NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM newsletter

Vol.2 No.3 March 2007

Village map drawn by an A.P. Health Link Worker

NRHM now in the villages

Progress under NRHM

Institutional arrangements

- State Health Missions constituted in all States/UTs.
- Orientation of DMs/CMOs completed in all focus states.
- Merger of Departments of Health & Family Welfare completed in all states.
- Merger of State level societies in 33 states. Rest in process.

ASHA

- Total 3.49 lakh ASHA selected till date (1.29 lakh in 2005-06 and 2.20 lakh in 2006-07).
- ASHA trained: 2.25 lakh
- Mentoring Group for ASHA set up and meetings held.
- Detailed guidelines for the mentoring of ASHAs in the states and the associated generic funding have been disseminated to the states.
- ASHA Training modules finalized.
- State/District/Block level trainers completed.

Infrastructure

- Facility Survey has been completed in 1554 CHCs across the country.
- Untied funds of Rs.10,000/- released to all sub-centres in the country. Total amount released: Rs. 205.87 crore in 2005-06 and Rs. 61.10 crore during 2006-07.
- Joint account of ANM and Pradhan opened in 69244 sub-centers.
- Indian Public Health Standards finalized for Sub Centres, PHCs and CHCs. Similar standards are in final stages of preparation for District Hospitals.
- 2045 CHCs have been identified for upgradation to IPHS. Total amount of Rs. 370 crores released during 2005-06 for starting the upgradation process and Rs. 326.40 crores during FY 2006-07 till date for this purpose.
- 10008 Rogi Kalyan Samitis set up at various levels.
- Mobility support being given for outreach programmes in the underserved areas. The states have operationalised 228 Mobile Medical Units and a total of Rs. 153.10 crores has been released for this purpose to various states during 2006-07.
- 136 Integrated District Health Action Plans have been prepared in various states. These plans are sector wide in import and address all aspects of health including the collateral health determinants like nutrition, sanitation, drinking water etc.

Human Resource Development

- Recommendations of the Task Group on Medical Education has been finalised and are under consideration by the Ministry.
- The Task Group on Identification, Training and Accreditation of RMPs in the final stages of deliberations.
- Positioning of accounts personnel at PHCs to strengthen the accounting of funds in view of the substantially larger number of transactions at that level has been approved by EPC / MSG.
- 22655 Doctors, ANMs and other paramedics have been appointed on contract by States to fill in critical gaps.
- Block pooling of doctors has been started in states so as to ensure that there is at least one functional health facility in each of the block. The other health facilities in the territorial jurisdiction are being serviced through outreach visits.
- Over 1265 professionals (CA/MBA) appointed in Program Management Units (PMU) to support NRHM. Similar management support is being planned at the level of the Block also.

Training

- National Health Resource Centre at Central level finalized.
- State level Health System Resource Centre for North East States set up at Guwahati.
- Additional training initiatives undertaken including :
- Upgradation of State Training Institutes/ANMS Colleges
- Integrated Skill Development Training ANMS/ LHV/MOs.
- Skilled Birth Attendants Training MO/ANMs
- Training on Emergency Obstetrics care for MOs.
- Training on No Scalpel Vasectomy (NSV) for MOs.
- Professional Development Programme for CMOs.
- Specialised skill development programme for MOs.
- Training program for Consultants of Program Management Units

New Programs & Innovations

- RCH II launched and under implementation
- Sterilization compensation scheme launched by GOI
- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) started this year in 25 States.
- With the help of Neonatology Forum initiated training on Newborn Care in 63 districts in the country.
- Integrated Disease Surveillance Project operationalized.
- Legal changes brought about to allow the ANMs to dispense medication and MBBS doctors to administer anesthesia.
- Short course for anesthesia being proposed.

Immunization

- Accelerated Routine Immunization (RI) taken up in all EAG states
- Coverage expected to be around 80 per cent .
- Catch up rounds taken up in Bihar, Jharkhand, Orissa and Assam and other states.
- Organizing sessions in urban slums and under served areas by outsourcing the sessions where ever necessary (Hiring of vaccinator in service deficient areas or where ANM is not available)
- Mobilization of children by ASHA and Anganwadi Workers (AWW) to increase coverage and convergence of Nutrition with Immunization
- JE vaccination initiated in 11 districts in 4 states 93 lakh children immunized.
- Groundwork for expansion of Hepatitis vaccine to 11 states finalized.
- AD Syringes introduced.
- Vaccine management addressed. BCG now in 10 dose vial.
- Development and implementation of a Routine Immunization Monitoring System Software.
- Neonatal Tetanus declared eliminated from 7 states.

Polio Eradication Program

- Over 5 million children in transit administered polio drops (2005-06).
- During 2006, till date 641 cases have been reported.

Operational Guidelines Disseminated

- IMNCI
- Skilled Birth Attendants
- Emergency Obstetric care
- First referral Unit and Blood Storage Units.

Partnership with Non Government Stakeholders

- 305 Mother NGOs appointed for 409 districts till date.
- Providing services, RCH out reach services, Ambulance Services, Mobile Medical Units, Mentoring of ASHA, Management of Health facilities (as in Gujarat, Tamil Nadu etc), Involvement of Medical colleges, Training programmes, ICCI, Partnership in polio/ immunization programmes etc.

IEC

- IEC Multi-media campaign on health issues including immunization, Iodized Salt, Save the Girl Child
- NRHM Newsletter
- Health Melas organized in different States.
- Information booklets disseminated.
- Behaviour change workshops being organized for key stakeholders including state IEC representatives.

TRAINING OF WOMEN

Health volunteers in Andhra Pradesh is a successful community intervention

Dr. M.S. Srinivas Rao
Jt. Director, RCH-II (AP)

The Women Health Volunteers' Training in Andhra Pradesh is a unique collaborative effort between three agencies, two government and one non government organization. This massive exercise of training around 50,000 women for 30 days at a stretch including 21 days residential training was carried out within a short period of 18 months. Skilled and committed trainers, well-designed training process, efficient monitoring system and effective coordination resulted in changing hesitant women to active health volunteers. The keystones to the success of the APWHV Model are briefly described below.

Skilled and committed trainers: The training of the women was carried out by 352 selected and trained trainers. Each trainer was screened and selected through a rigorous process. All the 352 were qualified ANMs with additional qualification who answered an advertisement to work as trainers for 12-15 months and were given an initial intensive training for 15 days and subsequent refresher training every quarter. Each trainer was responsible for only 15 women whom she followed over the one month in the classroom and in the PHC after the field training. She trained them, ensured they received training materials,

encouraged their participation in group activities, conducted assessments, maintained formats and prepared reports. Each trainer trained between 100-150 WHVs during the Project period.

Each trainer looked after only 15 trainees in the classroom as well as in the PHC after field training.

Well-designed training process: The programme was designed to train 3500 - 4000 each month in the 22 districts of Andhra Pradesh. There was one training centre in every district. Each centre admitted two batches of 90 WHVs with one week gap. Each batch had 7-8 trainers whose work was facilitated by a training coordinator (a public health nurse). The batch was divided into six groups of 15 women each. Each group had its own classroom, living space, training materials, attendance books and records. They were entrusted with total responsibility for the 15 women. The training was conducted in three parts: Classroom training for 21 days, field training with the ANM for five days and review in the PHC for two days. Classroom training was done for 21 days without a break. The 22nd day was for travel. Days 23 and 28 were holidays.

Simple and participatory training methods and materials: Training was designed to be participatory and learner oriented. Overall personality development, empowerment, self confidence and orientation to health were the main objectives of the programme. A simple module was developed for the women.

Training was in the form of discussions, practical experiences, exercises, reviews, quiz programmes. Songs, video shows and folk arts were widely used. Trainers followed a well designed schedule that was put into the form of a book Trainers' Guide. The day started with wake-up call at 6.00 am and Yoga at 6.30.

Training started with Assembly at 8.00 am where all the groups came together to discuss the theme of the day and start the training programme. Breakfast was served at 8.30 am and classes started at 9.00. From 9.00 am to 1.00 pm each group went through different sessions of the day with the help of the trainer. The training coordinator went to each group to observe and support the trainer and the group. After lunch, the groups undertook review of the morning sessions in the form of small group activities, module reading and exercises. From 4.00 to 5.00 pm, all the groups came together to review the day. This was done in the form of presentations and quiz programmes. The participants spent an hour in sports and games and then they had free time to do their personal work. Around dinner time, one of the group trainers facilitated a video session for one hour and this helped in reinforcing the information of the day.

The training of Women Health volunteers is backed by an efficient monitoring system comprising of dedicated personnel for the job

Efficient monitoring system: The key to the success of the AP model of WHVs' training is the well planned and rigorous monitoring at every level. At the training level, the training coordinator and the district training administrator monitored the progress of training. The District training manager (a senior DPHNO) monitored the nomination, field training, review and the distribution of kits and remuneration. At the regional and state level, special staff were appointed to monitor training in each training centre and keep close watch over the programme. At the state level, close monitoring was done with DM&HOs and other officers in-charge of the programme. A state level coordinator and assistants were appointed to ensure monitoring was done regularly according to plan. A mobile and communication team provided support to ensure that gaps in knowledge and processes were filled regularly. Monitoring and coordination meetings were held for different categories at the district and state level on a quarterly basis or as required. The senior officials at the state level took special

interest to monitor progress regularly.

Coordinated work: Three key agencies performed vital functions in the programme. The Academy for Nursing Studies, a reputed NGO with expertise in large scale training was nominated as the nodal agency for planning and conducting the training programme. The AP Women's Finance Corporation provided venue for training, accommodation, food arrangements and training facilities. The Commissionerate of Family Welfare ensured transfer of funds in a smooth and timely manner, held regular meetings of the key stakeholders and gave instructions to the districts to ensure correct selection of WHVs.

Outcome of the training programme: Initially doubts were expressed about the ability of women to stay for 21 days away from homes. This proved to be a misconception since the drop out was less than one percent. Women enjoyed the programme and did not want to leave after the first few days. They participated actively specially in the exercises and folk methods used. They enjoyed the daily test, review, sports, quiz and video show. By the end of the first week, the women showed a difference in their behaviour dressing, talking, participation. Many developed new skills and participated actively. They gained new fervour to become health volunteers and serve their communities.

The success of 21 day long stay training can be measured from the fact that dropout of trainees was less then 1%

Impact of the training programme: The trained women are taking active part in community health activities in their villages and areas. They have started bringing women for institutional deliveries, they are supporting ANMs in conducting ante-natal and immunization clinics. They are organizing health melas, meetings and Gramsabhas in their villages. They are the first person to speak about MCH in their villages. Their area of work has broadened to include activism for social causes such as discouraging early marriages of girls, ensuring education of girls, village sanitation, etc. ANMs and other health staff have

In the heartland of Worlis, Gholwad PHC weaves magic

Gholwad Health Centre is in the running for the award of best PHC of the State. Whether it wins the award or not, the PHC has won the heart of the local people. A report by **RK Sarkar**

The Pestonjis are well known for their philanthropic activities in the western part of the country. A number of major institutions in Mumbai were established in the last century with their active support and funding. That this support of Pestonjis extended 150 kms far from the Metro, to a village, was a revelation. Seventy two years ago, in 1935, Pestonjis supported a Maternity home in the village of Gholwad, on the seashore of Thane district, Maharashtra.

In 1984, the Govt. of Maharashtra took over the beautiful two-storey building and converted into a Primary Health Centre. Needless to say, the tradition of maternal care at the same premises for fifty years, has only taken this PHC forward.

Covering a total area of 150 sq. km, 15 villages and a population of 41000, mostly tribals, the Gholwad PHC has that remarkable stamp of an efficient health centre which works in two shifts- morning as well as in the evening.

Staff at the PHC

There are 11 Sub centres attached to this PHC, which has already trained 64 traditional birth attendants (Dai) for maternal care.

Led by the in-charge doctor, Dr. Smita Bari and her colleague Dr Husein Mamujee, the PHC boasts of an active team of 35 professionals whose work is reflected in small and tiny operational details. For example, the record room of the PHC, keeping 30years

details, is unusually clean and tidy. So is the small Library almirah where important publications are kept for reference and reading of the staff. The OPD has medical charts and graphs and the Labour room and six-beds for patients- all in airy and hygienic conditions.

But what bowls you over is the stunning series of Worli paintings on the walls of PHC, depicting the lifestyle of tribals in that area. The Warli tribes, who belong to this area, have created a unique style of folk painting that is already very famous in the country.

Traditional Rangoli painting depicting

The stunning series of Worli paintings on the PHC walls bowls you over...

The average number of patients at the OPD is 60. Two-three patients are admitted daily and care is easy and without interruption because both the medical officers stay on the first floor of PHC and their supporting staff- the ANMs also live in the campus. This efficient team handled 55000 beneficiaries of Janani Suraksha Yojana during 2005-06. During 2006-07, the number of beneficiaries has doubled to 110,000.

The Gholwad PHC has also faced challenges. In 2004 there have been 45 cases of malnourished children in that area. With the help of Dr Shanbag, a local paediatrician, the PHC staff organized regular monthly camps and brought down the number to just 7 (grade III). “We plan to bring it to “nil” during this year through our sustained efforts, said Dr Bari.

The Worli paintings

That the PHC has risen steadily in the esteem of local populace is also due to staff's proximity and friendship with them. Apart from the well-equipped setup, the public relations of the PHC staff is excellent. Dr.Bari, the incharge of PHC, is actually the daughter-in-law of the village. She married a local boy and got transferred to this PHC about six years ago. Since then she has earned the goodwill of people through good work at the Health Centre.

7 Steps to Safe Motherhood

The location of the PHC, on the seashore near Maharashtra-Gujarat border, has been vital for the beneficiaries to access healthcare. But the access has really been accentuated by the friendly, helpful staff at the PHC. That is why, private and public support to the PHC has been consistently growing. A solicitor of Mumbai, who is a native of Gholwad, has pledged to upgrade the facilities on his own at a cost of Rs 4 lakhs. The Govt. has also decided to construct new ANM's quarters (in place of the old ones which are in bad shape) for Rs 24 lakhs. The public has donated a water cooler, power inverter, and medicine racks to the PHC during 2005-06.

NRHM issues at the PHC courtyard

Gholwad PHC, which has already won many honours from the district administration, is now vying for coveted position of best PHC in the state of Maharashtra. Whether it wins that award or not, it has won what matters the most- the heart of Golwad's people.

How to take care of a sick person

We begin a new series on basic Health Care with this excerpts from the Indian adaptation of "Where there is no Doctor" which was recently brought out by the Ministry of Health & Family Welfare Govt. of India, for the use of field Health workers.

Sickness weakens the body. To gain strength and get well quickly special care is needed.

The care a sick person receives is frequently the most important part of his treatment.

Medicines are often not necessary. But good care is always important. The following are the basis of good care :

1. Comfort of the Sick Person

A person who is sick should rest in a quiet, comfortable place with plenty of fresh air and light. He should keep from getting too hot or cold. If the air is cold or the person is chilled, cover him with a sheet or blanket. But if the weather is hot or the person has a fever, do not cover him at all.

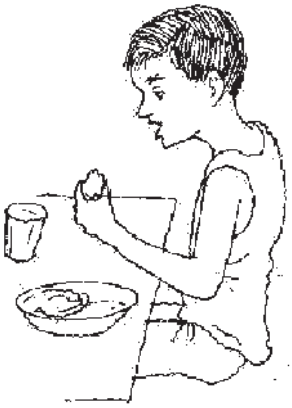
2. Liquids

In nearly every sickness, especially when there is fever or diarrhea, the sick person should drink plenty of liquids : ORS, water, tea, juices, soups, etc. Give small amount frequently but it is necessary to avoid dehydration.

A SICK PERSON SHOULD BE BATHED EVERY DAY

3. Personal Cleanliness

It is important to keep the sick person clean. He should be bathed every day. If he is too sick to get out of bed, wash him with a sponge or cloth and lukewarm water. His clothes, sheets, and covers must also be kept clean. Take care to keep crumbs and bits of food out of the bed. His position in bed, if he is very weak, should be changed to avoid bed sore.



4. Good Food

If the sick person feels like eating, let him. Most sicknesses do not require special diets.

A sick person should drink plenty of liquids and eat body-building and nourishing foods like milk, cheese, chicken, eggs, meat, fish, beans, green vegetables, and fruit.

If the person is very weak, give him the same foods, but make them into soups or juices.

Energy foods are also important - for example, porridges of rice, wheat, oatmeal, potato, or cassava. Adding a little sugar and vegetable oil will increase the energy. Also encourage the sick person to drink plenty of sweetened drinks, especially if he will not eat much. A few problems do require special diets.

Special care for a person who is very sick

1. Liquids

It is extremely important that a very sick person drinks enough liquid. If he can drink a little at a time, give him small amounts often. If he can barely swallow give him sips every 5 or 10 minutes.

Measure the amount of liquids the person drinks each day. An adult needs to drink 2 liters or more every day and should urinate 3 or 4 times daily. If the person is not drinking or urinating enough, or if he begins to show signs of dehydration, encourage him to drink more. He should drink nutritious liquids, usually with a little salt added. If he will not drink these, give him Rehydration Drink (ORS). If he cannot drink enough of this, and develops signs of dehydration, a health worker may be able to give him intravenous solution. But the need for this can usually be avoided if the person is urged to take small sips often.

2. Food

If the person is too sick to eat solid foods, give him soups, milk, juices, broths, and other nutritious liquids. A porridge of cornmeal, oatmeal, or rice is also good, but should be given together with body-building foods. Soups can be made with egg, beans, or well-chopped meat, fish, or chicken. If the person can eat only a little at a time, he should eat several small meals each day.

3. Cleanliness and Changing Position in Bed

Personal cleanliness is very important for a seriously ill person. He should be bathed every day with warm water. Change the bed clothes daily and each time they become dirty.

A person who is very weak and cannot turn over alone should be helped to change position in bed many times each day. This helps prevent bed sores.

A child who is sick for a long time should be held frequently on his mother's lap.

Frequent changing of the person's position also helps to prevent pneumonia, a constant danger for anyone who is very weak or ill and must stay in bed for a long time. If the person has a fever, begins to cough, and breathes with fast, shallow breaths, he probably has pneumonia.

4. Watching for Changes

You should watch for any change in the sick person's condition that may tell you whether he is getting better or worse : Keep a record of his 'vital signs'. Write down the following facts 4 times a day :

temperature
(how many degrees)

pulse
(beats per minute)

breathing
(breaths per minute)

Also write down the amount of liquids the person drinks and how many times a day he urinates and has a bowel movement. Save this information for the health worker or doctor.

It is very important to look for signs that warn you that the person's sickness is serious or dangerous. A list of Signs of Dangerous Illness is on the next page. If the person shows any of these signs, Seek medical help immediately.

Signs of dangerous illness

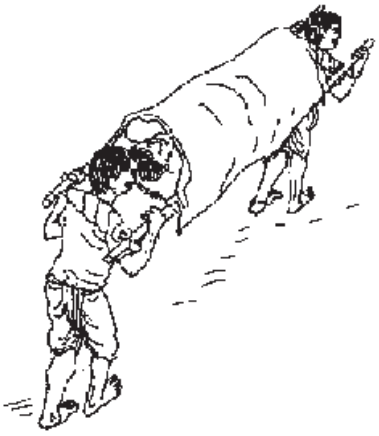
A person who has one or more of the following signs is probably too sick to be treated at home without skilled medical help. His life may be in danger. Seek medical help as soon as possible.

1. Loss of large amounts of blood from anywhere in the body
2. Coughing up blood
3. Marked blueness of lips and nails (if it is new)
4. Great difficulty in breathing; does not improve with rest
5. The person cannot be awakened (coma)
6. The person is so weak he faints when he stands up
7. A day or more without being able to urinate
8. A day or more without being able to drink any liquids
9. Heavy vomiting or severe diarrhea that lasts for more than one day or more than a few hours in babies
10. Black stools like tar, or vomit with blood or faeces
11. Strong, continuous stomach pains with vomiting in a person who does not have diarrhea or cannot have a bowel movement
12. Any strong continuous pain that lasts for more than 3 days
13. Stiff neck with arched back, with or without a stiff jaw
14. More than one fit (convulsions)in someone with fever or serious illness
15. High fever (101^{0} F) that cannot be brought down or that lasts more than 4 or 5 days
16. Weight loss over an extended time
17. Blood in the urine
18. Sores that keep growing and do not go away with treatment
19. A lump in any part of the body that keeps getting bigger
20. Problems with pregnancy and childbirth : any bleeding during pregnancy swollen face and trouble seeing in the last months long delay once the waters have broken and labour has begun severe bleeding.

When and how to look for medical help

Seek medical help at the first sign of a dangerous illness. Do not wait until the person is so sick that it becomes difficult or impossible to take him to a health center or hospital.

If a sick or injured person's condition could be made worse by the difficulties in moving him to a health center, try to bring a health worker to the person. But in an emergency when very special attention or an operation may be needed (for example, appendicitis), do not wait for the health worker. Take the person to the health center or the hospital at once.

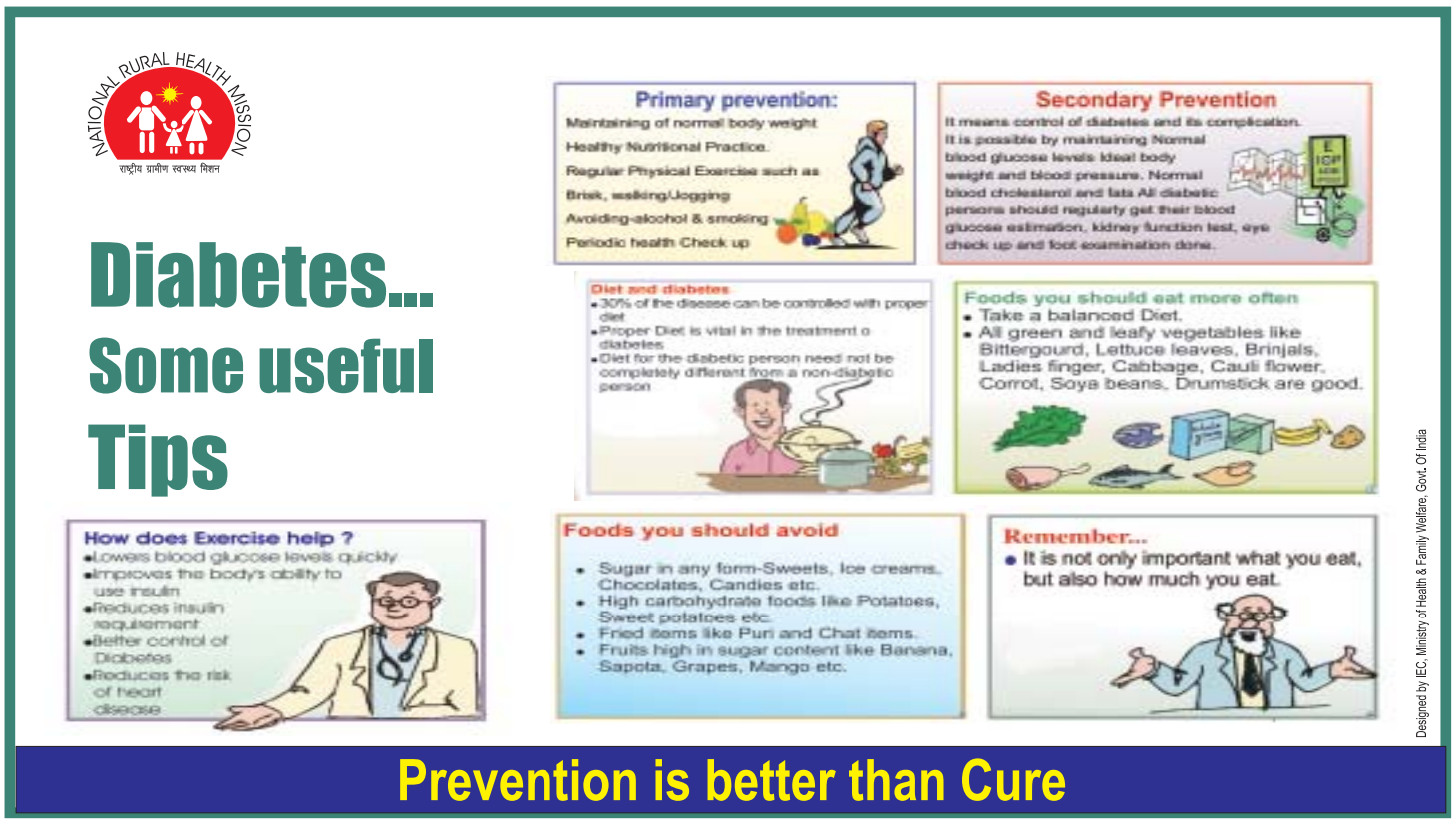


When you need to carry a person on a stretcher, make sure he is as comfortable as possible and cannot fall. If he has any broken bones, splint them before moving him. If the sun is very strong, rig a sheet over the stretcher to give shade yet allow fresh air to pass underneath. You can use other mode of conveyance (cycle rickshaw etc.)

What to tell the health worker

For a health worker or doctor to recommend treatment or prescribe medicine wisely, he should see the sick person. If the sick person cannot be moved, have the health worker come to him. If this is not possible, send a responsible person who knows the details of the illness. Never send a small child or a fool.

Before sending for medical help, examine the sick person carefully and completely. Then write down the details of his disease and general condition.



Letters

Dear Sir,

I am working as an Evaluation Officer in the subordinate office of the Ministry of Health & Family Welfare, Government of India located in Bangalore. My job responsibilities consists of evaluation of NRHM-RCH programme. I am required to tour 3 states: Karnataka, Andhra Pradesh and Maharashtra for evaluation of NRHM including RCH-II components such as JSY, PNDT, ASHA, Dais Training and 24-hours delivery care and other such components. The Evaluation Team consists of two Evaluation Assistants beside myself. The tours are conducted every month as per the technical directions of the Chief Director (Statistics), Statistics Division, Department of Family Welfare, Nirman Bhavan, New Delhi. I am regularly reading your newsletter by borrowing from the State Government institutions wherever I visit during my monthly tours. I find the contents of your newsletter highly informative and quite relevant for our day-to-day work. Therefore, I want to have my own copies and keep them as references for my evaluation work and preparation of monthly evaluation reports. I request you to kindly register my name and address as given below and include in the mailing list of NRHM Newsletter. Kindly send me all the forthcoming issues.

Shri J.V. Basavanthappa
Evaluation Officer,
Regional Office for Health & Family Welfare
F-Wing, II Floor, Kendriya Sada, Koramangala,
Bangalore 560 034

Dear Sir,

I got a copy of NRHM Newsletter and I have gone through it. The topics covered in the newsletter are useful and informative. I am interested in knowing more about the NRHM programmes. I request you to kindly send me the NRHM newsletter regularly.

Dr. Dalvi B.K.,
A/20, Rukmini Garden,
Mangalwar Peth, KARAD,
Distt. Satara,
Maharashtra.

Dear Sir,

We are the Technical Assistance and Support Team (TAST) to the Department of Health and Family Welfare (DHFW), Government of West Bengal, under the DFID funded Health Sector Development Initiative (HSDI) programme. As part of our technical support to the DHFW, we are managing the State Health Resource Centre, which has been set up by the Department recently. The idea is to build up a resource base mainly on Health Systems and Policy aspects, which can be used by DHFW officials, academicians for their work. In this respect, we would like to receive the NRHM newsletter for our readers including the back issues if any. We would like to be included in your mailing list so that we continue to receive your newsletter on a regular basis.

Ms. Anurima Mukherjee Basu,
Documentation and Learning Expert,
Technical Assistant and Support Team (TAST),
Department of Health & Family Welfare
Government of West Bengal

Dear Sir,

I congratulate to you and your team for introducing a very much essential newsletter for all the people. It gives the latest information regarding Rural Health Mission as well as it helps to improve health qualities in the rural areas and to provide better services to them. Kindly send me a copy regularly.

Dr. S.S. Sunkad,
Medical Officer,
PHC Paparao Camp,
Post: Jawalgera
Tq: Sindhanur, Distt. Raichur
Karnataka.

Dear Sir,

I am working as Medical Officer in Primary Health Centre, Bhadasar in Churu District of Rajasthan. This Newsletter is useful for medical and para-medical staff. Kindly send the newsletter regularly.

Dr. Ramlal Chaudhary,
Medical Officer,
Primary Healthy Centre,
Bhadasar, Sardarshahar,
Churu,
Rajasthan.

Dear Sir,

As I am involved in all the National Health Programmes, I will be glad to receive your newsletter regularly.

Dr. A.K. Mishra,
ABHA Niwas,
Madhuban Para,
Raigarh 496001
Chhattisgarh.

Dear Sir,

I am working as Medical Consultant at Indian Institute of Health and Family Welfare, Hyderabad. I request you to send NRHM bi-monthly Newsletter to the address given below.

Dr. V. Syamlamba,
Medical Consultant,
D.No. 8-3-318/6/10, Yellareddyguda,
Hyderabad 500 073
Andhra Pradesh

Dear Sir,

Ours is a registered not for profit voluntary organization working in Jharkhand at districts Saraikela Kharsawan and East Singhbhum. One of our programme interventions is in the area of health. We work in active partnership with various stakeholders, including the State Government. I got a copy of your newsletter at Bhopal through the health officials in DGHS. The newsletter is very informative and useful. I shall be highly obliged if you kindly enroll our institution's name in your mailing list for sending NRHM Newsletter in English.

Shri A.K. Tiwari,
Chief Executive Officer,
The Janaki Foundation,
M-15, Old Housing Colony,
Adityapur, Jamshedpur 831 013
Jharkhand.

Dear Sir,

In the NRHM Newsletter Vol. I, No. 3, you have highlighted about surveillance under Polio Programme which is one of the components of Polio Eradication programme. This newsletter has helped me to do this job effectively.

Shri Waman Rao,
KUDUR 561 101
Karnataka.

Dear Sir,

I am a reporter by profession and I spend much time for social work. I received your NRHM Newsletter from field publicity office. It is very useful. Please include my name in your mailing list.

Shashanka Sekhar Dash,
At-Arangabad,
PO Bari, Distt. Jajpur,
Orissa 755 003

Dear Sir,

I am in receipt of a copy of NRHM newsletter through CMO's office, Aligarh. I have gone through it and found it informative. I am working as General Secretary in National Integrated Medical Association and as vice-President in Dr. Zakir Hussain Foundation, Aligarh which is an NGO working in different fields. Health is one of the area and we are working among BPLs. You are requested to send the NRHM Newsletter regularly in English and Urdu for the benefit of our NGO.

Dr. H.A. Siddiqi,
General Secretary,
National Integrated Medical Association,
4.1170, Sir Syed Nagar,
Aligarh

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Save Your Child from Six Killer Diseases

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Tetanus

Polio

Measles

Diphtheria

Tuberculosis

Whooping Cough

Japanese Encephalitis vaccine introduced in select districts of U P, Bihar, Karnataka & West Bengal

TT Immunization for Pregnant women

IMMUNIZATION SCHEDULE

FOR THE PREGNANT WOMAN	
Early in pregnancy	T.T. - 1 (Injection)
One month after T.T.-1	T.T.-2 or T.T. Booster (injection)
FOR THE INFANT	
At 1½ months	B.C.G. (Injection)*
	D.P.T.-1 (Injection) and
	O.P.V.-1 (dose)
At 2½ months	D.P.T.-2 (Injection) and
	O.P.V.-2 (dose)
At 3½ months	D.P.T.-3 (Injection) and
	O.P.V.-3 (dose)
At 9 months	Measles (Injection)
At 16 to 24 months	D.P.T. Booster (Injection) and
	O.P.V. Booster (dose)

* If the infant has been delivered in a hospital/clinic, she/he should be given the B.C.G. injection at birth. Even if you are late for an injection / dose, you must still get it. Consult your health worker.

Immunize Your Child

Immunization facilities available at all Anganwadi Centres, Health Sub Centres, Primary Health Centres, Community Health Centres, District Hospitals and major hospitals.

Ministry of Health & Family Welfare, Government of India

AD Syringes are used now in Immunization for Injection Safety