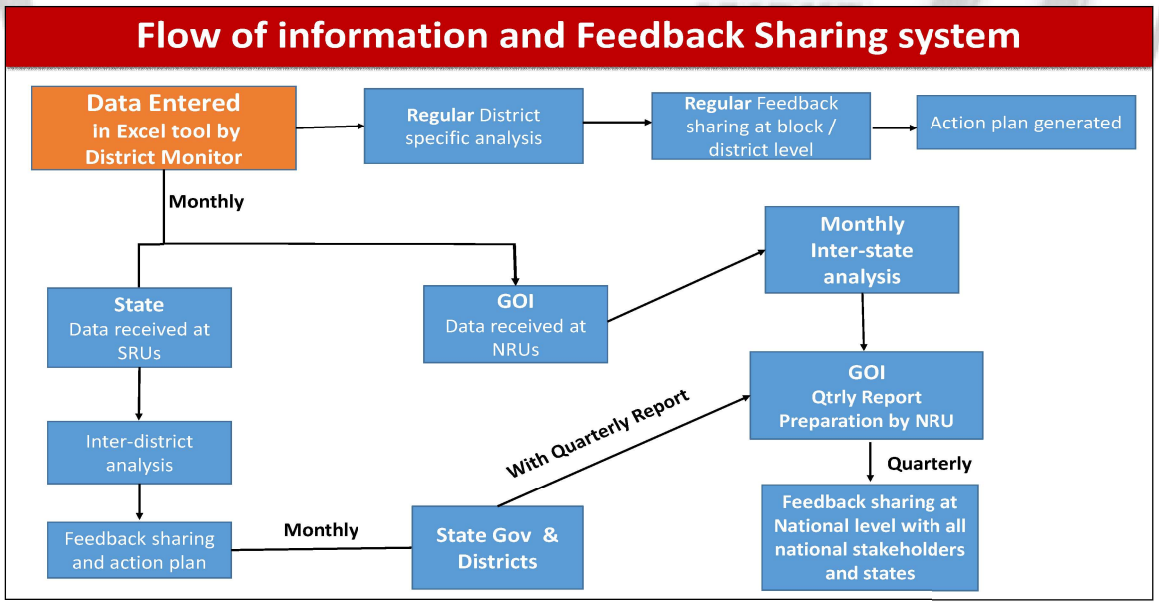
RMNCH+A Initiative was launched by government of India in 2013. The main purpose of RMNCH+A was to bring all the components of continuum of care together to ensure the holistic development of the most vulnerable population groups in districts which have lagged behind their respective states. This can be achieved only when all the life stages (viz. Reproductive, Maternal, Newborn, Child and Adolescent) are given appropriate attention and will be served across different level of care (from district level health facilities to village level Sub-Centres and even including community through ASHA and ANM).

To maximize the impact of RMNCH+A programme, total 184 high priority districts (HPDs) were identified for each state which are mainly lagging behind and responsible for overall poor performance of the state. In Rajasthan, there are such 10 HPDs where RMNCH+A is currently focused.

To strengthen the scenario of facilities especially delivery points at facility level and support the districts in analyzing the problem and devise appropriate solutions the MoHFW has prepared a Supportive Supervision checklist. This checklist is a simplified three paged tool covering all the essential components of RMNCH+A to be measured at a health facility. The main objective of the supportive supervision visit (SSV) is to evaluate performance of a health unit (L1, L2 and L3) and also to use the information collected for further planning and action.

1. SSV mechanism – data collection and feedback sharing process

The district facilitator visits the identified facilities as per the plan every month and fill the SSV sheet for the district. The SSV sheets shared with the state RMNCH+A unit within 3rd day of the month. The sheets were compiled and cross checked by SRU and if any discrepancies found then corrected by 6th of every month. All the sheets are being shared with NRU before 10th and also data compiled and consolidated report generated at state. The flow chart below shows the mechanism of how the visit information is being shared –



Sharing the information:

- **Facility level:** sharing information with MOICs immediately after visit
- **Block level:** sharing with ANM at monthly meeting
- **District level:** at district monthly meeting. And also sharing district report to CMHO on regular basis

- **State and National level:** sharing monthly consolidated report for all HPDs. and during reviews meetings

SSV data can be used for action though possible analysis of the information collected. Types of analysis can be done using SSV data and their usages are –

- **Trend analysis to be used for performance tracking –** trend analysis or changes in each of the parameters or elements can be found from visit wise analysis of L1, L2 and L3 facilities over the period.
- **Appropriate action points to be identified at different levels –** can be found from the level of care wise analysis. The consolidated report will provide the scenario for all visited facilities of L1, L2 and L3 by districts from visits April onwards (SSV started from April 2015). For some cases the action can be taken at district level or at state level if there is gap across all level of facilities or for all districts.
- **Prioritize indicators for immediate action or for long term interventions –** the consolidated SSV report can point out for which indicator or which parameter we need to focus more.

COMMUNITY MONITORING

Introduction to Community Monitoring –

Community Monitoring is seen as an important aspect of promoting community led action in the field of health. The provision for Monitoring and Planning Committees has been made at PHC, Block, District and State levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM, places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

The community monitoring process involves a three way partnership between health care providers and managers (health system); the community, community based organizations and NGOs and the Panchayati Raj Institutions. The success of the community monitoring process will depend upon the ownership of the process by all three parties and a developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding.

The objectives Community Based Monitoring can be seen as follows:

- It will provide regular and systematic information about community needs, which will be used to guide the planning process appropriatel .
- It will provide feedback according to the locally developed yardsticks, as well as on some key indicators.
- It will provide feedback on the status of fulfillment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- It will enable the community and community-based organizations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health

SUGGESTED FRAMEWORK

Level	Agency	Activity (Quarterly for Village, PHC, Block and District levels; Six monthly for State level)
Village	Village Health and Sanitation Committee	Reviews Village Health register, Village health calendar Reviews performance of ANM, MPW, ASHA Sends brief three monthly report to PHC committee
PHC	PHC Monitoring and Planning Committee	Reviews and collates reports from all VHSCs An NGO / PRI sub team conducts FGDs in three sample villages under PHC Visit PHC, review records, discuss with RKS members Send brief three monthly report to Block committee
Block (including CHC)	Block Monitoring and Planning Committee	Reviews and collates reports from all PHCs NGO / PRI sub team visits at least one PHC of the block, conduct interviews with MO and make observations Visit CHC and review records, discuss with RKS members Send brief three monthly report to District committee
District (including District hospital)	District Monitoring and Planning Committee	Reviews and collates reports from all Blocks An NGO / PRI sub team visits at least one CHC of the District, conducts interviews with Incharge, meets Block committee members and RKS members, makes observations c. Visits District hospital and reviews records, discuss with RKS members Send brief three monthly report to State committee
State	State Monitoring and Planning Committee	Reviews and collates reports from all Districts An NGO / PRI sub team visits 3 to 5 Districts, conducts interviews with DHO and District Committee members, makes observations on DH Sends six monthly report to NHM / Union Health Ministry

While operationalising this framework, the following mode of functioning may be kept in mind:

- The Monitoring committee at each level would review and collate the summary reports coming from the committees dealing with units immediately below it. This enables it to make an assessment of the situation prevailing in all the units under its purview, and to make a report at its level. For example, the District committee would receive and review the reports from all Block committees.
- However Monitoring committees would not only rely on reports, but would also directly interact in the field situation and get feedback. Firstly, each committee would appoint a small sub-team drawn from its NGO and PRI representatives who would visit on a quarterly / six monthly basis a small sample of units (say one facility or two villages) under their purview and directly review the conditions there. This enables the committee to not just rely on reports but to also have a first-hand assessment of conditions in their area. For example, the PHC committee representatives would visit two villages and conduct Group discussions there, in each trimester selecting different villages by rotation. Similarly the Block committee representatives would visit one PHC by rotation in each trimester.
- Secondly, monitoring committees at PHC, Block and District level would be involved in six-monthly or annual Jan Samvads or Public hearings at their respective levels, where committee

members would get direct feedback of the situation including possible presentation of cases of denial of health care. Similarly, it is suggested that the State health mission could conduct an annual public meeting open to all civil society representatives where the State mission report and independent reports would be presented and various aspects of design and implementation of NHM in the state, including State specific health schemes, would be reviewed and discussed enabling corrective action to be taken.

Tools for monitoring:

- Format for Village Health register
- Format for Village Health Calendar
- Guideline for information to be collected in Village group discussion
- Schedule of ASHA Interview
- Interview format for MO PHC / CHC
- Format for Exit interview (PHC / CHC)
- Format for independent additional observations regarding PHC / CHC
- Documentation of testimony of denial of health care
- Guidelines for organising public hearing

National Urban Health Mission

Session- National Urban Health Mission

Session Objective-

- To inform and make aware the participants about NUHM, Strategy and components
- To aware the trainees about their role and responsibilities to achieve the goals and targets of different programs, schemes and interventions under NUHM

Contents of session

NUHM Concept, Goal, Objectives, Institutional mechanism, strategies, Guidelines of these programs and schemes

Health care delivery System in Urban areas, PMU at State and District, Role of Municipal Corporations, Counsils, Mahila Arogya Samity, its Formation and functions

Methodology – PPT, Discussions and Brain storming Case Studies, Role play, Quize

Duration of session – 1.30 Hour

Note for Trainer's

Actity-1 Duration-45 minutes

Session should be started with brief introduction of NUHM as one of the critical component of NHM. A PPT can be presented for this purpose.

Activity -2 Duration-30 minutes

All the participants may be divided into three groups. Each group may be given a task to write problems and issues RMNCH+A in slum and sami urban population.
Presentation may be given by each group. At the end facilitator give his/her comments.

At last 10 minutes may be kept for discussion on question participants may have.

NATIONAL URBAN HEALTH MISSION

1. INTRODUCTION –

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013.

NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

NUHM would endeavour to achieve its goal through:-

I. Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections.

II. Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.

III. Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.

IV. Availability of resources for providing essential primary health care to urban poor.

V. Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

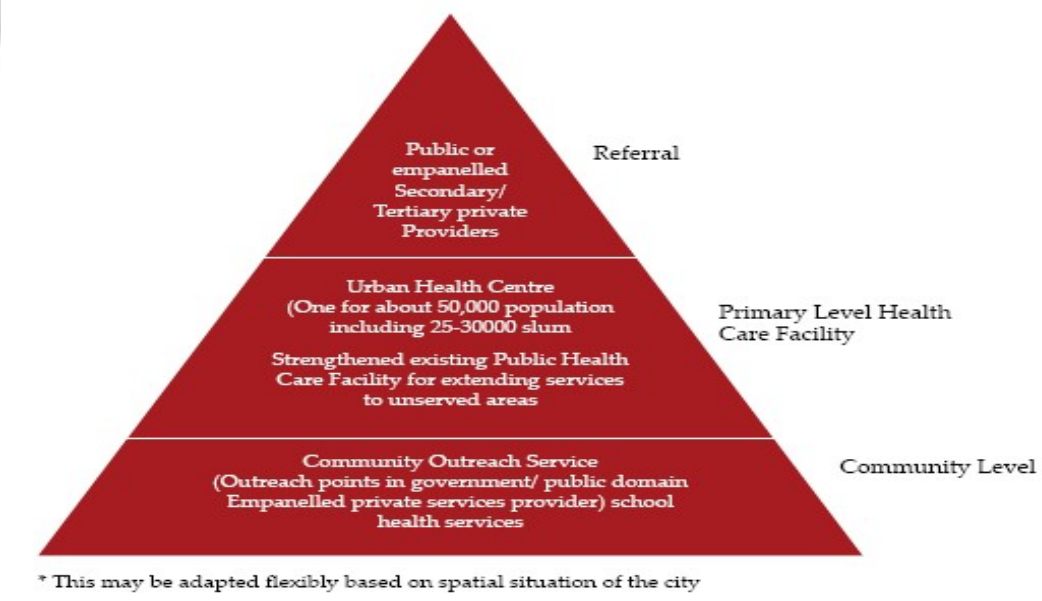
NUHM would cover all State capitals, district headquarters and cities/towns with a population of more than 50000. It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers.

The centre-state funding pattern will be 75:25 for all the States except North-Eastern states including Sikkim and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the centre-state funding pattern will be 90:10.

2. Institutional Mechanism

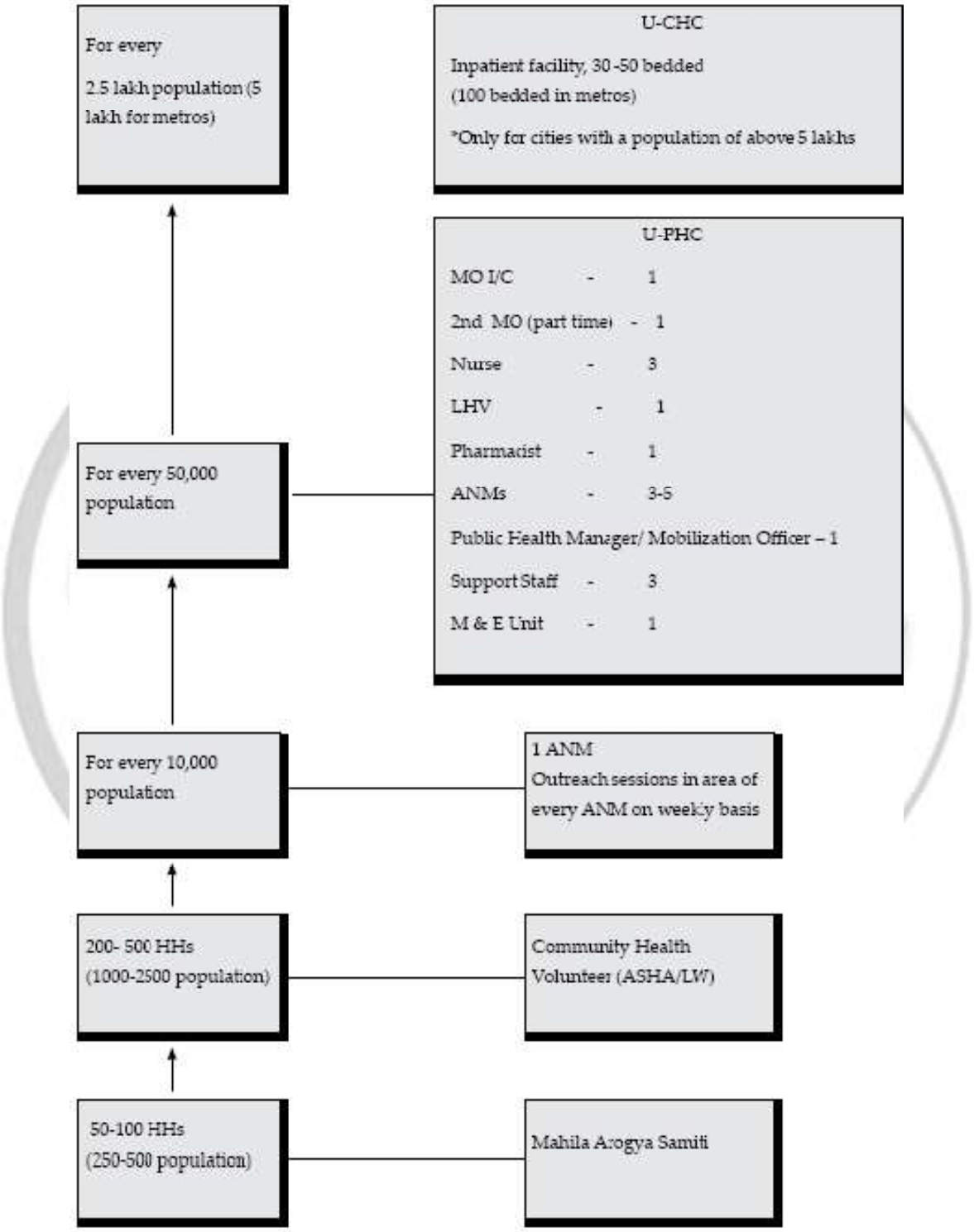
National Level	NHM Mission Steering Group (Chair HFM)	To be modified by including members to ensure focus on Urban Health
	NHM Empowered Programme Committee (Chair Union Health Secretary)	
	NHM Programme Coordination Committee (Chair AS and Mission Director)	
	Serviced by National Programme Management Unit	To be created
State Level	State Health Mission (Chair CM)	To be modified by including members to focus on Urban Health
	State Health Society (Chair CS)	
	NHM Mission Director serviced by Urban Health Division/Cell (Planning, Coordination, Monitoring and Finance)	To be strengthened
City Level	District/City Health Mission	Headed by Mayor/ Chairman
	District/City Health Society	Headed by DM/ MC.
	PMU for NUHM	To be established
Community Level	Mahila Arogya Samiti (MAS) Synergies with community structures under SJSRY	

3. Urban Health Care Delivery Model



* This may be adapted flexibly based on spatial situation of the city

4. Population Criteria and Human Resource for Urban Health Facility



Name of Facility	Population Coverage and features	Providers	Available Services
Urban Primary Health Centre (U-PHC)	50,000-60,000 population located preferably within a slum or near a slum within half a kilometer radius, catering to a slum population of around 25,000-30,000 with provision for evening OPD	One full time Medical Officer In charge One part time Medical Officer 3 Staff Nurses 1 Pharmacist 1 Lab Technician 1 LHV 4-5 ANMs Secretarial staff for account keeping and MIS Support staff	OPD services Basic Diagnostic services Referral services Collection and reporting of vital events and IDSP Counselling Services for Non Communicable Diseases- Screening and Preventive Medication
Urban Community Health Centre (U-CHC)	30-50 bedded facility for every 2.5 lakh population (in non-metro cities with a population of above 5 lakh) and 75-100 bedded facility for metro cities, acts as referral unit for 4-5 UPHCs	5-6 doctors including specialists for different types of health care. Nurses and Paramedical staff as per the need	Apart from all services that an urban PHC is meant to provide as detailed above, each CHC also provides clinical care services in some of the specialist areas and institutional delivery services. Some CHCs are designated and equipped to provide services of Caesarean section.
Outreach Services		One ANM per 10,000 population	**Routine outreach sessions -** Immunization & ANC check up **Special outreach sessions** - Health Camp with doctors, specialists, pharmacist, lab technicians providing screening and check-up services. Social Mobilization and Community level activities

5. Mahila Arogya Samiti

Introduction

MAS in one of the key interventions under National Health Mission aimed at promoting community participation in health at all levels, including planning, implementing and monitoring of health programmes. MAS is expected to take collective action on issues related to Health, Nutrition, Water, Sanitation and social determinants at the slum level. It is envisaged as being central to 'local collective action', which would gradually develop to the process of decentralized health planning.

Objective of MAS

The major objectives of MAS are to:

- Provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
- Provide a mechanism for the community to voice health needs, experiences and issues with access to health services.
- Generate community level awareness on locally relevant health issues and to promote the acceptance of best practices in health by the community.
- Focus on preventive and promotive health care activities and management of untied fund.
- Support and facilitate the work of community service providers like ASHA and other frontline workers who form a crucial interface between the community and health institutions.
- Provide an institutional mechanism for the community to be informed of various health programmes and other government initiatives and to participate in the planning and implementation of these programmes, leading to better health outcomes.
- Organize or facilitate community level services and referral linkages for health services.

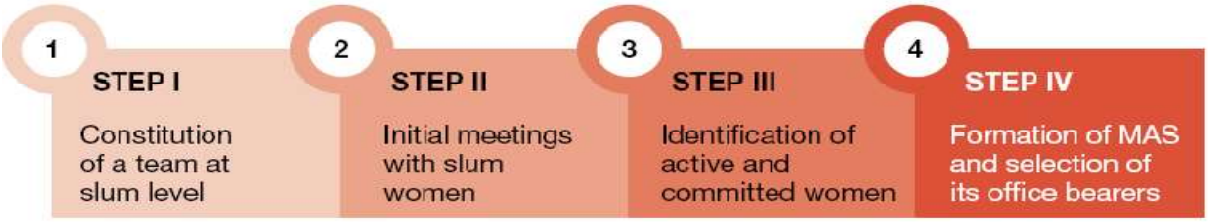
Composition of MAS

MAS should be formed covering 50-100 households and have 10-12 members, depending on the size of the slum/cluster, but the group should not have less than 5 or more than 20 members. Members of the MAS will be drawn from a neighbourhood cluster, by drawing one

committee member from each cluster of 10 to 20 houses. Every ASHA would be linked to between two to five such groups. In case of MAS formed in a slum with different social groups, representation should be ensured from all groups and pockets of the slum. So long, in case of small slums of less than 50 families or presence of disparate groups within each slum, the coverage of MAS should be aligned with the coverage area of anganwadi centre and has to cover all pockets of the slum.

Process of MAS Formation

ASHA and the ASHA facilitator play an important role in formation of MAS. Various steps involved in the formation of MAS are depicted as below -

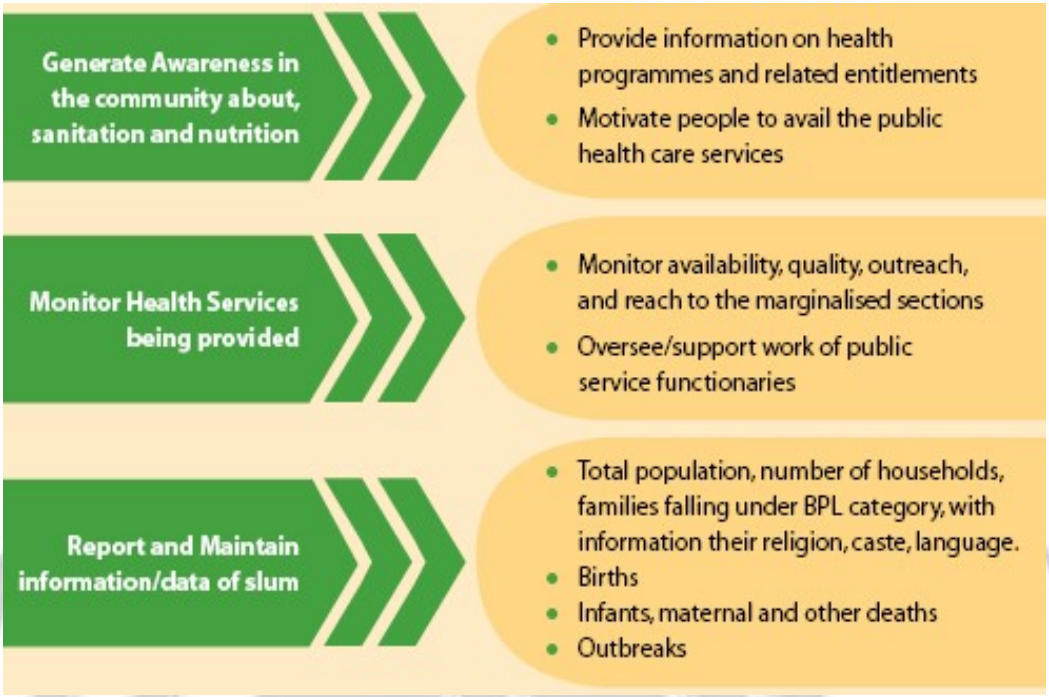


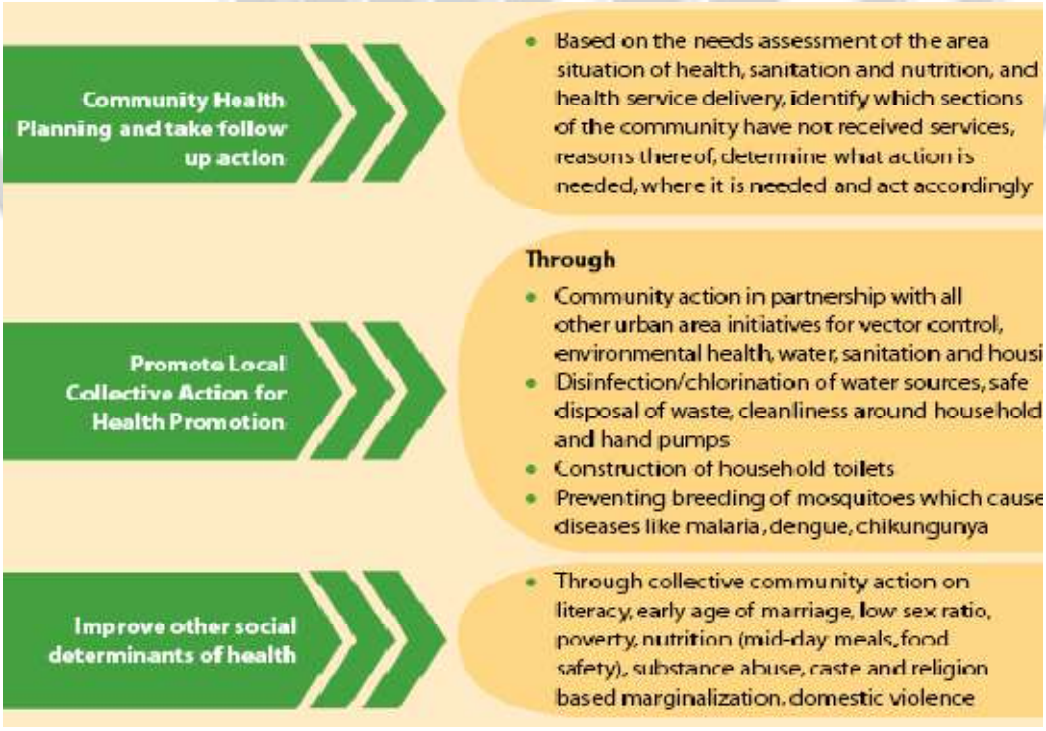
Once the women decide to work as a local collective, a resolution is passed for formalizing the MAS formation. The newly constituted MAS is oriented about its roles and responsibilities and the names and details of MAS members are recorded in the MAS registration sheet. Thereafter, ASHA facilitates the selection of the Chairperson of the MAS unanimously by the group members.

Documentary evidence for MAS formation includes:

- Resolution copy
- MAS registration sheet

Roles and Responsibilities of MAS





National Health Program

Session- National Health Program
Session Objective-

- ❖ To acquaint the participants about various National Health Programs – RNTPC, NVBDC, NTCP,NCCP, NLCP, NPHC, NMHP, NPCB, Etc
- ❖ Explain about Objectives Tragets, strategies, structurs and components of NHPs

Contents-

What are the National Health Programs

- RNTPC,NVBDCP,IDSP,NTCP,NMHP,NPCB, NPCDCS,NPHCE,NLEP

Methodology- Quiz, PPT Presentation, Brainstorming, Discussions

Duration of Session – 3 Hour

Note for Trainers

Activity-1

- Facilitator should initiate the session by conducting a quiz on NHPs...
- Facilitator should develop a questioner from the contents of session to be covered. Each of the participants needs to involve in this quiz. Some incentives may be announced for the best performing participants in the form of appreciation or some chocolates or toffees

Activity -2

Participants may be divided into 7 groups

TOR for group work is to be given to each group.

- Group-1 RNTCP program in India key guidelines, struction and role of MOs
- Group-2 NVBDC program in India key guidelines, struction and role of MOs
- Group-3 NTCP program in India key guidelines, struction and role of MOs
- Group-4 NPCDCS program in India key guidelines, struction and role of MOs
- Group-5 NMHP program in India key guidelines, struction and role of MOs
- Group-6 NPCB program in India key guidelines, struction and role of MOs
- Group-7 NLEP program in India key guidelines, struction and role of MOs

Each group is to discuss their Roles and responsibilities in implementing the NHP intheir respective areas at facility and community level.

After 20 minutes of group discussion each grop is to presents its discussion points and issues.

Activity -3

With help of PPT facilitator need to elaborate key aspects of health care delivery system norms, functions. There should scope of question answer at the end of the session. So 10 -15 minutes should be given to the participants for discussions.

National Programes

1. Revised National Tuberculosis Control Program (RNTCP):

As per the National Strategic Plan 2012–17, the program has a vision of achieving a **"TB free India"**, and aims to achieve Universal Access to TB control services. The program provides, various free of cost, quality tuberculosis diagnosis and treatment services across the country through the government health system.

Objectives of RNTCP:-

1. To achieve cure rate of at least 85% of new smear positive cases of Tuberculosis
2. To achieve detection rate of at least 70% of sputum positive cases after reaching 85% cure rate

Tb Disease Burden in India

Though India is the second-most populous country in the world one-fourth of the global incident TB cases occur in India annually. In 2013, out of the estimated global annual incidence of 9 million TB cases, 2.1 million were estimated to have occurred in India.

Tuberculosis incidence per lakh population has reduced from 216 in year 1990 to 171 in 2013. Tuberculosis mortality per lakh population has reduced from 38 in year 1990 to 19 in 2012. In absolute numbers, morality due to TB has reduced from 3.3 lakhs to 2.4 lakhs annually. India's TB Control Program is on track as far as reduction in disease burden is concerned. There is 50% reduction in TB mortality rate by 2013 as compared to 1990 level. Similarly, there is 55% reduction in TB prevalence rate by 2013 as compared to 1990 level.

In 2014, RNTCP covered a population of 12,656 lakh. A total of 87, 83,551 TB suspects were examined by sputum smear microscopy and 14,43,942 cases were registered for treatment. 72% of all registered TB cases knew their HIV status. 94% HIV infected TB patients were initiated on CPT and 91% were initiated on ART. **(TB INDIA 2015)**

Key Component of RNTCP:

A. Case finding and diagnostics:

- Early identification of all infectious TB cases. Improved integration with the general health system, and leverage field staff for home-based case finding.
- Improve communication and outreach
- Screening clinically and socially vulnerable risk groups for TB.
- Develop improved sputum collection and transportation systems.
- Deployment of higher-sensitivity diagnostic tests for TB suspects (and incorporate new tests) and decentralized DST services
- Catch patients already diagnosed through notification from all sources, improved referral for treatment mechanisms, and deployment of laboratory and private provider notification

B. Patient friendly treatment services:

- Promptly and appropriately treating TB, increasingly guided by DST.
- Making DOTS more patients friendly through increased commoditization of DOT; pilot incentives/offsets for patient costs to help patient's complete treatment and better monitoring through information technology.
- Improving partnerships between public and private sector—establish 'Indian Standards for TB Care' which can be used to engage providers using existing private treatment and improve care with some public sector support and supervision.
- Research will guide improvements in regimens and delivery systems.
- National Treatment Committee/TWG for regular review of regimens, all treatment related technical guidance

C. Scale-up of Programmatic Management of Drug Resistant TB

- Developing network of C&DST laboratories and strengthening of reference laboratories
- Decentralized DST at district level for early MDR detection
- Improved information system for PMDT
- Manpower support for additional workload by aligning with NRHM health blocks and rationalization of number of patients per STS
- Improved drug management of second-line anti-TB drugs

D. Scale-up of joint TB-HIV collaborative activities

- Activities will aim at early, rapid TB diagnosis with high sensitivity tests for HIV-infected TB suspects and ART for all HIV-infected TB patients, with transport support.

E. Integration with health systems

- Integrating the RNTCP with the overall health system will increase effectiveness and efficiencies of TB care and control which has been depicted in the picture.
- In rural areas the RNTCP can focus integration through the National Rural Health Mission.
- In urban areas the RNTCP can integrate through the private sector and the evolving National Urban Health Mission.

RNTCP in Rajasthan

The RNTCP is the vehicle through which through which the WHO recommended DOTS (Directly Observed Therapy Short course) is implemented in India. All the districts of Rajasthan are being covered. As part of the Programme Designated Microscopy centers (DMCs) have been established at PHC, CHC and district hospitals. RNTPC supports the salary of laboratory technicians, laboratory supplies and consumables. All medical officers are trained under RNTCP for diagnosis management and referral. All SCs, PHCs, CHCs and district hospitals function as DOTS centres. Community level DOTS providers are also trained in delivery of drugs. Para medical staff is trained in monitoring consumption of ant TB drugs. The RNTCP also involves the civil society organizations in its outreach of communication efforts.

Under NRHM the ASHA will be the facilitator for early access to the diagnosis, referral and follow-up as a community DOTS provider.

2. National Vector Borne Disease Control Programme (NVBDCP)

The National Vector Borne Disease Control Programme (NVBDCP) is an umbrella programme for prevention and control of vector borne diseases viz. Malaria, Japanese Encephalitis (JE), Dengue, Chikungunya, Kala-azar and Lymphatic Filariasis.

Malaria, Filaria, Japanese Encephalitis, Dengue and Chikungunya are transmitted by mosquitoes whereas Kala-azar is transmitted by sand-flies

The general strategy for prevention and control of vector borne diseases under NVBDCP is described below:

1. **Integrated Vector Management** including Indoor Residual Spraying (IRS) in selected high risk areas, Long Lasting Insecticidal Nets (LLINs), use of larvivorous fish, anti-larval measures in urban areas including bio-larvicides and minor environmental engineering including source reduction

2. Disease Management including early case detection with active, passive and sentinel surveillance and complete effective treatment, strengthening of referral services, epidemic preparedness and rapid response.

3.Supportive Interventions including Behaviour Change Communication (BCC), Intersectoral Convergence, Human Resource Development through capacity building.

4. Vaccination only against J.E.

5. Annual Mass Drugs Administration (only against Lymphatic Filariasis)

Disease burden in India and Rajasthan (2014):-

Malaria-

	India	Rajasthan
Blood Slide Examination	124066331	8810139
Malaria Cases	1102205	15118
PF cases	722546	803
Deaths	562	4

Dengue and Chikungunya (2014) -

	Cases	Deaths
Dengue	1243	7
Chikungunya	50	-

Malaria Control Strategies:-

- Early Case Detection & Prompt Treatment (EDPT)
- Vector Control
  - Chemical Control
  - Biological Control
- Personal Prophylatic Measures
- Community Participation
- Environmental Management & Source Reduction Methods
- Monitoring and Evaluation of the Program

Dengue Control Measures:-

- Personal Prophalatic Measures
- Biological Control
- Chemical Control
- Environmental Management & Source Reduction Methods
- Health Education
- Community Participation

3. Integrated Disease Surveillance Project

Integrated Disease Surveillance Programme (IDSP) was launched with World Bank assistance in November 2004 to detect and respond to disease outbreaks quickly.

Aims:-

- To detect early warning signals of impending outbreak and help initiate an effective response in time
- To provide essential data to monitor progress of on-going disease control program and help allocate resources more efficiently

Objectives:-

- To establish a ***decentralized*** district based system of disease surveillance ***for timely*** and ***effective public health action***
- To improve the efficiency of disease surveillance ***for use in health planning, management and evaluating control strategies***

Project Components:-

1. Central-level Disease Surveillance Unit
2. Integrate and strengthen disease surveillance at the state and district levels
3. Improve Laboratory Support Training Human Resource for Disease Surveillance and Action
4. Use of Information Technology and Networking in disease surveillance
5. Weekly data on epidemic prone disease are being collected from reporting units.
6. The data are being collected on 'S'; 'P'; & 'L' formats using standard case definitions.

Methods of Data Collection:-

- Routine reporting; Passive surveillance
- Sentinel surveillance
- Active surveillance
- Vector surveillance
- Laboratory surveillance#
- Sample Surveys
- Outbreak investigation
- Special studies

Diseases conditions under the surveillance program:-

Regular Surveillance	
Vector Borne Disease	Malaria
Water Borne Disease	Acute Diarrheal Disease (Cholera) Typhoid Jaundice
Respiratory Diseases	Tuberculosis Acute Respiratory Infection
Vaccine Preventable Diseases	Measles
Diseases under eradication	Polio
Other Conditions	Road Traffic Accidents
Other International commitments	Plague Yellow fever
Unusual clinical syndromes	Menigoencephalitis/ Respiratory Distress, Hemorrhagic fevers
Sentinel Surveillance	
Sexually transmitted diseases /Blood borne	HIV, HBV, HCV
Other Conditions	Water Quality Outdoor Air-Quality
Regular periodic surveys	Anthropometry, Physical Activity Blood Pressure Nutrition Tobacco
State specific diseases	Dengue, JE, Leptospirosis

Pre-requisites for effective surveillance:-

- Standard case definitions
- Regularity, Completeness *(importance of Nil report)* and Timeliness of reports
- Timely and effective action report
- Effective links and mechanisms
- Feedback and improvement

Strengths of IDSP:-

1. Functional integration of surveillance components of vertical programmes
2. Reporting of suspect, probable and confirmed cases (Standard case Definition)
3. Strong IT component for data analysis
4. Trigger levels for graded response
5. Action component in the reporting formats
6. Streamlined flow of funds to the districts
7. Standard Formats, Operations & Training Manuals
8. Involvement of Private Sector

4. National Tobacco Control Programme (NTCP) :-

Introduction-

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. India is the 2nd largest producer and consumer of tobacco and a variety of forms of tobacco use is unique to India. Apart from the smoked forms that include cigarettes, bidis and cigars, a plethora of smokeless forms of consumption exist in the country.

The Government of India has enacted the national tobacco-control legislation namely, "**The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003**" in May, 2003. India also ratified the WHO-Framework Convention on Tobacco Control (WHO-FCTC) in February 2004. Further, in order to facilitate the effective implementation of the Tobacco Control Law, to bring about greater awareness about the harmful effects of tobacco as well as to fulfill the obligations under the WHO-FCTC, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Control Programme (NTCP) in 2007- 08 .

Objectives:

- Create awareness about the harmful effects of tobacco consumption
- Reduce the production and supply of tobacco products
- Ensure effective implementation of the provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA)
- Help the people quit tobacco use
- Facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control

The various activities planned to control tobacco use are as follows:

Relevant COTPA sections:-

1. Section 4: Prohibition of smoking in public places
2. Section 5: Prohibition of direct and indirect advertisement, promotion and sponsorship of cigarette and other tobacco products.
3. Section 6(a): Prohibition of sale of cigarette and other tobacco products to a person below the age of eighteen years.
4. Section 6(b): Prohibition of sale of tobacco products within a radius of 100 yards of educational institutions.
5. Section 7: Mandatory depiction of statutory warnings (including pictorial warnings) on tobacco packs.)
6. Section 7(5): Display of tar and nicotine contents on tobacco packs.

FCTC, WHO's MPOWER and COTPA:-

	Policy	COTPA
M	**Monitor Prevalence**	
P	**Protect people from SHS**	Section 4: Prohibition of smoking in public places
O	**Offer Help to Quit**	
W	**Warn about Dangers of Tobacco**	Section 7: Mandatory depiction of statutory warnings (including pictorial warnings) on tobacco packs.)
E	**Enforcement of TC Rules**	Section 5: Prohibition of direct and indirect advertisement, promotion and sponsorship of cigarette and other tobacco products.
R	**Raise Taxes**	
Others		
	FCTC Article 15	Section 6(a): Prohibition of sale of cigarette and other tobacco products to a person below the age of eighteen years
		7. Section 6(b): Prohibition of sale of tobacco products within a radius of 100 yards of educational institutions.

Global Adult Tobacco Survey (GATS) - India, 2010-

Global Adult Tobacco Survey- India (GATS) is a nationally representative household survey conducted by Government of India, with technical support of WHO and Centre of Disease Control (CDC, Atlanta). It was conducted among population aged 15 and above to systematically monitor adult tobacco use and track key tobacco control indicators.

Findings:-

1. 275 million adults in India (15 years and above), nearly 35% of the population, consume some form of tobacco
2. The most prevalent form of tobacco usage is smokeless tobacco with 206 million users. Smokeless tobacco use in India is the highest in the world with 25.9% of the adults, 32.9% of men and 18.4% women, using it.
3. Among smokeless forms of tobacco, khaini (tobacco with lime mixture) is the most prevalent form (11.6%) followed by Gutkha (8.2%) and betel quid with tobacco (6.2%).
4. Among smoking forms of tobacco, bidis are the most prevalent form (9.2%) followed by cigarettes (5.7%).
5. The average age at initiation of tobacco use was 17.8 years with 25.8% of females starting tobacco use before the age of 15 years.

5. National Mental Health Programme (NMHP)

Background

It is estimated that 6-7 % of population suffers from mental disorders. The World Bank report (1993) revealed that the Disability Adjusted Life Year (DALY) loss due to neuro-psychiatric disorder is much higher than diarrhea, malaria, worm infestations and tuberculosis if taken individually. Together these disorders account for 12% of the global burden of disease (GBD) and an analysis of trends indicates this will increase to 15% by 2020 (World Health Report, 2001). One in four families is likely to have at least one member with a behavioral or mental disorder (WHO 2001). These families not only provide physical and emotional support, but also bear the negative impact of stigma and discrimination. Most of them (>90%) remain un-treated. Poor awareness about symptoms of mental illness, myths & stigma related to it, lack of knowledge on the treatment availability & potential benefits of seeking treatment are important causes for the high treatment gap. The Government of India has launched the National Mental Health Programme (NMHP) in 1982, with the **following objectives:**

1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population;
2. To encourage the application of mental health knowledge in general healthcare and in social development; and
3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

The District Mental Health Program (DMHP) was launched under NMHP in the year 1996 (in IX Five Year Plan). The DMHP was based on 'Bellary Model' with the following components:

1. Early detection & treatment.
2. Training: imparting short term training to general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist. The Health workers are being trained in identifying mentally ill persons.
3. IEC: Public awareness generation.
4. Monitoring: the purpose is for simple Record Keeping.

Starting with 4 districts in 1996, the program was expanded to 27 districts by the end of the IX plan.

The NMHP was re-strategized in the year 2003 (in X Five Year Plan) with the following components:

1. Extension of DMHP to 100 districts
2. Up gradation of Psychiatry wings of Government Medical Colleges/ General Hospitals
3. Modernization of State Mental hospitals
4. IEC
5. Monitoring & Evaluation

Up gradation of Psychiatry wings of Government Medical Colleges/ General Hospitals and Modernization of State Mental hospitals were the new schemes/components.

In the XI Five Year Plan, the NMHP has the following components/schemes:

1. District Mental Health Programme (DMHP)
2. Manpower Development Schemes - Centers Of Excellence And Setting Up/ Strengthening PG Training Departments of Mental Health Specialities
3. Modernization Of State Run Mental Hospitals
4. Up gradation of Psychiatric Wings of Medical Colleges/General Hospitals
5. IEC
6. Training & Research
7. Monitoring & Evaluation

Manpower Development Schemes - Centers of Excellence and Setting Up/ Strengthening PG Training Departments of Mental Health Specialities are the new schemes/components.

1. District Mental Health Programme (DMHP)

The main objective of DMHP is to provide Community Mental Health Services and integration of mental health with General health services through decentralization of treatment from Specialized Mental Hospital based care to primary health care services. On the basis of “Bellary model” District Mental Health Program was launched in 1996 in 4 districts under NMHP and was expanded to 27 districts of the country by the end of IXth Five year plan period. Presently the DMHP is being implemented in 123 districts of the country. The DMHP envisages a community based approach to the problem, which includes:

- Training of mental health team at identified nodal institutions.
- Increase awareness & reduce stigma related to Mental Health problems.
- Provide service for early detection & treatment of mental illness in the community (OPD/ Indoor & follow up).

Provide valuable data & experience at the level of community at the state & center for future planning & improvement in service & research.

Based on the evaluation conducted by an independent agency in 2008 and feedback received from a series of consultations, it was decided by the Government of India that DMHP should be revised and consolidated assistance on new pattern with added components of Life skills education & counselling in schools, College counselling services, Work place stress management and suicide prevention services should be provided. These components are in addition to the existing components of clinical services, training of general health care functionaries, and IEC activities in DMHP. The team of workers at the

district under the program consists of a Psychiatrist, a Clinical Psychologist, a Psychiatric Social worker, a Psychiatry/Community Nurse, a Program Manager, a Program/Case Registry Assistant and a Record Keeper.

2. Modernization of State Run Mental Hospitals

Most of the state run mental hospitals in the country were established long ago and are now in dilapidated state. The infrastructure of these hospitals stands on custodial care pattern. The assistance under this scheme is provided for modernization of state run mental hospitals from custodial care to comprehensive management. As per the existing scheme to modernize the existing state-run mental hospitals, a one-time grant with a ceiling of Rs.3.00 crores per hospital is provided. The grant covers activities such as construction/repair of existing building(s), purchase of cots and equipments, provision of infrastructure such as water- tanks and toilet facilities etc. It does not cover recurring expenses towards running the mental hospitals and cost towards drugs and consumables. This is the grant for modernization of the mental hospitals only and any increase in the number of beds in the hospital is not permitted.

3. Up gradation of Psychiatric Wings of Medical Colleges/General Hospitals

Every medical college should ideally have a Department of Psychiatry with minimum of three faculty members and inpatient facilities of about 30 beds as per the norms laid down by the Medical Council of India. Out of the existing medical colleges in the country, approximately 1/3rd of them do not have adequate psychiatric services. This is a scheme for strengthening of the psychiatric wings of government medical colleges/hospitals which provides for a one-time grant of Rs.50 lakhs for up gradation of infrastructure and equipment as per the existing norms. The aim of the scheme is to strengthen the training facilities for Under-Graduates & Post-Graduates at Psychiatry wings of government medical colleges/hospitals. The grant covers construction of new ward, repair of existing ward, procurement of items like cots, tables and equipments for psychiatric use such as modified ECTs.

4. Manpower Development Scheme

In order to improve the training infrastructure in mental health, Government of India has approved the Manpower Development Components of NMHP for XIth Five Year Plan. It has two schemes which are as follows:

A. Centers of Excellence (Scheme A)

Under Scheme-A, at least 11 Centres of Excellence in mental health were to be established in the IXth plan period by upgrading existing mental health institutions/hospitals. A grant of up to Rs.30 crores is available for each centre. The support includes capital work (academic block, library, hostel, lab, supportive departments, lecture theatres etc.), equipments and furnishing, support for faculty induction

and retention for the plan period. The commitment to take over the entire funding of the scheme after the 11th five year plan period from the state government is required. The proposal of the State Governments for these centers must include definite plan with timelines for initiating/ increasing PG courses in Psychiatry, Clinical Psychology, PSW and Psychiatric Nursing.

B. Setting Up/ Strengthening PG Training Departments of Mental Health Specialties (Scheme B)

To provide further impetus to manpower development in Mental Health, Government Medical Colleges/ Hospitals are supported to start PG courses in Mental Health or to increase the intake capacity for PG training in Mental Health. The support involves capital work for establishing/improving mental health departments (Psychiatry, Clinical Psychology, Psychiatric Social Work, and Psychiatric Nursing), equipments, tools and basic infrastructure, support for engaging required/deficient faculty for starting/enhancing the PG courses. The support of up to Rs. 51 lacs to Rs. 1 crore per PG department is available.

5. IEC Activities

NMHP has dedicated funds for IEC activities for the purpose of increasing awareness and removal of stigma for mental illness. The funds are allocated at central and state levels for IEC activities. An amount of Rs. one crore is allocated for the purpose of IEC activities at central level.

The team of workers at the central level in the National Mental Health Cell is as follows:

- Two Consultants
- Two Research Associates

6. National Programme for Control of Blindness

National Programme for Control of Blindness was launched in the year 1976 as a 100% Centrally Sponsored scheme with the goal to reduce the prevalence of blindness from 1.4% to 0.3%. As per Survey in 2001-02, prevalence of blindness is estimated to be 1.1%. Rapid Survey on Avoidable Blindness conducted under NPCB during 2006-07 showed reduction in the prevalence of blindness from 1.1% (2001-02) to 1% (2006-07). Various activities/initiatives undertaken during the Five Year Plans under NPCB are targeted towards achieving the goal of reducing the prevalence of blindness to 0.3% by the year 2020.

Main causes of blindness are as follows: - Cataract (62.6%) Refractive Error (19.70%) Corneal Blindness (0.90%), Glaucoma (5.80%), Surgical Complication (1.20%) Posterior Capsular Opacification (0.90%) Posterior Segment Disorder (4.70%), Others (4.19%) Estimated National Prevalence of Childhood Blindness /Low Vision is 0.80 per thousand

Goals & Objectives of NPCB in the XII Plan

- To reduce the backlog of blindness through identification and treatment of blind at primary, secondary and tertiary levels based on assessment of the overall burden of visual impairment in the country.
- Develop and strengthen the strategy of NPCB for “Eye Health” and prevention of visual impairment; through provision of comprehensive eye care services and quality service delivery.
- Strengthening and upgradation of RIOs to become centre of excellence in various sub-specialities of ophthalmology.
- Strengthening the existing and developing additional human resources and infrastructure facilities for providing high quality comprehensive Eye Care in all Districts of the country;
- To enhance community awareness on eye care and lay stress on preventive measures;
- Increase and expand research for prevention of blindness and visual impairment.
- To secure participation of Voluntary Organizations/Private Practitioners in eye Care.

7. National Programme of prevention and control of cancer, diabetes, cardiovascular diseases and Strokes (NPCDCS)

Introduction / Definition

It has been observed that out of the 57 million global deaths, 36 million deaths, or 63% are due to NCDs, principally cardiovascular diseases, diabetes, cancers and chronic respiratory diseases. Nearly 80% of NCD deaths occur in low-and middle-income countries. It is projected that globally NCDs will account for nearly 44 million deaths in 2020. The leading causes of NCD deaths in the past years were: cardiovascular diseases (17 million deaths, or 48%of NCD deaths); cancers (7.6 million, or 21% of NCD deaths); respiratory diseases, including asthma and chronic obstructive pulmonary disease (COPD), (4.2 million) and diabetes (1.3 million deaths). NCDs kill at a younger age in low- and middle-income countries, where 29% of NCD deaths occur among people under the age of 60, compared to 13% in high-income countries. (*Global status report on non-communicable diseases 2010)*

In India, the estimated deaths due to NCDs were 5.3 million *(World Health Organization - NCD Country Profiles, 2011).* The overall prevalence of diabetes, hypertension, Ischemic Heart Diseases (IHD) and stroke in India is 62.47, 159.46, 37.00 and 1.54 respectively per 1000 population. (*Indian council for Medical Research, 2006).*

Based on National Cancer Registry Programme (NCRP) of Indian Council of Medical Research (ICMR), it is estimated that there are about 28 lakh cases of different type of Cancers in the country with occurrence of about 11 lakh new cases and about 5 lakh deaths annually. The common cancers are breast, cervical and oral cancer.

Most NCDs are strongly associated and causally linked with four major behaviour risk factors: Tobacco use; Physical inactivity; Unhealthy diet including high intake of salt (sodium chloride) and Harmful use of alcohol. The other risk factors include stress, lack of fiber (food and vegetable), intake of trans-fatty acids etc.

If the above behavioural risk factors are not being managed /modified then they may lead to biological risk factors as overweight/obesity; high blood pressure; raised blood sugar and raised total cholesterol/lipids.

The other non-modifiable risk factors such as age, sex and heredity are also associated with the occurrence of NCDs.

States implementing NPCDCS have already initiated some of the activities for prevention and control of non-communicable diseases (NCDs) especially cancer, diabetes, CVDs and stroke. The Central Government is supplementing their efforts by providing technical, financial and logistics support through National Program for Prevention and Control of Cancer, Diabetes, CVD and Stroke (NPCDCS).

The NPCDCS aims at integration of NCD interventions in the NHM framework for optimization of scarce resources and provision of seamless services to the end customer / patients as also for ensuring long-term sustainability of interventions. Thus, the institutionalization of NPCDCS at district level within the District Health Society, sharing administrative and financial structure of NHM becomes a crucial

programme strategy for NPCDCS.

The NCD cell at various levels aims tol ensure implementation and supervision of the programme activities related to health promotion, early diagnosis, treatment and referral, and further facilitates partnership with laboratories for early diagnosis in the private sector. Simultaneously, it will also attempt to create a wider knowledge base in the community for effective prevention, detection, referrals and treatment strategies through convergence with the ongoing interventions of National Health Mission (NHM), National Tobacco Control Programme (NTCP), and National Programme for Health Care of Elderly (NPHCE) etc. and build a strong monitoring and evaluation system through the public health infrastructure.

Objectives

- Health promotion through behavior change with involvement of community, civil society, community based organizations, media etc.
- Opportunistic screening at all levels in the health care delivery system from sub-centre and above for early detection of diabetes, hypertension and common cancers. Outreach camps are also envisaged.
- Prevent and control chronic Non-Communicable diseases, especially Cancer, Diabetes, CVDs and Stroke.
- Build capacity at various levels of health care for prevention, early diagnosis, treatment, IEC/BCC, operational research and rehabilitation.
- Support for diagnosis and cost effective treatment at primary, secondary and tertiary levels of health care.
- Support for development of database of NCDs through Surveillance System and to monitor NCD morbidity and mortality and risk factors.

Strategy

1. Health promotion, awareness generation and promotion of healthy lifestyle
2. Screening and early detection
3. Timely, affordable and accurate diagnosis
4. Access to affordable treatment,
5. Rehabilitation

During the 12th FYP, while the coverage is proposed to be pan India, the focus of the programme is on health promotion, prevention, detection, treatment and rehabilitative services at decentralized level up to district hospital under the overall umbrella of National Health Mission for primary and secondary level health care services.

Health Promotion

Given that the major determinants to hypertension, obesity, high blood glucose and high blood lipid levels

are unhealthy diet, physical inactivity, stress and consumption of tobacco and alcohol, awareness will be generated in the community to promote healthy life style habits. For such awareness generation and community education, various strategies will be devised /formulated for behavior change and communication by inter personal communication (IPC), involvement of various categories of mass media, civil society, community based organization, panchayats/local bodies, other government departments and private sector. The focus of health promotion activities will be on:

- Increased intake of healthy foods
- Salt reduction
- Increased physical activity/regular exercise
- Avoidance of tobacco and alcohol
- Reduction of obesity
- Stress management
- Awareness about warning signs of cancer etc.
- Regular health check-up

Screening, diagnosis and treatment

Screening and early detection of non-communicable diseases especially diabetes, high blood pressure and common cancers would be an important component. The suspected cases will be referred to higher health facilities for further diagnosis and treatment

Common cancers (breast, cervical and oral), diabetes and high blood pressure screening of target population (age 30 years and above,) will be conducted either through opportunistic and/or camp approach at different levels of health facilities and also in urban slums of large cities.

The screening of the urban slum population would be carried out by the local government/municipalities in cities with population of more than 1 million.

The ANMs will be trained for conducting screening so that the same can be also conducted at sub centre level. Each district will be linked to nearby tertiary cancer care (TCC) facilities to provide referral and outreach services. The suspected cases will be referred to District Hospital and tertiary cancer care (TCC) facilities.

For screening of diabetes, support for Glucometers, Glucostrips and lancets would be provided.

Expected Outcomes

The programmes and interventions would establish a comprehensive sustainable system for reducing rapid rise of NCDs, disability as well as deaths due to NCDs. Broadly, following outcomes are expected at the end of the 12th Plan:

1. Early detection and timely treatment leading to increase in cure rate and survival
2. Reduction in exposure to risk factors, life style changes leading to reduction in NCDs
3. Improved mental health and better quality of life

4. Reduction in prevalence of physical disabilities including blindness and deafness
5. Providing user friendly health services to the elderly population of the country
6. Reduction in deaths and disability due to trauma, burns and disasters
7. Reduction in out-of-pocket expenditure on management of NCDs and thereby preventing catastrophic implication on affected individual

Key Monitoring Indicators and Targets (wherever applicable) for each Programme:

Cancer		
Monitoring Indicators	Status by March 2012	Target by March 2017
National Cancer Institutes established	0	2
No. of State Cancer Institutes established	0	20
No. of Tertiary Care Cancer Centres supported and functioning	0	50
No. of districts providing day care facilities for chemotherapy in District Hospitals	-	Atleast 25% of Districts
No. of institutes networking on Cancer Registry	27	70

Prevention and Control of Diabetes, CVD & Stroke		
Monitoring Indicators	Status by March 2012	Target by March 2017
No. of NCD Clinics set up in District Hospitals	100	640
No. of NCD Clinic at SDH/CHC/PHCs	800	2500
No. of State NCD Cells established	21	35
No. of District NCD Cells established and functioning	100	640
No. of districts providing CCU facilities in District Hospitals	-	300

Establishment/Strengthening of Health infrastructure

Management Structure:

Composition of National NCD Cell:

The Deputy Director General and Addl. Deputy Director Generals in DGHS will be assisted by following contractual staff in National NCD Cell**:**

1. National Programme Coordinator
2. Epidemiologist
3. Consultant (Training)
4. Consultant (Monitoring & Evaluation)
5. Consultant (Public Health) – 2
6. Consultant (Health Promotion / IEC) – 2
7. Consultant (Management Information System)

8. Consultant Finance & Logistics
9. Accountant
10. Logistic Manager
11. Data Analyst – 2
12. Data Entry Operators - 7
13. Public Health Consultant (state based) - 23

Role and responsibilities of the National NCD Cell is as under:

1. Nodal body to roll out NPCDCS in the country
2. Plan, Coordinate, and Monitor all the activities at National and State level.
3. Develop operational guidelines, Standard Operating Procedures (SOP), Training modules, Quality benchmarks, Monitoring and reporting systems and tools.
4. Monitoring and evaluation of the programme through HMIS, Review meetings, Field observations, surveillance, operational research and evaluation studies.
5. Prepare National Training Plan: Curriculum, Training resource centres, training modules and organize national level training programmes
6. Procurement of equipment and supplies for items to be provided as commodity assistance;
7. Release of funds and monitoring of expenditure

State NCD cell

State NCD Cell is established in the Directorate of Health Services or any other space provided by the State Government. The NCD Cell is responsible for overall planning, implementation, monitoring and evaluation of the different activities, and achievement of physical and financial targets planned under the programme in the State.

A senior level officer from the Health services is designated by State Government as State Nodal Officer. The State NCD Cell functions under the overall supervision of State Nodal Officer and is supported by the identified officers from the State Directorate of Health Services and contractual staff hired under NPCDCS.

Composition: State NCD Cell will have following contractual staff under NPCDCS **:**

1. State Programme Officer – 1.
2. State Programme Coordinator – 1.
3. Finance cum Logistics Consultant – 1.
4. Data Entry Operator – 1.

Role and responsibilities of the State NCD Cell is as under:

1. Preparation of State action plan for implementation of NPCDCS strategies.
2. Develop district wise information of NCD diseases including cancer, diabetes, cardiovascular disease and stroke through health facilities including sentinel sites.
3. Organize State & district level trainings for capacity building
4. Ensure appointment of contractual staff sanctioned for various facilities
5. Release of funds to districts for continuous flow of funds and submit Statement of Expenditure and Utilization Certificates
6. Maintaining State and District level data on physical, financial, epidemiological profile
7. Convergence with NHM activities and other related departments in the State / District
8. Ensure availability of palliative and rehabilitative services including oral morphine
9. Monitoring of the programme through HMIS, Review meetings, Field observations.
10. Public awareness regarding health promotion and prevention of NCDs through following approaches:
11. Development of communication messages for audio-visual and print media Distribution of pamphlets and hand-outs
12. Campaigns through mass media channels (electronic and print media)
13. Social mobilization through involvement of women's self-help groups, community leaders, NGOs etc.
14. Advocacy and public awareness through media (Street Plays, folk methods, wall paintings, hoardings etc.)
15. Flip charts to ground level workers for health education in the community.

District NCD Cell

The NCD Cell will be responsible for overall planning, implementation, monitoring and evaluation of the different activities and achievement of physical and financial targets planned under the programme in the District.

One officer is designated by State Government as District Nodal Officer. The District NCD Cell functions under the overall supervision of District Nodal Officer and is supported by the contractual staff hired under NPCDCS.

Composition: District NCD Cell will be supported by following contractual staff:

1. District Programme Officer – 1.
2. District Programme Coordinator – 1.
3. Finance cum Logistics Consultant – 1.
4. Data Entry Operator – 1.

Role and responsibilities of the District NCD Cell

1. Preparation of District action plan for implementation of NPCDCS strategies.
2. Maintain and update district database of NCD diseases including cancer, diabetes, cardiovascular disease and stroke.
3. Conduct sub-district/ CHC level trainings for capacity building
4. Engage contractual personnel sanctioned for various facilities in the district
5. Maintain fund flow and submit financial reports to State NCD Cell.
6. Maintaining District level data on physical, financial, epidemiological progress
7. Convergence with NHM activities; and
8. Convergence with the other related departments in the States/ District

Activities under NPCDCS at various levels

Sub Centre

Under the NPCDCS Sub Centers will perform following activities:

Health promotion:

Behaviour and life style changes through health promotion is an important component of the programme at sub centre level and would be carried out by the front line health workers- ANM and (or) Male Health Worker. Various approaches can be used such as camp, interpersonal communication (IPC), posters, banners etc. to educate people at community/school/workplace settings. Camps may be organized for this activity in the village, on Village Health and Nutrition Days when the Health Worker goes to the village for immunization and other health services. During the camps/days these health workers will discuss the various aspects of healthy life style and its benefits with the target groups and motivate them to adopt healthy lifestyle and to practice regularly prevention of common NCDs. Key messages that need to be conveyed to the public include increased intake of healthy foods; increased physical activity through sports, exercise etc.; avoidance of tobacco and alcohol; stress management and warning signs of cancer etc.

Opportunistic Screening:

During the camps/ designated day ANM will record history of persons at and above the age of 30 years for alcohol and tobacco intake, physical activity, blood sugar and blood pressure. She will also record Body Mass Index (BMI) etc. For blood sugar measurement, glucometer , glucostrips and lancets will be provided to Health Worker. ANM will be trained for such screening.

Data recording and reporting:

ANM at Sub Centre will maintain in prescribed format

1. Common Register of all the persons (>30 years) screened at sub centre / camps / VND / Health Melas or under any other activity.
2. Referral Card in duplicate one to be given to the patient (the suspected case >140 dl. /mg) and other to be retained at the sub centre for future reference and follow up.

3. Follow up Register of the confirmed patients for maintaining record of blood glucose at regular intervals, record of availability of basic medicines to the patient and record any complications of the patient related to Diabetes, Hypertension and Cancer

Activities at Community Health Centre

Each CHC shall establish a free 'NCD clinic' for comprehensive examination of patients referred from sub centre as well as reporting directly. The clinic shall run on all working days or at least thrice a week. Following activities will be performed by a CHC under the NPCDCS:

Screening:

Opportunistic screening of persons above the age of 30 years shall be carried out at CHC. Such screening will involve simple history (such as family history of Diabetes history of alcohol, tobacco consumption, dietary habits etc.) General Physical examination, calculation of BMI, blood pressure, blood sugar estimation etc.) to identify those individuals who are at a high risk of developing cancer, diabetes and CVD, warranting further investigation/ action.

Prevention and health promotion:

Apart from clinical services CHC shall be involved in promotion of healthy lifestyle through health education and counseling to the patients and their attendants at the time of their visit to health facility about the benefit in prevention of NCDs. Key messages that need to be conveyed to the public include increased intake of healthy foods; increased physical activity through sports, exercise, etc.; avoidance of tobacco and alcohol; stress management; warning signs of cancer. Counselor appointed under the programme shall counsel on the merits of Healthy diet and nutrition, harmful effect tobacco, alcohol, warning signs of cancer etc.

Lab. investigations and Diagnostics:

Blood sugar, Total Cholesterol , Lipid Profile, Blood Urea, XR, ECG, USG

Diagnosis and Management:

Diagnosis, management , counseling and rehabilitation related to common CVDs, diabetes and stroke cases will be undertaken at OPD/IPD level.

Referral:

Complicated cases of diabetes, high blood pressure etc. shall be referred from CHC to the District Hospital for further investigations and management.

Data recording and reporting

"NCD Clinic" at CHC shall maintain individual diagnosis, treatment and referral records on the patient chronic disease card, with verbal and pictorial advice for the patient. This record shall be send monthly to the District NCD Cell set up under National Cancer Control Programme.

Role of NCD Clinic at CHC

1. Conduct opportunistic screening
2. Laboratory Investigations for Blood sugar, Blood cholesterol etc.

3. Diagnose and treat Diabetes and Hypertension
4. Provide Health education to the patients and general public
5. Refer the complicated cases to district hospital

Role of Doctor

1. To conduct comprehensive examination for diagnosis and management of the NCD cases
2. To rule out complications or advanced stage
3. To refer complicated cases to higher care facility
4. To provide follow up care to the patients
5. Overall supervision of NCD Unit.
6. Assist in training of health personnel

Role of Nurse

1. To conduct screening of Diabetes, Hypertension and common Cancers
2. To assist the Physician during the examination of patients
3. To explain the patient and family about risk factors of NCDs and promote Healthy Lifestyle.
4. To assist in follow up care

Role of Counselor

1. To provide counseling on diet and life style management
2. To assist in follow up care and referral

Activities at District Level

Following activities will be performed by a District under the NPCDCS:

Opportunistic screening

NCD clinic at district hospital shall screen persons above the age of 30 years for diabetes, hypertension, cardiovascular diseases and common cancers (*>30 years)* and identify individuals who are at a high risk of developing NCDs warranting further investigation/ action. Such screening will involve simple history (such as family history of Diabetes history of alcohol, tobacco consumption, dietary habits etc.) General Physical examination, calculation of BMI, blood pressure, blood sugar estimation etc.) to identify those individuals who are at a high risk of developing cancer, diabetes and CVDs, warranting further investigation/ action.

Detailed investigation

Detailed investigation of persons those who are at high risk of developing NCDs after screening and those who are referred from CHCs will be done at district hospital. Laboratory services at district hospital will be strengthened/established to provide necessary Lab. investigations and Diagnostics such as Blood sugar, Lipid Profile, KFT,XR, ECG,USG ,ECHO, CT Scan, MRI etc

Out-patient and In-patient Care

NCD Clinic at District Hospital shall provide regular management and annual assessment of persons

suffering from cancer, diabetes and hypertension. People with established cardiovascular diseases shall also be managed at district hospital. Cardiac care unit established at hospital shall manage acute and emergent cases of cardiovascular diseases. The hospital shall ensure the availability of essential drugs.

Day Care Chemotherapy Facility

Identified district hospital shall provide a day care chemotherapy facility for patients on simple chemotherapy regimens. The day care facility shall have 2 beds along with necessary equipments such as IV stands, BP instruments, sterilizer etc.

Palliative Care

District hospital shall provide guidance to develop skills for Home based palliative care for chronic and debilitating patients. A team consisting of nurse and counselor from the Health System shall be trained in identifying symptoms, pain management, communication, psychosocial & emotional care, nursing needs of the terminally ill and ethics of palliative care. The nurse shall be trained in wound dressing, mouth care, oral morphine use, diet, hygiene etc.

Referral & Transport facility to serious patients

To ensure timely and emergent care to the patient at distant CHC or below, district hospital shall make provision for transporting the serious patients to the hospital or at nearest tertiary level facility.

Complicated cases shall be referred to nearest tertiary health care facility with a referral card. Patients suffering from lymphoma and leukaemia shall be referred to tertiary care centres (TCC) for Chemotherapy as blood bank facilities and required human resources are available there.

Health promotion

Apart from clinical services district hospital shall be involved in promotion of healthy lifestyle through health education and counseling to the patients and their attendants regarding increased intake of healthy foods increased physical activity through sports, exercise, etc.; avoidance of tobacco and alcohol; stress management warning signs of cancer etc

Human Resources at District Hospital

Following staff will be recruited on contract basis under the programme to manage NCD clinic /CCU and to provide emergency and OPD services, counseling, rehabilitative services:

I. NCD Clinic:

General Physician	1
GNM	2
Technician	1
Physiotherapist	1
Counselor	1
Data Entry Operator	1

II. CCU:

Specialist – Cardiology / General Physician	1
GNM	4

Activities at State level

Following activities will be performed at the State level:

Community awareness

Public awareness through various channels of communication will be organized by the State NCD cell to sensitize public about the risk factors, promotion of healthy life style and services made available under the programme. Key messages that need to be conveyed to the public include: increased intake of healthy foods; increased physical activity through sports, exercise, etc.; avoidance of tobacco and alcohol; stress management; warning signs of cancer etc.

Mass media through Radio, Television, Print media will be used for public awareness using the most effective channels that have reach to the community. Locally prevalent folk media may also be used to reach the targeted population, particularly in rural and urban deprived population.

Planning, Monitoring and Supervision:

The State NCD cell will undertake situational analysis and prepare State Plan that spells out physical targets, means of coordination, supervision and monitoring related to various components of NPCDCS in the State. Formats prescribed for reporting to Central NCD Cell will be used to report physical and financial progress made under the programme.

Training of Human Resources

Key areas of training will be health promotion, NCD prevention, early detection and management of Diabetes, CVD and Stroke.

9. National Programme for health care of Elderlys NPHCE

Introduction

The unprecedented increase in human longevity in 20th century has resulted in the phenomenon of population ageing all over the world. Countries with large population such as India have large number of people now aged 60 years or more. The population over the age of 60 years has tripled in last 50 years in India and will relentlessly increase in near future.

Along with rising numbers, the expectancy of life at birth is also consistently increasing indicating that a large number of people are likely to live longer than before. Non-communicable diseases requiring large quantum of health and social care are extremely common in old age, irrespective of socio-economic status. Disabilities resulting from these non-communicable diseases are very frequent which affect functionality compromising the ability to pursue the activities of daily living. The treatment/management of these chronic diseases is also costly, especially for cancer treatment, joint replacements, heart surgery, neurosurgical procedures etc thereby making it out of bound for elderly whose income decreases post retirement and more so for the elderly in the unorganized sector and dependent elderly women

The various sample survey have shown that:

• The burden of morbidity in old age is enormous.

• Non-communicable diseases (life style related and degenerative) are extremely common in older people irrespective of socio- economic status.

• Disabilities are very frequent which affect the functionality in old age compromising the ability to pursue the activities of daily living.

The National Sample Survey of 2004 (60th Round) provides a comprehensive status report on older persons. According to it, the prevalence and incidence of diseases as well as hospitalization rates are much higher in older people than the total population. It also reported that about 8% of older Indians were confined to their home or bed. The proportion of such immobile or home bound people rose with age to 27% after the age of 80 years.

Women were more frequently affected than males in both villages and cities. The survey estimated the state of self perceived health status of older people. A good or fair condition of health was reported by 55-63% of people with a sickness and 77-78% of people without one. In contrast about 13-17% of survey population without any sickness reported ill health. It is possible that many older people take ill health in their stride as a part of "usual/normal ageing". This observation has a lot of significance as self perceived health status is an important indicator of health service utilization and compliance to treatment interventions.

However, very little effort has been made to develop a model of health and social care in tune with the changing need and time. The developed world have evolved many models for elderly care e.g. nursing home care, health insurance etc. As no such model for older people exists in India, as well as most other societies with similar socioeconomic situation, it may be an opportunity for innovation in health system development, though it is a major challenge. The requirements for health care of the elderly are also different for our country. India still has family as the primary care giver to the elderly and scope for training this lot provide support to the programme. Presently Elderly are provided health care by the general health care delivery system in the country. At the primary care level, the infrastructure is grossly deficient. And otherwise the health system machinery is geared up to deal with the maternal and child health and communicable diseases. Elderly suffer from multiple and chronic diseases. They need long term and constant care. Their health problems also need specialist care from various disciplines e.g. ophthalmology, orthopedics, psychiatry, cardiovascular, dental, urology to name a few. Thus a model of care providing comprehensive health services to elderly at all levels of health care delivery is imperative to meet the growing health need of elderly. Moreover, the immobile and disabled elderly need care close to their homes.

As per the NPOP, Ministry of Health & Family Welfare was entrusted with the following agenda to attend to the health care needs of the elderly:

• Establishing Geriatric ward for elderly patients at all district level hospitals

• Expansion of treatment facilities for chronic, terminal and degenerative diseases

• Providing Improved medical facilities to those not able to attend medical centers – strengthening of CHCs / PHCs / Mobile Clinics

• Inclusion of geriatric care in the syllabus of medical courses including courses for nurses
• Reservation of beds for elderly in public hospitals
• Training of Geriatric Care Givers
• Setting up research institutes for chronic elderly diseases such as Dementia & Alzheimer

India was among the first countries to ratify UN Convention on the Rights of Persons with Disabilities (UNCRPD) which have come into effect from 3rd May, 2008. As per the provisions under Article 25 of UNCRPD, the health services needed by persons with disabilities should be provided as close to people's own communities, including in rural areas. In addition, at present there is huge shortage of manpower in geriatrics in the country. Elderly health care is part of the general health care system. As the elderly suffer from multiple chronic and disabling diseases, it becomes difficult for them to run from pillar and post to get appropriate health care. Moreover the general health care system is not adequately sensitized to the health needs of elderly. The undergraduate medical curriculum does not cover all aspects of geriatric care adequately. Postgraduate geriatric courses are grossly deficient in the country. Over and above, there are no posts to absorb the miniscule trained manpower, which is produced by only one medical college in the country i.e. Madras Medical College, Chennai. There is no incentive for the trained postgraduates and nearly half of the available lot has migrated to the countries where regular jobs are available for them.

As the elderly population is likely to increase in future, and there is definite shift in the disease pattern i.e. from communicable to non communicable, it is high time that the health care system gears itself to growing health needs of the elderly in an optimal and comprehensive manner. There is definite need to emphasize the fact that disease and disability are not part of old age and help must be sought to address the health problems.

The concept of Active and Healthy Ageing needs to be promoted not only among the elderly but the younger age groups as well, which includes promotional and preventive and rehabilitative aspects of health.

The Vision, Objectives & Expected Outcome

The National Programme for the Health Care for the Elderly (NPHCE) is an articulation of the International and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons (NPOP) adopted by the Government of India in 1999 & Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of Senior Citizen.

The Vision of the NPHCE is:

• To provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population;
• Creating a new "architecture" for Ageing;
• To build a framework to create an enabling environment for "a Society for all Ages";
• To promote the concept of Active and Healthy Ageing;

Specific Objectives of NPHCE are:

• To provide an easy access to promotional, preventive, curative and rehabilitative services to the elderly through community based primary health care approach

• To identify health problems in the elderly and provide appropriate health interventions in the community with a strong referral backup support.

• To build capacity of the medical and paramedical professionals as well as the care-takers within the family for providing health care to the elderly.

• To provide referral services to the elderly patients through district hospitals, regional medical institutions

• Convergence with National Rural Health Mission, AYUSH and other line departments like Ministry of Social Justice and Empowerment.

Core Strategies to achieve the Objectives of the programme are:

• Community based primary health care approach including domiciliary visits by trained health care workers.

• Dedicated services at PHC/CHC level including provision of machinery, equipment, training, additional human resources (CHC), IEC, etc.

• Dedicated facilities at District Hospital with 10 bedded wards, additional human resources, machinery & equipment, consumables & drugs, training and IEC.

• Strengthening of 8 Regional Medical Institutes to provide dedicated tertiary level medical facilities for the Elderly, introducing PG courses in Geriatric Medicine, and in-service training of health personnel at all levels.

• Information, Education & Communication (IEC) using mass media, folk media and other communication channels to reach out to the target community.

• Continuous monitoring and independent evaluation of the Programme and research in Geriatrics and implementation of NPHCE.

Supplementary Strategies include:

• Promotion of public private partnerships in Geriatric Health Care.

• Mainstreaming AYUSH – revitalizing local health traditions, and convergence with programmes of Ministry of Social Justice and Empowerment in the field of geriatrics.

• Reorienting medical education to support geriatric issues.

Expected Outcomes of NPHCE

• Regional Geriatric Centres (RGC) in 8 Regional Medical Institutions by setting up Regional Geriatric Centres with a dedicated Geriatric OPD and 30-bedded Geriatric ward for management of specific diseases of the elderly, training

of health personnel in geriatric health care and conducting research;

• Post-graduates in Geriatric Medicine (16) from the 8 regional medical institutions;

• Video Conferencing Units in the 8 Regional Medical Institutions to be utilized for capacity building and mentoring;

• District Geriatric Units with dedicated Geriatric OPD and 10-bedded Geriatric ward in 80-100 District Hospitals;

• Geriatric Clinics/Rehabilitation units set up for domiciliary visits in Community/Primary Health Centres in the selected districts;

• Sub-centres provided with equipment for community outreach services;

• Training of Human Resources in the Public Health Care System in Geriatric Care.S

Package of Services

In the programme, it is envisaged providing promotional, preventive, curative and rehabilitative services in an integrated manner for the Elderly in various Government health facilities. The package of services would depend on the level of health facility and may vary from facility to facility. The range of services will include health promotion, preventive services, diagnosis and management of geriatric medical problems (out and in-patient), day care services, rehabilitative services and home based care as needed.

Districts will be linked to Regional Geriatric Centres for providing tertiary level care. The services under the programme would be integrated below district level and will be integral part of existing primary health care delivery system and vertical at district and above as more specialized health care are needed for the elderly.

Packages of services to be made available at different levels under NPHCE

Health Facility	Packages of services
Sub-centre	• Health Education related to healthy ageing • Domiciliary visits for attention and care to home bound / bedridden elderly persons and provide training to the family care providers in looking after the disabled elderly persons. • Arrange for suitable callipers and supportive devices from the PHC to the elderly disabled persons to make them ambulatory. • Linkage with other support groups and day care centres etc. operational in the area
Primary Health Centre	• Weekly geriatric clinic run by a trained Medical Officer • Maintain record of the Elderly using standard format during their first visit • Conducting a routine health assessment of the elderly persons based on simple clinical examination relating to eye, BP, blood sugar, etc. • Provision of medicines and proper advice on chronic ailments • Public awareness on promotional, preventive and rehabilitative aspects of geriatrics during health and village sanitation day/camps. • Referral for diseases needing further investigation and treatment, to Community Health Centre or the District Hospital as per need.

Community Health Centre	• First Referral Unit (FRU) for the Elderly from PHCs and below. • Geriatric Clinic for the elderly persons twice a week. • Rehabilitation Unit for physiotherapy and counselling • Domiciliary visits by the rehabilitation worker for bed ridden elderly and counselling of the family members on their home-based care. • Health promotion and Prevention • Referral of difficult cases to District Hospital/higher health care facility
District Hospital	• Geriatric Clinic for regular dedicated OPD services to the Elderly. • Facilities for laboratory investigations for diagnosis and provision of medicines for geriatric medical and health problems • Ten-bedded Geriatric Ward for in-patient care of the Elderly • Existing specialities like General Medicine; Orthopaedics, Ophthalmology; ENT services etc. will provide services needed by elderly patients. • Provide services for the elderly patients referred by the CHCs/PHCs etc • Conducting camps for Geriatric Services in PHCs/CHCs and other sites • Referral services for severe cases to tertiary level hospitals
Regional Geriatric Centre	• Geriatric Clinic (Specialized OPD for the Elderly) • 30-bedded Geriatric Ward for in-patient care and dedicated beds for the elderly patients in the various specialties viz. Surgery, Orthopedics, Psychiatry, Urology, Ophthalmology, Neurology etc. • Laboratory investigation required for elderly with a special sample collection centre in the OPD block. • Tertiary health care to the cases referred from medical colleges, district hospitals and below

Activities under NPHCE at various levels

Sub Centre

The activities at the sub-centre are as follows:

• The ANM/Male Health Worker will provide elderly persons or the family /community health care providers information on interventions such as: Health Education related to healthy ageing, environmental modifications, nutritional requirements, life styles and behavioural changes.

• They will give special attention to home bound / bedridden elderly persons and provide training to the family health care providers in looking after the disabled elderly persons.

• They will arrange suitable callipers and supportive devices from the PHC and provide the same to the elderly disabled persons to make them ambulatory.

• Linkage with other support groups and day care centres etc. operational in the area Annual check-up of all the elderly at village level need to be organized by PHC/ CHC and information updated in Standard

Health Card for the Elderly to be developed by the National NCD cell. Role of ASHA at village level need to be worked out particularly for mobilize of the elderly to attend camps and home-based care for bed-ridden elderly Following items will be made available at the Sub-centre level:

• Walking Sticks
• Calipers
• Infrared Lamp
• Shoulder Wheel
• Pulley
• Walker (ordinary)

Primary Health Centre:

The PHC Medical Officer will be in-charge for coordination, implementation and promoting health care of the elderly. Following activities will be undertaken at the PHC:

• A weekly geriatric clinic will be arranged at PHC level by trained Medical Officer
• Conducting health assessment of the elderly persons based on simple clinical examination relating to vision, joints, hearing, chest, BP and simple investigations including blood sugar, etc. A simple questionnaire will be
filled up during the first visit of each Elderly and record updated and maintained.
• Proper advice on chronic ailments like Chronic Obstructive Lung Disease, Arthritis, Diabetes, Hypertension, etc. including dietary regulations.
• Public awareness during health and village sanitation day/camps.
• Provision of medicine to the elderly for their medical ailments.
• Referral for further investigations and treatment to Community Health Centre or the District Hospital as per need.

Following items will be made available at the PHC:

• Nebulizer
• Glucometer
• Shoulder Wheel
• Walker (ordinary)
• Cervical traction (manual)
• Exercise Bicycle
• Lumber Traction
• Gait Training Apparatus
• Infrared Lamp etc.

Community Health Centre

The Basic activities and role of the CHC under NPHCE are as under:

• First Referral Unit: CHC will be the first medical referral unit for patients from PHCs and below.

• Geriatric Clinic: CHC will arrange dedicated and specialized Geriatric Clinics for the elderly persons twice a week.

• Rehabilitation Services: Physiotherapist/Rehabilitation worker will be provided at CHC for physiotherapy and medical rehabilitation. Domiciliary visits by the rehabilitation worker will be undertaken for bed-ridden elderly and counseling to family members for care such patients.

• Referral for further investigations and treatment to District Hospitals/Medical Colleges as per need.

• Data Compilation: Compilation of data received from all the PHCs in jurisdiction of CHCs on elderly and forwarding the same to the District

Programme Officer (NCD)

Following items will be made available at the CHC:

• Nebulizer

• Glucometer

• ECG Machine

• Pulse Oximeter

• Defibrillator

• Multi - Channel Monitor

• Shortwave Diathermy

• Cervical traction (intermittent)

• Walking for gait training equipment

• Walking Sticks / Calipers

• Shoulder Wheel

• Pulley

• Walker (ordinary)

• Cervical traction (manual).

District Hospital

Geriatric Unit will be set up in District Hospitals with following functions:

• Geriatric Clinic for providing regular dedicated OPD services to the Elderly for examination and management of their illnesses.

• Geriatric Ward (10-bedded) for in-patient care to the Elderly. Out of the 10 beds, 2 beds will be earmarked in a separate room for the provision of respite care to the bed ridden.

• Facilities for laboratory investigations and provision of medicines for geriatric medical and health problems

• Existing specialities like General Medicine; Orthopaedics, Ophthalmology; ENT services etc. will provide services needed by elderly patients.

• Providing training to the Medical officers and paramedical staff of CHC's and PHC's

• Provide referral services to the elderly patients referred by the CHCs/PHCs etc

• Conducting camps for Geriatric Services in PHCs/CHCs and other sites

• Referral services for severe cases to tertiary level hospitals/ Regional Geriatric Centres

To carry out various functions at the District level, District Geriatric Unit will be set up as per following guidelines:

(b) Ten-bedded Geriatric ward will be established at each of the identified District Hospital for providing dedicated health care to the geriatric patients. Out of these 10 beds, 2 beds will be earmarked in a separate room for the provision of respite care to elderly bed ridden / home bound persons.

(c) Geriatric Clinic for specialized OPD services. Efforts should be made to minimize movement of the Elderly in the hospital for examination by Specialists and laboratory investigations.

(d) Keeping in view the scarcity of specialists in geriatric field, the existing specialists in various fields who are either trained in geriatric or interested in the field be utilized for managing Geriatric Clinic and Geriatric Wards.

Additional staff sanctioned under NPHCE are given below:

(e) Investigations: It will be the responsibility of the concerned district hospital to provide lab services, x - ray and other special investigations required for the elderly. A special collection centre should be provided in the OPD block.

(f) Referral Services: The institution will be responsible to provide secondary health care to the cases referred from within the district.

(g) Drugs and Consumables: Additional drugs and consumables can be purchased out of provision of Rs. 10 lakh under the Programme. Any further expenses on this count shall be borne from hospital's own resources.

Following items will be made available at the District Hospital:

• Nebulizer
• Glucometer
• ECG Machine
• Defibrillator
• Multi-channel Monitor
• Non invasive Ventilator
• Shortwave Diathermy
• Ultrasound Therapy
• Cervical traction (intermittent)
• Pelvic traction (intermittent)
• Tran electric Nerve stimulator (TENS)
• Adjustable Walker.

Regional Geriatrics Centres

The programme will support establishment of Geriatrics Centres in the Department of Medicine of 8 following selected Medical Institutions of the country.

Regional Institutes States Linked

1 All India Institute of Medical Sciences, New Delhi Delhi, Haryana, Uttarakhand, Punjab Himachal Pradesh, Madhya Pradesh

2 Institute of Medical Sciences, Banaras Hindu Uttar Pradesh, Bihar, Jharkhand, West Bengal University, Uttar Pradesh

3 Sher-e-Kashmir Institute of Medical Sciences, Jammu & Kashmir Srinagar, Jammu & Kashmir

4 Govt. Medical College, Tiruvananthapuram, Kerala, Southern Districts of Karnataka & Tamil Kerala Nadu

5 Guwahati Medical College, Guwahati, Assam Assam & NE States

6 Madras Medical College, Chennai, Tamil Nadu Tamil Nadu, Andhra Pradesh, Orissa

7 SN Medical College, Jodhpur, Rajasthan Rajasthan & Gujarat

8 Grants Medical College & JJ Hospital, Mumbai, Maharashtra, Goa, Northern Districts of Karnataka, Maharashtra Chattisgarh

These will be termed as Regional Geriatric Centres. Following will be the key functions of the Regional Geriatric Centres:

• Provide tertiary level services for complicated/serious Geriatric Cases referred from Medical Colleges, District Hospitals and below.

• Conducting post graduate courses in Geriatric Medicine.

• Providing training to the trainers of identified District hospitals and Medical Colleges

• Developing evidence based treatment protocols for Geriatric diseases prevalent in the country.

• Developing/and updating Training modules, guidelines and IEC materials.

• Research on specific elderly diseases.

10. National Leprosy Eradication Programme

The National Leprosy Eradication Programme is a centrally sponsored Health Scheme of the Ministry of Health and Family Welfare, Govt. of India. The Programme is headed by the Deputy Director of Health Services (Leprosy) under the administrative control of the Directorate General Health Services Govt. of India. While the NLEP strategies and plans are formulated centrally, the programme is implemented by the States/UTs. The Programme is also supported as Partners by the World Health Organization, The International Federation of Anti-leprosy Associations (ILEP) and few othe Non-Govt. Organizations.

Strategy - Leprosy Elimination in India

- Decentralized integrated leprosy services through General Health Care system.
- Early detection & complete treatment of new leprosy cases.
- Carrying out house hold contact survey in detection of Multibacillary (MB) & child cases.
- Early diagnosis & prompt MDT, through routine and special efforts
- Involvement of Accredited Social Health Activists (ASHAs) in the detection & complete treatment of Leprosy cases for leprosy work
- Strengthening of Disability Prevention & Medical Rehabilitation (DPMR) services.
- Information, Education & Communication (IEC) activities in the community to improve self reporting to Primary Health Centre (PHC) and reduction of stigma.
- Intensive monitoring and supervision at Primary Health Centre/Community Health Centre.

Community Processes under NHM in Rajasthan

Session- Community Processes under NHM in Rajasthan

Sessions Objective-

1. To develop understating of Community processes under NRHM
2. To gain knowledge about interventions under Community Processes, including
    a) ASHA Programme
    b) VHSNC (Village, Health, Sanitation and Nutrition Committee)
    c) MCHN day (Maternal and Child Health and Nutrition Day)
3. To understand the role of Panchayati Raaj in Health

Contents-

- ASHA- Seletion,Roles and Responsibility, Capacity Building and Training, Incentives, Home Visit,
- VHSNC- Structure, Members, Meetings, Responsibilities, Untied fund and its use,
- MCHN Day- Planning, due list, beneficieries, Role of functionaries AAA, Logistics requirements, Community involvement ,
- PRI and Health –Aapno Swasthya –Apni Panchyat

Methodology

Group Exercise, Presentation, Brain storming

Duration -1.30 Hours

Note for Trainer's

Session may be devided into three parts

- Community process and structure
- Key areas of community process
- ASHA, VHSNC, PRI and Health

Session shoud be begin with discussions on need of communitization of health services and role of community

- Participants may be asked following questions
    - ❖ What is community?
    - ❖ Who are the stakeholders..
    - ❖ Need to understand the vulnerability and vulnerable
    - ❖ Key plate forms of community involvement in NHM

Activity -1

Facilitator should develop the PPTs of ASHA program, VHSC and PRI and Health.

Activity-2

After presentation Role play can be performed to understand the functioning of VHSNC and Observation of MCHN Day and Meeting of Panchyat on Health Issues.
After role play discussion may be held on each component

At last 10 minutes may be kept for discussion on questions of participants may have.

Community Processes

Objectives: Following are the learning objectives of this session:

4. To develop understating of Community processes under NRHM
5. To gain knowledge about interventions under Community Processes, including
   d) ASHA Programme
   e) VHSNC (Village, Health, Sanitation and Nutrition Committee)
   f) MCHN day (Maternal and Child Health and Nutrition Day)
6. To understand the role of Panchayati Raaj in Health

Definition of Community Processes: These are the interventions with community engagement to ensure people's participation in health and to enable action on social determinants of health. Under NRHM it is important to strengthen community processes interventions, thereby reducing gap between service utilization and service provision through attention to field implementation that will result in achieving health outcomes.

ASHA (Accredited Social Health Activist) Programme

Since inception of NRHM in 2005, ASHA (known as ASHA Sahyogini in Rajasthan) has played an important and critical role in implementation of health activities under NRHM. The ASHA programme was introduced as a key component of the community process intervention and now it has emerged as the largest community health worker programme in the world and is considered a critical contribution to enabling people's participation in health.

ASHA is a community level worker whose role is to function as a health care facilitator, a service provider and to generate awareness on health issues. Besides delivering key services to maternal child health and family planning, she also renders important services under National Disease Control Programme.

ASHA`s Work Profile:

- Ensuring 4 antenatal checkups, institutional delivery and post natal checkups.
- Identifying the risk and referring the mother & child to the health institution.
- Promoting attendance of children at anganwadi on village health and nutrition day for immunization.
- Holding monthly meetings of Village Health and Sanitation Committee.
- Counselling couples for family planning and distributing contraceptives to eligible couples.
- Counselling mothers fo immunization of child at every household.
- Interface between community and health services to control diseases such as Malaria, T.B., Blindness etc.

Accredited Social Health Activists - ASHA

Every village/large habitat all over the country has a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. ASHA is a bridge between the ANM and the village is accountable to the Panchayat. She is an honorary volunteer, receiving performance-based compensation. ASHA is responsible for:

- Creating awareness on health and its social determinants

- Mobilising the community towards local health planning and increased utilisation and accountability of the existing health services.
- Promoting good health practices.

Will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

Policy Framework and Institutional mechanisms for ASHA

Selection

ASHAs must primarily be female residents of the village that they have been selected to serve, who are likely to remain in that village for the foreseeable future. Married, widowed or divorced women are preferred over women who have yet to marry since Indian cultural norms dictate that upon marriage a woman leaves her village and migrates to that of her husband. ASHAs must have class eight education or higher, preferably be between the ages of 25 and 45, and are selected by and accountable to the gram panchayat (local government). If there is no suitable literate candidate, a semi-literate woman with a formal education lower than eighth standard, may be selected.

For the sustainability of ASHA programme, there is a need to plan for atleast 5% turnover and fresh selection every year. States need to engage more ASHAs to meet the deficit due to rise in rural population (as per 2011 Census). The general norm will continue to be 'One ASHA per 1000 population'. When the population exceeds one thousand, another ASHA can be engaged. Where there is more than one ASHA in a village, each ASHA needs to be allocated a set of households so that no households, particularly those in the periphery and outlying hamlets are missed. In tribal, hilly and desert areas, the norm can be relaxed to one ASHA per habitation, depending on the workload, geographic dispersion, and difficult terrain. In urban habitations with a population of 50,000 or less, ASHAs will be selected as in rural areas. The urban health mission is expected to extend the ASHA program to all urban areas.

Selection of ASHAs is near completion in all states according to the norms laid during the first phase of NRHM. For the sustainability of programme, there is a need to plan for atleast 5% turnover and fresh selection every year. States need to engage more ASHAs to meet the deficit due to rise in rural population (as per 2011 Census). The general norm will continue to be 'One ASHA per 1000 population'. When the population exceeds one thousand, another ASHA can be engaged. Where there is more than one ASHA in a village, each ASHA needs to be allocated a set of households so that no households, particularly those in the periphery and outlying hamlets are missed. In tribal, hilly and desert areas, the norm can be relaxed to one ASHA per habitation, depending on the workload, geographic dispersion, and difficult terrain. In urban habitations with a population of 50,000 or less, ASHAs will be selected as in rural areas. The urban health mission is expected to extend the ASHA program to all urban areas.

Selection of ASHAs is complete across most states. Except Bihar, Rajasthan and UP, all high focus states have close to or above 95% ASHAs in place.

Rajasthan has 87% ASHAs in place against the target. The gap in Rajasthan is due to increased targets based on population increase as per 2011 census and identification of non functional ASHAs (source: NHSRC Report Update on ASHA Programme, January 2015).

The District Health Society is expected to oversee the process. The Society should designate a District Nodal Officer who belongs to the regular cadre to oversee the process of selection in the entire district. She/He will be supported by the District Community Mobilizer (DCM).

At the block level, the Society should designate a Block Nodal Officers, who belongs to the regular cadre, such as the Block Medical Officer or Block Extension Educator (BEE). The Bock nodal officer will be supported by the Block Community Mobilizers (BCM) and ASHA facilitator in the selection process. The BCM and ASHA facilitators will work closely with the community in selecting the ASHA.

The ASHA Facilitators should be oriented to the selection process as part of their training in the Handbook for ASHA Facilitator. Training the BCM and facilitator is the responsibility of the state ASHA and Community Processes Resource Centre (CPRC).

The facilitators are required to raise awareness in the community about the roles and responsibilities of the ASHA and the criteria on which she is to be selected. This is done through community interaction in the form of meetings, Focus Group Discussions (FGDs) and mobilizational events such as Kala Jathas. These processes enthuse women to apply to become ASHA.

The trained facilitator will organize meeting of the households for which an ASHA is to be selected. In order to organize the meetings, the facilitators should engage actively with representatives of the Panchayat Raj Institutions (PRI), women's Self-Help groups, other Community based groups, and local Civil Society Institutions. In the meeting the facilitator will explain the roles and responsibilities of the ASHA and ask the community to select their ASHA from amongst the women interested in taking up this role. This interaction should result in short listing of at least three names from each village.

Ideally, a meeting of the Gram Sabha should be convened to select one of the three shortlisted names. The minutes of the approval process in Gram Sabha shall be recorded. The name will be forwarded by the Gram Panchayat to the Block and Nodal Officer for the record.

State Governments may modify the guidelines and the details of the selection process, based on their context except that no change may be made in the basic criteria of ASHA being a woman volunteer, with minimum education up to VIII class, (only to be relaxed in selected areas where no such candidate is available) and that she would be a resident of the village. In case any of the selection guidelines or process is modified, these should be widely disseminated in local languages.

ASHA Database

An ASHA database/register will be maintained at Block, District and State levels. The function of the register is to maintain updated information on the ASHA, population coverage, households allocated, training inputs received, and performance, data on drop-outs and new appointments. This should be updated as specified.

Database registers will be maintained at block and district levels by the nodal officers, updated as and when required. On an annual basis the data will be consolidated and sent to the state as an aggregate number as specified in the Annexure I This would help in maintaining a comprehensive record of all the ASHAs working in the district as well as drop outs from the programme. The register will also record the number of areas without an ASHA.

Criteria for declaring an ASHA as a "drop out"

ASHA is to be considered as drop out if:

- She has submitted a letter of resignation to the VHSNC and her facilitator OR
- She has not attended the three consecutive VHNDs AND not given reasons for the same OR
- She has not been active in most of the activities AND Block Community Mobilizer/Coordinator visited the village of the ASHA and ascertained through discussions with all VHSNC members that she is indeed not active.

If there is a genuine problem, she should be supported until it is overcome through the VHSNC or village SHG. If the problem persists and the community also agrees that ASHA should not continue, a signed letter stating this should be obtained from her and approved by Block Community Mobilizer after due validation from Gram Sabha/Panchayat. In case of her contesting her removal, it should be referred to the district community mobilizer or other person appointed by the secretary of the district health society who would listen to her views, record them and then take a final view. It is desirable in case of all 'dropouts' whatever the reason, to conduct and document an exit interview.

Vacancies howsoever they arise, should be filled in by the same selection process as laid down by state government, based on the guidelines of NHSRC(Guidelines for Community Processes at http://www.nhsrcindia.org/index.php).

Rajasthan Initiative: ASHA Sahayogini

Only in Rajasthan state, ASHA worker is known as ASHA Sahyogini.

Convergence of DWCD and NRHM

In each Anganwadi Center apart from Anganwadi Worker and Sahayoka one additional worker named 'Sahyogini' is envisaged to provide door to door information and services of Nutrition, Health, preschool education. Her role is quite similar to the role of ASHA under NRHM. So to avoid duplication of workers providing same types of services in the same area, the decision was taken at State level, that there will be only one worker coterminous with Anganwadi, who will work with DWCD and DMHS. This worker is called as 'ASHA Sahyogini, selected by the community through Gram Panchayat and responsible to the community.

Criteria for selection

- One ASHA Sahyogini for each Anganwadi Center.
- Woman resident of that area, Married/ Widow/ Divorcee
- Age between 21 to 45 years
- ASHA Sahyogini should have effective communication skills, leadership qualities and be able to reach out to the community.
- ASHA Sahyogini should be literate woman with formal education up to eighth class, In tribal and desert areas the educational qualification may be relaxed if the 8th pass candidate is not available. This is permitted only after the approval of State level Committee.
- Adequate representation from disadvantaged population groups

Roles and Responsibilities of an ASHA

The roles and responsibilities of an ASHA include the functions of a healthcare facilitator, a service provider and a health activist. Broadly her functions involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services; participation in health campaigns and enabling people to claim health entitlements.

Her roles and responsibilities would be as follows:

- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely use of health services.
- She will counsel women and families on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will mobilize the community and facilitate people's access to health and health related services available at the village/sub-centre/primary health centres, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She will work with the Village Health, Sanitation and Nutrition Committee to develop a comprehensive village health plan, and promote convergent action by the committee on social determinants of health. In support with VHSNC, ASHAs will assist and mobilize the community for action against gender based violence.
- She will arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre- identified health facility i.e. Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC/FRU).
- ASHA will provide community level curative care for minor ailments such as diarrhoea, fevers, care for the normal and sick newborn, childhood illnesses and first aid. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential health products appropriate to local community needs. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. These will be updated from time to time, States can add to the list as appropriate.
- The ASHA's role as a care provider can be enhanced based on state needs. States can explore the possibility of graded training to the ASHA to provide palliative care, screening for noncommunicable diseases, childhood disability, mental health, geriatric care and others.
- The ASHA will provide information on about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre. She will promote construction of household toilets under Total Sanitation Campaign.

Key Five Activities

The ASHA will fulfill her role through five activities:

1. Home Visits: For up to two hours every day, for at least four or five days a week, the ASHA should visit the families living in her allotted area, with first priority being accorded to marginalized families. Home visits are intended for health promotion and preventive care. They are important not only for the services that ASHA provides for reproductive, maternal, newborn and child health interventions, but also for non- communicable diseases, disability, and mental health. The ASHA should prioritize homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child. Home visits to these households should take place at least once in a month. Where there is a new born in the house, a series of six visits or more becomes essential.

2. Attending the Village Health and Nutrition Day (VHND): The ASHA should promote attendance at the monthly Village Health and Nutrition Day by those who need Aganwadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services.

3. Visits to the health facility: This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility based care. The ASHA is expected to attend the monthly review meeting held at the PHC.

4. Holding village level meeting: As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), the ASHA is expected to help convene the monthly meeting of the VHSNC and provide leadership and guidance to its functioning.

These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.

5. Maintain records: Maintaining records which help her in organizing her work and help her to plan better for the health of the people.

The first three activities relate to facilitation or provision of healthcare, the fourth is mobilizational and fifth is supportive of other roles.

Drug Kit for ASHA

- **Drug Kit for ASHA Sahyogini -** The drug Kit is provided to ASHA Sahyogini to provide primary Health Care to the community like minor elements like fever, pain, First Aid etc. The replenishment of medicines is made from PHC /Subcenter stocks.
- **Monthly Meetings -** The joint monthly meetings are conducted at PHCs by DWCD and DMHS. ASHA Sahyoginis are interacting with service providers in this monthly meeting. The replenishment of Medicines and payment of incentives are ensured during these meetings.
- ASHA Sahyoginis are expected to maintain all the information of their village. There these diaries are prepared and given to ASHAs.

ASHA Diary

- This diary will help ASHAs to collect and maintain all the relevant information. This diary will help ASHA to have evidence based arguments at village level health discussions. Pictorial methods have been used in this diary to aware them regarding their roles and responsibilities. All the ASHAs are directed to maintain the diary regularly and clearly.

ASHA and MCHN

- Common platform for people to access services
- Held at AWC
- Once every month

ASHA Training

Training Programme for ASHA-Sahyogini

Objective: To develop capacity of ASHA Sahyogini to support NRHM interventions in Rajasthan.

Induction Training

The eight days training covers content of five modules (Module1-5). The training inducts the newly selected ASHA about functioning and goals of NRHM and trains them about roles and responsibilities.

Module 5 Training

The training of Module 5 were conducted in the financial year 2014 only for completing the backlog of earlier years. This was a four day training and was implemented at District and Block level. This training helped ASHA in developing necessary skills which are required by her to perform better. However, Module 5 trainings were stopped after year 2014.

Module 6 & 7

The training of Module 6 and Module 7 is done in four round of combination of both module contents- Round 1, Round 2, Round 3 and Round 4.

Training for each round is of 5 days each. There should be a gap of about two-three months. The training is based on key competencies in maternal, new born, children's health and nutrition. The training aims at developing necessary technical skills of ASHA sahyogini in order to contribute to HBNC and other health care services.

ToT for Training of ASHA Facilitators

For implementation of trainings at District level, a Training of Trainers was done at State level. Training for State Trainers are organised at National Level on recognized traiing centres such as Gadchiroli in Maharastra etc. ToTs are organised in rounds-Round 1, Round 2 and Round 3.

Refresher Trainings for ASHA Facilitators in State

Refresher trainings of 5 days duration were conducted for ASHA facilitators. Trainings were implemented at District level. The training was based on ASHA Facilitators Handbook. ASHA Facilitators/ supervisors/ PHC supervisors/ health supervisors. The training was organised to train ASHA facilitators in skills of problem solving and assisting ASHA sahyogini and to refresh the monitoring and supervisory skills of ASHA facilitators.

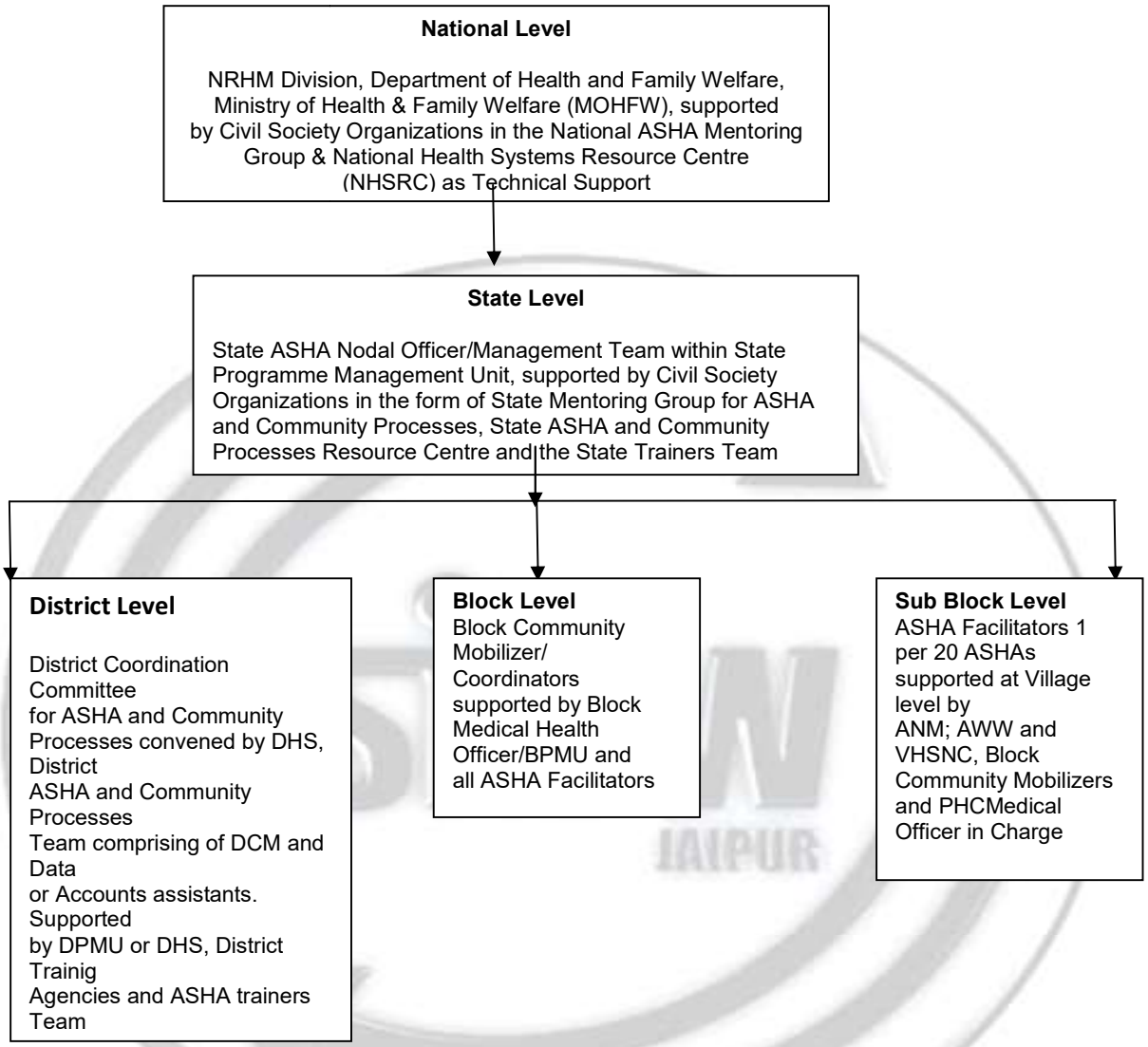
Support Structure for ASHA

Composition of Support Structures for ASHA and Community Processes At the state level the programme is expected to be supported by Community Processes Resource Centre (with different nomenclature across states) led by a team leader, and a team of Programme Managers and consultants (for ASHA Programme/VHSNC/ Communications and Documentation/Training and Regional/Zonal coordinators).CPRC will focus on resource & technical support and training. State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organizations, is expected to provide policy guidance and programmatic oversight. At the district level, the team of a District Nodal Officer supported by a District Community Mobiliser and Data Assistant is expected to manage the programme. At the block level, a Block Community Mobilizer and ASHA facilitators (one ASHA Facilitator for 10 to 20 ASHAs) are expected to provide support and supervision. The recently

revised guidelines envisage that these support structures at all levels will support ASHA programme, VHSNC and all other community processes interventions.

This support structures with adequate capacity building is essential for effective implementation of Community Processes and provide adequate support to ASHAs as well as VHSNC. Many states have made efforts to build convergence between the management structures for ASHA and VHSNC. The learning has been that integration of state management structures leads to improved coherence and better use of resources. It also helps the state in expediting the process of selection and trainings of ASHAs and VHSNC members and utilize the ASHA trainers as trainers for other community processes as well.

Support Structure for ASHA



Maternal, Child Health and Nutrition Day

The MCHN day is organised once every month preferably on Thursdays.

It is organised for those villages and areas which have been left out, on any other day of the same month. Venue is Anganwari Centre of the village and / or Health centre. Community mobilization is done by field functionaries including ANMs, ASHA and Anganwari Workers.

Strategy for MCHN Day

Each PHC will be the planning unit. Medical officer will be the overall in Charge.

Team:

Vaccinators:All the ANms and LHVs will form the PHC team. When required, additional vaccinators could be deployed from neighbouring PHCs where activities are not planned.
Social mobilizers: In each village, ANM/LHV will identify 1 mobillizer (AWW, Sahyogini, ASHA: if none of these are available, identify another local woman)

Sites:

Sub- center, Anganwadi, school, panchayat ghar. For remote hamlets, a site as close to the hamlets as possible should be identified. For scattered hamlets, mobile teams should cover the populations.
Remember: Conduct the MCHN session as scheduled on Thursdays

Conducting a MCHN session

Timing:

10:00 am to 05:00 pm. If two sessions are planned, conduct sessions from 10-1 pm and 2:00 to 05:00.

Informing families and mobililzing children:

One day prior to the session, social mobilizer should be requested to conduct house-to-house canvassing ans community line-listing to identify all eligible children and pregnant women.

Preparing the vaccine and logistics:

Cold chain handler at the PHC will be vaccine- carrier as per the requirements specified in the PHC plan, and label each vaccine- carrier.

Transporting vaccines, logistics and staff:

One vehicle will be hired at the vaccine depot for transporting vaccines, logistics and manpower to the session- site. Vehicle will leave the vaccine depot at 07:00 am so as to cover all the session sites by 10:00 am. If all session- sites cannot be reached in three hours due to large distance/ inaccessibility, another vehicle may be hired.

Supervising:

Supervisor (LHV and or MO) will monitor the sessions using the monitoring Checklist using the same

vehicle after dropping the vaccines and logistics. In the evening, same vehicle will return to the vaccine depot, collecting all the vaccine carriers and dropping back the staff.

ANC Services at MCHN Day

- Complete history of the current and previous pregnancy and any medical/surgical problem in the past
- Weight, BP, Blood test for Hb, urine and abdominal examination
- 100 IFA tablets and TT
- Counselling on nutritious diet and proper rest
- Identification of High Risk Pregnancy
- Referral, if needed and counselling for precautions

Complete Service Package

Maternal Health

- Early registration of pregnancies.
- Focused ANC.
- Referral for women with signs of complications during pregnancy and those needing emergency care.
- Referral for safe abortion to approved MTP centres.
- Counseling on:
- Education of girls.
- Age at marriage.
- Care during pregnancy.
- Danger signs during pregnancy.
- Birth preparedness.
- Importance of nutrition.
- Institutional delivery.
- Identification of referral transport.
- Availability of funds under the JSY for referral transport.
- Post-natal care.
- Breastfeeding and complementary feeding.
- Care of a newborn.
- Contraception.
- Organizing group discussions on maternal deaths, if any, that have occurred during the previous month in order to identify and analyse the possible causes.

Child Health

- Infants up to 1 year :
    - Registration of new births.
    - Counselling for care of newborns and feeding.
    - Complete routine immunization.
    - Immunization for dropout children.
    - First dose of Vitamin A along with measles vaccine.
    - Weighing.

Children aged 1-3 years

- Booster dose of DPT/OPV
- Second to fifth dose of Vitamin A
- Table IFA – (small) to children with clinical anaemia.
- Weighing

- Provision of supplementary food for grades of mild malnutrition and referral for cases of severe malnutrition

All children below 5 years

- Tracking and vaccination of missed children by ASHA and AWW.
- Case management of those suffering from diarrhea and Acute Respiratory infections.
- Counseling to all mothers on home management and where to go in even of complications.
- Organizing ORS depots at the session site.
- Counseling on nutrition supplementation and balanced diet.
- Counseling on and management of worm infestations.

Family Planning

- Information on use of contraceptives.
- Distribution – provision of contraceptive counseling and provision of non-clinic contraceptives such as condoms and OCPs.
- Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

RTI/STI

- Counseling on prevention of RTIs and STIs, including HIV/AIDS, and referral of cases for diagnosis and treatment.
- Counseling for perimenopausal and post-menopausal problems
- Communication on causation, transmission, and prevention of HIV/AIDS and distribution of condoms for dual protection
- Referral for VCTC and PPTCT services to the appropriate institutions.

Sanitation

- Identification of households for the construction of sanitary latrines
- Guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the Total Sanitation Campaign.
- Avoidance of breeding sites for mosquitoes.
- Mobilization of community action for safe disposal of household refuse and garbage.

Communicable Diseases

- Group communication activities for raising awareness about signs and symptoms of leprosy, suspected cases, and referrals.
- Group communication activities for elimination of breeding sites for mosquitoes, management of fever cases, i.e. importance of collection of blood film for MP and presumptive treatment.
- Awareness generation about symptoms of TB (Coughing for more than three weeks), importance of continued treatment, referral of symptomatic for sputum examination at the nearest health centre.
- Provision of anti-TB drugs to patients.
- Reporting of unusual numbers of cases of any disease or disease outbreak in village.

Gender Issues

- Communication activities for prevention of pre-natal sex selection, illegality of pre-natal sex selection, and special alert for one daughter families.
- Communication on the Prevention of Violence against Women, Domestic Violence Act, 2006.
- Age at marriage, especially the importance of raising the age at marriage for girls.

AYUSH

- Home remedies for common ailments based on certain common herbs and medicinal plants like tulsi found in the locality.
- Information related to other AYUSH components, including drugs for treating conditions like anaemia.

Health Promotion

- Chronic diseases can be prevented by providing information and counseling on:
- Tobacco chewing
- Healthy lifestyle
- Proper diet
- Proper exercise

Nutrition

Diseases due to nutritional deficiencies can be prevented by giving information and counseling on:

- Healthy food habits.
- Hygienic and correct cooking practices.
- Checking for anaemia, especially in adolescent girls and pregnant women; checking, advising, and referring.
- Weighing of infants and children.
- Importance of iron supplements, vitamins, and micronutrients
- Food that can be grown locally.
- Focus on adolescent pregnant women and infants aged 6 months to 2 years.

Role of ANM

- Immunization-to pregnant women and children
- ANC care to pregnant women
- Counselling and contraceptive services to eligible couples
- Basic level curative care for minor illness with referral

Who will attend

- Members of the PRI
- Women members of the community
- Pregnant women
- Women with children under two
- Adolescent girls
- General community members

What should ASHA do?

Make a list of the following-

- Pregnant women for ANC care and mothers needing PNC
- Infants who need their next dose of immunization
- Malnourished children
- TB patients who are on anti-TB drugs
- Those with fever who have not been able to see a doctor or need follow up
- Eligible couples who need contraceptive services or counseling
- Any others who need care by ANM
- **Ensure presence of the above to bridge the gap between Service Utilisation and Service Provision**

ASHA should consider including-

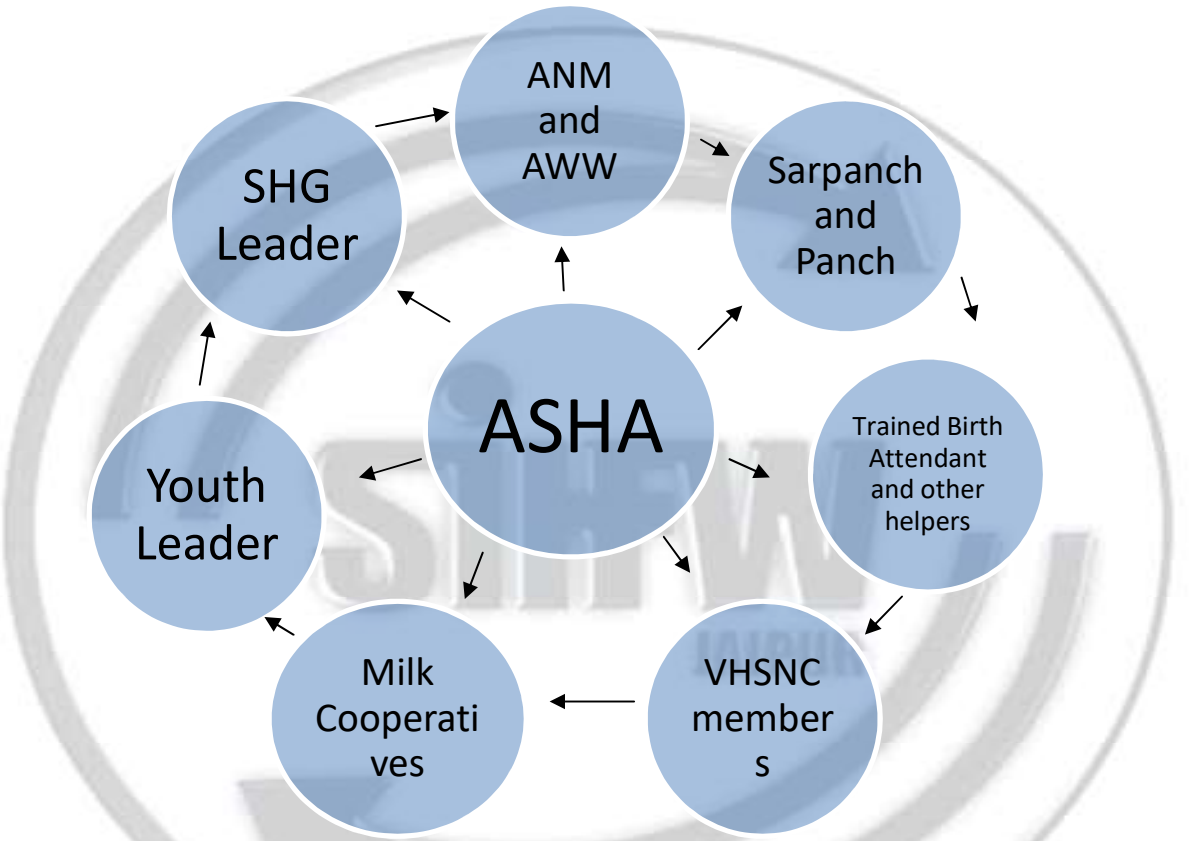
- In the list

- Individuals from families of new migrants
- Living in distant hamlets
- Vulnerable persons because of poverty or marginalised

Coordination with ANM and AWW

- Coordinate with ANM and AWW to know in advance which day the MCHN day is scheduled
- Location of MCHN day
- So as to inform those who need these services and the community, specially the VHSNC members

Coordination Linkages



Topics of MCHN Day-IEC

- Care in pregnancy, including nutrition, importance of antenatal care and danger sign recognition
- Planning for safe deliveries and postnatal care
- Exclusive breastfeeding and the importance of appropriate complimentary feeding
- Immunization: the schedule and the importance of adhering
- Importance of safe drinking water, hygiene and sanitation, and discussion on what actions can be taken locally to improve the situation
- Delaying the age at marriage, postponing the first pregnancy and the need for spacing
- Adolescent health awareness, including nutrition, retention in school till high/higher secondary level, anaemia correction, menstrual hygiene and responsible sexual behaviour
- Prevention of Malaria, TB and other communicable diseases
- Awareness on prevention and seeking care for RTI/STI and HIV/AIDS
- Prevention of tobacco use and alcoholism

ASHA INCENTIVES

.S.No	Activity Name	Budget Head	Incentives	
			Rural	Urban
Maternal Health Services				
1.	3 ANC Checkups	A1.3.4.1	300	200
2.	Institutional Delivery Promotion	A1.3.4.2	300	200
3.	Woman Death Reporting	B1.1.3.1.1	200	
4.	Collecting Bank Account And Aadhar	A1.3.3	5	
Child Health Services				
5.	HBNC Plus	NIPI	500	
6.	HBNC	B1.1.3.2.1	250	
7.	Child Death Reporting	A.2.8	50	
8.	Followups of SAM Child after Discharge from MTC	B1.1.3.2.5	150	
9.	SNCU Followups	B1.1.3.2.3	600	
Immunization Services				
10.	Social Mobilization	C.1.h	150	
11.	Full Immunisation	C.5	100	
12.	Booster Doses	C.5	50	
Family Planning Services				
13.	Post Partum Sterilisation	B1.1.3.3.1	300	
14.	Female Sterlisation	A.3.1.3	200	
15.	Male Sterlisation	A.3.1.4	300	
16.	Sterlisation on 1 or 2 Children	B1.1.3.3.3	1000	
17.	Ensuring 2 years Delay of Child Births After Marriage	B1.1.3.3.2	500	
18.	For 3 years Difference Between Age of Two Children	B1.1.3.3.4	500	
19.	Postpartum Intrauterine Contraceptive Device (PPIUCD)	B1.1.3.3.1	150	
National Programme				
20.	DOTs Patients - Category 1st		1000	
21.	DOTs Patients - Category 2nd		1500	
22.	DOTs Patients - Drug Resistant TB (at the end of IP)		2000	
23.	DOTs Patients - Drug Resistant TB (at the end of CP)		3000	
24.	Cataract Patients		250	
25.	Leprosy Patients Registration - PB and MB Cases	H 1.1	250	
26.	Leprosy Treatment Completion - PB Cases	1.3	400	
27.	Leprosy Treatment Completion - MB Cases	1.3	600	
28.	Malaria Cases - Full RT	F.1.1.b	75	
29.	Blood Slides Preparation	F.1.1.b	15	
Monthly Meetings				
30.	Monthly Meetings at Sector Level	B1.1.3.6.2	150	
31.	Routine Monthly Activities	B1.1.3.6.3	100	

VHSNC-Village Health, Sanitation, Nutrition Committee

As community empowerment approach, the NRHM envisaged to put village health and sanitation committee as incharge for local decentralized planning & monitoring at the village level. With 43,440 VHSCs constituted across the state, it was a humangous task to sensitize the VHSC members towards health issues particularly in relation to their rights and duties Village Health & Sanitation committee (VHSC) which is the fifth committee (Development Committee) of the Gram Panchayat level, is the key agency for developing Village Health Plan in view of the prevalent problematic health issues and execute pragmatic and prudent solutions in consultation with the stakeholders. Village Health Committees are the first step towards communitization of health care services and for making health as a people's movement. This committee comprises of Panchayat representatives, ANM, MTW, Anganwadi workers, Teachers, Community health volunteers, ASHA besides representative from SHG, NGO, and MSS etc. ASHA Sahyogini is the Convener for this Committee.

Village Health Committee will facilitate in addressing the health needs of the entire village with the help of health providers and health institutions. VHSCs will play an important role in planning and monitoring of the health care services through community monitoring mechanism. Composition of the Village Health & Sanitation Committee To enable the Village Health & Sanitation Committee to reflect the aspirations of the local community especially of the poor households and women, it has been suggested that:

a. At least 50% members on the Village Health & Sanitation Committee should be women.
b. Every hamlet within a revenue village must be given due representation on the Village Health and Sanitation Committee to ensure that the needs of the weaker sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committee.
c. A provision of at least 30% representation from the Non-governmental sector.
d. Representation to women's self-help group etc. on these committees etc. will enable the Committee to undertake women's health activities more effectively.
e. Notwithstanding the above, the overall composition and nomenclature of the Village Health & Sanitation Committees is left to the State Governments as long as these committees were within the umbrella of PRIs.

Roles and Responsibilities of VHSC members

- Awareness Generation
- Supervision and Monitoring and Death Audit
- Health problems Identification and development of a VHP
- Feedback for corrective measures.
- Maintenance of Village Health Register and Calendar
- Ensuring Visits of MPW, ANM
- Management of Untied fund for VHC

Role of Village Health Committee: Activities

a. Create Public Awareness about the essentials of health programs.

b. Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community.

c. Analyze key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present annual health report of the village in the Gram Sabha.

d. Participatory Rapid Assessment: to ascertain the major health problems and health related issues in the village. Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping will also take into account the health resources and the unhealthy influences within village boundaries.

e. Maintenance of a village health register and health information board/calendar: The health register and board put up at the most frequented section of the village will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc.

f. Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW.

g. Get a bi-monthly health delivery report from health service providers during their visit to the village.

h. Take into consideration all the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.

i. Discuss every maternal death or neonatal death that occurs in their village, analyze it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.

j. Managing the Village health fund. Village Health Fund: Untied Fund An untied fund for VHCs- There is a provision of Rs.10, 000/- as untied funds for each VHSC per year. This untied fund is to be deposited in concerned Subcenters Account which is jointly operated by ANM and Sarpanch. The untied fund is utilized for demand generation for health care services, sanitation drives, emergency health care needs, rewards for exceptional work in health sector, publicity of MCHN days, RCH camps etc. The untied funds are to be used for the community actions for improvement of health status of the community, for any of the following activities: -

a. As a revolving fund from which households could draw in times of need to be returned in installments thereafter.

b. For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.

c. In extraordinary case of a destitute women or very poor household, the Village Health & Sanitation Committee untied grants could even be used for health care need of the poor household.

d. The untied grant is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household. Nutrition, Education & Sanitation, Environmental Protection, and Public Health Measures shall be key areas where these funds could be utilized.

e. Every village is free to contribute additional grant towards the Village Health & Sanitation Committee. In villages where the community contributes financial resources to the Village Health & Sanitation Committee untied grant of Rs.10, 000/-, additional incentive and financial assistance to the village could be explored. The intention of this untied grant is to enable local action and to ensure that Public Health activities at the village level receive priority attention.

Roles and Responsibilities

Role of ASHA Sahyogini in VHSC

• Constitution of VHSC
• Continued interaction
• Keep the members informed
• Maintain registers
• Support intensive training programs
• Facilitate VHP

Profile of VHSC

Name of the Village
Name of the Village
Name of GP
Name of Pancha yat Samitee
District
Name, address and phone no. of Chairperson
Member Secretary
Members

Untied Funds for VHC

• Rs. 10,000/ Rs. 10,000/ - per Village Health per Village Health Committee
• Joint account -ANM and Sar panch
• Village under PHC and not sub center new account in the name of Medical Officer I/C and Sarpanch

Utilization of Funds

• Sanitation drive
• School Health activities
• ICDS, AW level activities ICDS, AW level activities
• Household surveys
• Destitute women or poor household Destitute women or poor household
• Nutrition, Education, Environment Protection, Public Health Measures Protection, Public Health Measures
• Publicity of MCHN days, RCH camps

Reporting System

Physical Report

1. No. of VHC's to be constituted
2. No. of VHC's Constituted
3. No. of monthly meeting to be held
4. No. of Monthly meeting held
5. Total Funds received in the district
6. Total Expenditures
7. % of expenditures incurred

Financial Report

• Sub center- ANM to submit the financial report (SoE) to M/O
• PHC- M thl C il ti b Monthly Compilation by LHV/Accountant- submit to Block CMHO
• Block Monthly Compilation by Accountant and submit to district
• District- compilation by DAM and submission compilation by DAM and submission to State.

Monitoring and Support system-NRHM

District level: CMHO, DPM, DAC are responsible for Constitution of VHCs

Block level:

- BCMHO and BPM are responsible

- Provide support to PHC level functionaries

PHC level:

• ASHA facilitator, PHC MO, LHV are responsible
• Constitution of VHSC
• Organizing Monthly Meetings Organizing Monthly Meetings
• Providing support in trainings
• Facilitate for development of Village Health Plan
• Facilitation in conflict redressal
• Other issues related to VHCs

PRI and Health

Panchayats in India are an age-old institution for governance at village level. In 1992, through the enactment of the 73rd Constitutional Amendment, Panchayati Raj Institutions (PRI) were strengthened as local government organizations with clear areas of jurisdiction, adequate power, authority and funds commensurate with responsibilities.

The main objective of the 73rd amendment was to create a new Panchayati Raj Institution (PRI) system with People's participation providing good governance at grassroots level. Through these amendments a separate schedule was added to the Constitution (Eleventh Schedule) listing 29 subjects that could be devolved to the local government institutions. Out of these 29 subject the 23rd one is health and sanitation, including hospitals, primary health centers and dispensaries.

Panchayats have been assigned 29 rural development activities, including several, which are related to health and population stabilization. The XI schedule includes Family Welfare, Health and Sanitation, (including hospitals, primary health centers, and dispensaries,) and the XII schedule includes Public Health. Thus the possible realm of influence of the Panchayats extends over a significant proportion of public health issues. The Gram Sabha, where empowered has the potential to act as a community level accountability mechanism to ensure that the functions of the village Panchayat in the area of public health and family welfare, actually respond to people's needs.

Increasingly it is being realized that strategies for achieving low infant, under five and maternal mortality depend on a functioning continuum of high quality services from community to secondary and sometimes higher levels of care. In addition community support for such services comes through behavior change to increase utilization as well as demand high quality services. In the RCH 2 implementation document, specific mention is made of plans to support PRI (and urban counterparts) in design, implementation, monitoring of RCH related interventions. This is also seen as a potential to address the social determinants of health through engagement with communities and PRI rather than a biomedical approach. It is also expected that PRI involvement will increase community understanding of issues of accountability for quality and reliability of health care services.

Critical Role of Panchayati Raj Institutions in NRHM

The National Rural Healthcare Mission, designed to integrate health and family welfare related interventions and address health from a holistic preventive, promotive and curative viewpoint takes a much more significant view of PRI engagement. The fulcrum of the NRHM programme is a social activist(ASHA) at the village level, who will work with the village level resource team

in providing preventive and promotive health care services. It is expected that she will be supervised and supported by the panchayats.

Thus there is opportunity for PRI involvement to address the non technical components of health care seeking, provided all PRI representatives are exposed to a perspective building exercise on health within the framework of gender and equity.

Linkage from the village to Gram Panchayat to Block and District

At the village and Gram Panchayat level: The VHSNC forms link between the Gram Panchayat and the community. The VHC would be responsible for working with the Gram Panchayat to ensure that the health plan is in harmony with the overall local plan. It is anticipated that this committee will prepare a Village Health Plan and maintain village level data, supervised by the Gram Panchayat. Engaging the Gram Sabha and other groups in planning and monitoring the Village Health Plan will presumably enforce transparency and accountability.

Under the NRHM, untied funds of Rs. 10,000 are placed with the ANM to meet unanticipated expenditures and to ensure that lack of drugs and other consumables is not an issue. An account has been opened with the Sarpanch for operationlization of the activities planned. At the subcentre level planning and use of these funds will be supported by the appropriate tier of the panchayat.

Block Level: At the block level a Block Co-ordination Committee with the Block Nodal Officer /Block Panchayat President as Chairperson and the involvement of PRIs and civil society will be formed for effective functioning and convergence. This will be linked to the Meeting of the Block level Committeess under the Pradhan.

District level: At the District level the District Health Mission will coordinate NRHM functions and are under the Zila Pramukh.

ASHA and the PRIs

The selection of ASHA is the responsibility of the Gram Panchayat where it will be finalized in a meeting of the Gram Sabha.

The success of ASHA scheme will depend on how well the scheme is implemented and monitored. It will also depend crucially on the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme.

(a) At the village level ASHA will receive support from the women's committees (like self help groups or women's health committees), Village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, the trainers of ASHA and mainly the Panchayat members.

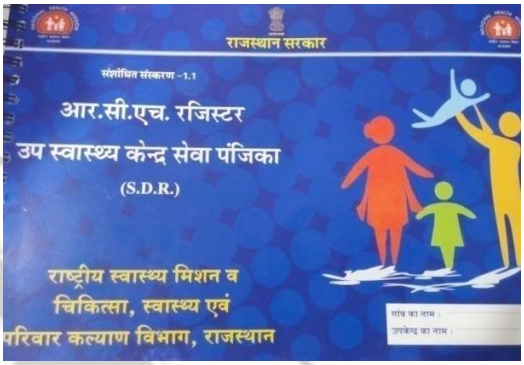
(b) At the block level, ASHA scheme will have a Block Co-ordination Committee with the Block Nodal Officer /Block Panchayat President as Chairperson and the involvement of PRIs and civil society.

(c) The Gram Panchayat would lead the ASHA initiative in selection of ASHA, providing regular support in undertaking many health related tasks through its statutory health committee, developing the village health plan and in the compensation incentive. All ASHAs will be in this

Village Heath & Sanitation Committee of the Panchayat either as members or as special invitees

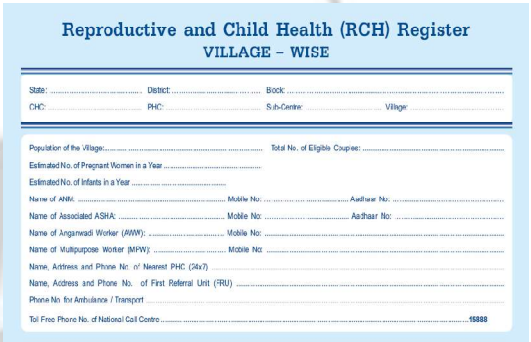
(d) The state level NRHM committee will monitor and support the District Health Society and District Nodal Officer.

RCH Register



Objectives: Key objective of this section of module is to develop knowledge and understating about RCH Register and to understand its importance in maintaining database under HMIS.

RCH or SDR Register is an important tool under Health Management and Information System (HMIS). Data filled in the SDR forms the basis for PCTS and ECTS data. Health service providers are oriented at Sector meetings, Block meetings and District level.


Reproductive and Child Health (RCH) Register
VILLAGE – WISE

State: ..... District: ..... Block: .....
CHC: ..... PHC: ..... Sub-Centre: ..... Village: .....

Population of the Village: ..... Total No. of Eligible Couples: .....
Estimated No. of Pregnant Women in a Year .....
Estimated No. of Infants in a Year .....
Name of ANM: ..... Mobile No: ..... Aadhaar No: .....
Name of Associated ASHA: ..... Mobile No: ..... Aadhaar No: .....
Name of Anganwadi Worker (AWW): ..... Mobile No: .....
Name of Multipurpose Worker (MPW): ..... Mobile No: .....
Name, Address and Phone No. of Nearest PHC (24x7) .....
Name, Address and Phone No. of First Referral Unit (FRU) .....
Phone No. for Ambulance / Transport .....
Toll Free Phone No. of National Call Centre 15388

It has a coloured cover and Village Profile (Sub-Centre wise) on inner side of the cover. Then is Index and pages for Remarks of Supervision/ Monitoring officers.

The Register has four Sections:

Section I: Tracking of Eligible Couples (EC) and use of Contraceptives

Section II: Services for Pregnant Women during ANC, During Labour and Post Natal Service

Section III: Care and Immunization for Children

Section IV: Annexure containing Calendar for EDD calculation, National Immunization Schedule and List of Abbreviations

The last pages also contain Blank space for making Notes.

Use of RCH Register:

1. To check the quality attributions of data-
- Completeness
- Correctness
- Consistency
- Timeliness

2. To cross verify the data with actual number of target beneficiaries or service utilization status as Field verification
3. To get reflection of Norms and How they get reflected in Data. For example:

   Example 1: Data for Early Registration of Pregnancy

   All pregnancies to be registered within 12 weeks of LMP

Implies: Late registration of pregnancy implies depriving the mother of timely preventive and promotive services

Reflection in data: No. of pregnancies registered and no. of pregnancies registered within 12 weeks should be equal

Example 2: Inj. TT at time of registration / first antenatal visit

Implies: On first visit, the pregnant mother would be given TT1 or TTb

Reflection in data: There should be no difference between no. of pregnancies registered and total of TT1 and TTb

4. To form the basis of due list preparation for field functionaries and actually immunized children/ pregnant women can be tallied with SDR for more accuracy to cover left out and drop out.