NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM
NEWSLETTER
Vol.6 No. 3 January-February 2011

FOCUS ON MENTAL HEALTH

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FOCUS ON
MENTAL HEALT

COMMUNICATING WITH PEOPLE

Progress under NRHM

ASHAs

- 8.33Lakh ASHA/Link workers Selected.
- 641421 ASHA given orientation training up to 4th Module and 5.70 lakh ASHA have been positioned with kits.

Institutional Delivery

- Janani Suraksha Yojana (JSY) is operationalised in all the States 7.04 lakh women are benefited in the year 2005-06, 29.31 lakh in 2006-07, 71.19 lakh in 1007-08, 85.42 lakh in 2008-09 and 92.29 in the year 2009-10.

Monthly H&N Days in Anganwadi

- Over 2.36 lakh Monthly Health and Nutrition Days have been organized at the Anganwadi Centres in various states during 2009-10.

Neo Natal Care

- Integrated Management of Neonatal and Childhood illnesses (IMNCI) started in 323 districts.
- With the help of Neonatology Forum over 3,09,818 health care personnel training conducted in Newborn Care in the country.
- Module for Home based new born care developed and ASHAs to be trained in Home based new born care.

Immunization

- Intense monitoring of Polio Progress – Services of ASHA useful.
- JE vaccination completed in 11 districts in 4 states – 93 lakh children immunized during 2006-07. JE vaccination has been implemented in 26 districts of 10 states in 2007. The 11 districts of 4 states where JE vaccination was carried out in 2006 have introduced JE vaccine in Routine Immunization to vaccinate new cohort between 1-2 years of age with booster dose of DPT.
- House tracking of polio cases and intense monitoring
- Neonatal Tetanus declared eliminated from 7 states in the country.
- Full immunization coverage evaluated at 43.5% at the national level (NFHS-III).
- Accelerated Immunization programme taken up for EAG and NE states.

Village Health & Sanitation Committees

- 4,94,085 Village Health and Sanitation Committees have been constituted by the States. They are being involved in dealing with health planning at grass root level.

Rogi Kalyan Samitis

- Over 29,904 Rogi Kalyan Samitis set up in various health centres and hospitals.

Infrastructure

- 1.45 lakhs Sub centres in the country are provided with untied funds of Rs. 10,000 each. 4,54,194 Sub centres & VHSC have operational joint accounts of ANMs and Pradhans for utilization of annual untied funds. 50,728 Sub centres are functional with second ANM.
- Out of 4510 Community Health Centres, 2921 CHCs have been selected for upgradation to IPHS and facility survey has been completed in 1141 CHCs (includes other also).
- 29,904 Rogi Kalyan Samitis have been registered at different level of facilities.
- 16,675 Sub centres for new construction and 9775 for renovation taken up under NRHM.
- 1473 Primary Health Centres taken up for new construction and 7090 for renovation under NRHM.
- 934 works at Community Health Centres for construction and 2276 works for renovation taken up under NRHM.

Manpower

- 11,205 Doctors and 1572 Specialist, 53,552 ANMs, 26,734 Staff Nurses, 18,272 Paramedics have been appointed on contract by States to fill in critical gaps.

Management Support

- 1,684 professionals (CA/MBA/MCA) have been appointed in the State, 635 District level Programme Management Units (PMU) and 3,529 blocks to support NRHM.

Mobile Medical Units

- 1,047 Mobile Medical Units operational under NRHM in States.
- Emergency Transport System operational in 12 States with the assistance of 2919 Ambulances
- Another 1674 Ambulances provided to States for working at PHC, CHC, Sub District and District Hospital.

Health Action Plans

- 35 State PIPs received in 2010-11.
- The first cut of Integrated District Health Action Plans (DHAP) has been finalized for 540 districts during 2010-11.

Mainstreaming of AYUSH

- Mainstreaming of AYUSH taken up in the States. AYUSH practitioners co-located in 14,766 facilities PHCs. AYUSH part of State Health Mission/Society as members.

Trainings

- Trainings in critical areas including Anesthesia Skilled Birth Attendance (SBA) taken up for MOs/ANMs. Integrated Skill Development Training for ANMs/LMVs/MOs. Training on Emergency Obstetrics care and No Scalpel Vasectomy (NSV) for Mos, Professional Development Programme for CMOs is on full swing.
- ANM Schools being upgraded in all States.
- New nursing schools taken up.

Mother NGOs

- 321 Mother NGOs appointed for 460 districts till date are fully involved in ASHA training and other activities.

Health Resource Centres

- National Health Systems Resource Centre (NHSRC) set up at the National level.
- Regional Resource Centre set up for NE.
- State Resource Centre being set up by States.

Monitoring and Evaluation

- Web based MIS operationalised.
- NFHS III & DLHS results disseminated.
- Independent evaluation of ASHAs/JSY by UNFPA/UNICEF/GTZ in 8 States.
- Ground work for community monitoring completed.

Financial Management

- Financial Management Group set up under NRHM in the Ministry.
- During the FY 2005-06, out of total allocation of Rs. 6731.16 crore for the Ministry, an amount of Rs. 5862.57 crore was released as part of NRHM.
- Against Rs. 9065 crore for NRHM activities during 2006-07, Rs. 7361.08 crore released.
- During the FY 2007-08, out of total allocation of Rs. 11,010 crore for the Ministry, an amount of Rs. 10,189.03 crore was released as part of NRHM.
- During the FY 2008-09, out of total allocation of Rs. 12,050 crore for the Ministry, an amount of Rs. 11,229.47 crore was released as part of NRHM.
- During the FY 2009-10, out of total allocation of Rs. 14,050 crore for the Ministry, an amount of Rs. 11,613.39 crore was released as part of NRHM.

FOCUS ON MENTAL HEALTH

"We recognize that mental health is a neglected area where awareness is low even among the health professionals. In recent years, we have given a lot of attention to the issue of mental health in India and have increased the allocation of resources for the programme more than 6 times for our current five year plan." These were the candid comments of Hon'ble Minister of Health & Family Welfare Sh. Ghulam Nabi Azad at the inaugural of an International Conference Cum Workshop of the Asia Pacific Community Mental Health Development Project on February 17, 2011.

The Minister noted that unfortunately there is still stigma attached towards persons with mental illness and epilepsy within the society. Public education and efforts to change the attitude of general population towards persons with mental illness and epilepsy need to be carried out, Sh. Azad said. He also highlighted that early identification and intervention can contribute to effective treatment. He added that the joint family system in our country proves to be supportive to the persons with severe mental illness. "One hopes that with progress, development and modernization, we do not lose our traditional social customs, values and life styles as these have proved to be positive." He also added that treatment of severe mental illness is incomplete without effective care, rehabilitation and reintegration of recovering mentally ill person into the society. Social and culturally acceptable and affordable rehabilitation measures need to be developed and implemented, Sh. Azad added.

Considering the available evidence that 6 to 7% of

Minister Shri Ghulam Nabi Azad at the inauguration of the workshop

population in India suffers from common mental disorders and 1-2 % of population suffers from severe mental disorders and the fact that globally it is estimated that the burden of mental disorders will increase to 15% by 2020, Sh. Azad noted that there is need to develop multinational partnerships to address this problem. The Minister thus hoped that scientific deliberations from international and national mental health leaders at this 3 day conference will help in developing a stronger network and innovative solutions for community mental health development.

The Minister informed that the National Mental Health Programme was launched in 1996 on a pilot basis in 4 districts. Today the programme covers 123 districts under the District Mental Health Programme (DMHP). The Minister informed that DMHP has been expanded to include the up gradation of Psychiatry departments of Government Medical Colleges, General Hospitals and modernization of State run Mental Hospitals. 89 psychiatry departments have been upgraded and 29 mental hospitals modernized. "Recognizing that one of the major constraints in implementing the National Mental Health Programme, remains the provision of adequate manpower, whether it is doctors, specialists, nurses, paramedics or other health professionals, we have invested in the creation of mental health professionals", Shri Azad said.

He also added that the National mental Health Programme has two components for manpower development. Under the first component, we are developing 11 Institutions across the country as centres of excellence in Mental Health. These 11 institutions will add 44 psychiatrists, 176 clinical psychologists, 176 psychiatric social workers and 220 psychiatric nurses annually. Under the second component, we propose to support states to start Post Graduate courses in Mental Health and other Institutions, including provision of basic infrastructure and faculty. These institutions will add 60 psychiatrists, 240 clinical psychologists, 240 psychiatric social workers and 600 psychiatric nurses annually. Together, these two schemes would help us to produce 1756 qualified mental health professional annually and enable us to bridge the gap between our requirement and the availability of mental health professions.

Sh. Azad noted that role of National Institute of Mental Health & Neurosciences Bangalore in taking up the National Mental Health Programme and the District Mental Health Programme has been significant. He also added that recent research on the use of Yoga in the severe mental illness as well as stress related mental disorders at National Institute of Mental Health & Neurosciences also appreciated. These have a scope in the community level also.

Speaking on the occasion, Secretary, Health & Family Welfare, Shri K. Chandramouli reiterated that global solutions to the mental health issues are required as mental health problems are still poorly understood. He said already many countries are part of the Asia Pacific network, yet there is need for developing partnerships and advocacy measures. The Secretary informed that Government is making efforts to expand the District Mental Health Programme from the current 123 districts to cover all 650 districts.

According to WHO data, the Asia Pacific region has close to half of the approximately 450 million people affected by mental illness globally. Mental disorders such as schizophrenia, mood disorders, substance abuse and dementia contribute more to global disease burden than cancer or cardiovascular disease. WHO has projected that by the year 2030 mental disorders will be one of the leading causes of the global disease burden.

COMMUNICATING WITH PEOPLE

Communication plays a very important and strategic role in the development and progress of every society. The whole process of communication is ever changing and is in a constant state of evolution. The term behavioural change communication signifies this strategic and decisive change in approach to communication. There are many theories and strategies that explain the concept of Behavioural Change Communication.

BCC activities help to bring about personal and interpersonal changes that empower people to absorb new ideas and practices that bring about qualitative changes in their life. Many health and development issues use BCC to improve people's health and well being.

BCC in Health Communications

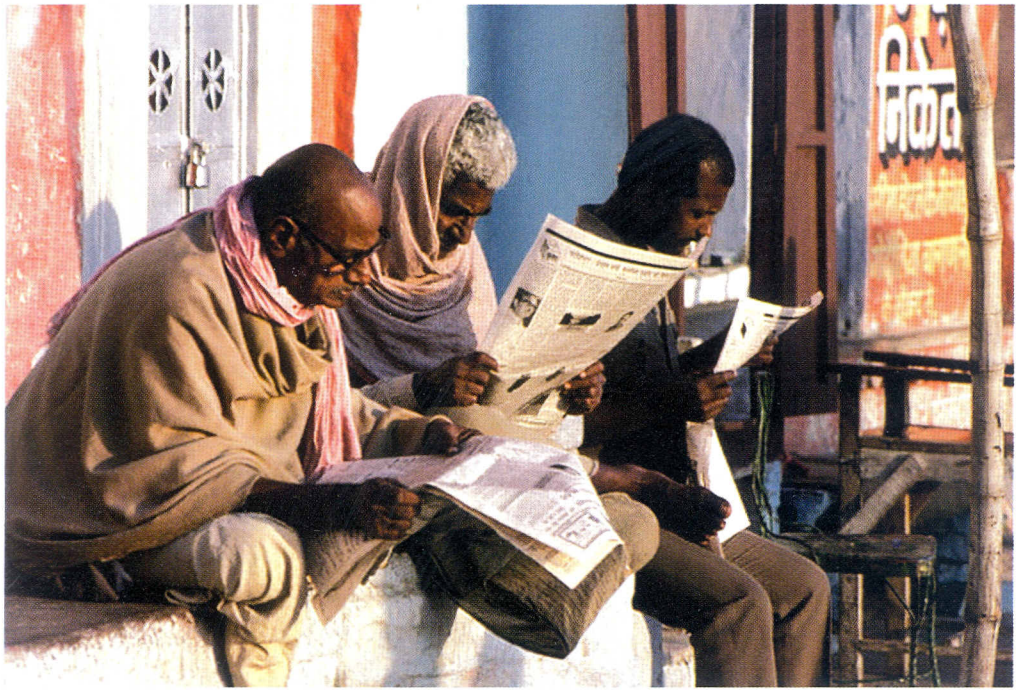
BCC interventions have been effectively used the world over to tackle various issues like reproductive health, family planning, maternal and child health and prevention of infectious diseases. BCC should support an effective service delivery system with a supportive policy environment. For example, BCC campaign can motivate people to go in for institutional delivery, but the health system has to respond with the necessary services to facilitate institutional delivery. If this does not happen, the BCC campaign will lose face and would not be successful.

Over the last decade BCC programmes are being used strategically the world over. Some of them have helped family planning programmes to meet their goals. Take for example the issue of reducing unmet needs for contraception, BCC interventions have helped people make right family planning choices, addressed worries about contraceptive side effects, opposition to family planning, encouraged couples to discuss reproductive health issues and have made contraception more socially acceptable.

Stages of behaviour change

Any planned Communication strategy will have to operate in a framework of stages. People usually move through several intermediate steps in the behaviour change process. They constitute distinct audiences and need different approaches and messages. The transformation stages involve the following: receiving information, understanding the received information, changing health behaviour and finally health seeking behaviour.The audience can be described as Pre-knowledgeable unaware of the problem, / Knowledgeable- aware of the problem/ Approving-in favour of the desired behaviours/Intending-intends to take the proposed

Interpersonal communication need support of Mass Media



Newspapers continue to be a powerful media

action/Practicing- practices the desired behaviour/ Advocating Practices the behaviour and advocates them to others.

Once a community attains the last two stages the demand factor sets in wherein quality of care in health services and information are the natural outcome in the cycle of the BCC process.

A successful BCC plan would also help in refuting myths and misunderstandings prevalent in the society by showcasing successful interventions and help shift social norms to encourage more healthy behaviour.

Need to be part of a larger framework

Today, various BCC interventions and case studies emphasise that BCC must work as a part of a larger programme and frame work that includes service delivery, advocacy activities and social mobilisation programmes. It is imperative that a successful BCC intervention requires stable and reliable service delivery infrastructure to supplement the BCC campaign.

There is also a pressing need for Advocacy initiatives to bring about policy and legal changes at the highest levels of the government and right up to the local governance level. The citizens of the country also need to be educated about changes in laws and be made aware of their rights to demand services that are to be provided mandatorily by the government to create an enabling climate for behavioural change especially in developing countries.

Steps involved in developing a planned BCC strategy

Successful BCC programmes follow a structured and systematic process. These approaches consists of five to six major steps and takes a holistic view of the whole behavioural process and how to address basic issues. Different organisations may give different name for these steps but the approaches are basically the same. The steps followed include Analysis, Budgeting for BCC, Strategic Design, Development and Pre-testing, implementation and Monitoring and Evaluation. The various subheads and methods used under this plan process might differ as per the available budgets; culturally specific approaches and the overall objective but the generic process and the methods remain the same. In short every BCC strategy to be effective should be research based, client cantered, benefit oriented, service linked, professionally developed and related to behavioural change.

Following a proven process helps programmes to work in a structured and efficient manner. A BCC strategy lays out a plan and a road map for reaching the desired behaviour

change objectives. A lot of work and collaboration precede implementation of an effective BCC strategy

1. Situational Analysis

Analysis or formative research involves defining the health problem, the intended audience, their communication needs and the effective modes of communication channels to reach out to the audience. Analysis also helps in collecting information about the audience, their knowledge attitude and barriers with reference to the health problem. Analysis can be carried out through primary and secondary research methods.

Successful BCC programmes follow a structured and systematic process. The steps include Analysis, Budgeting for BCC, Strategic Design, Development and Pre-testing, implementation and Monitoring and Evaluation.

2. Budgeting for BCC

It is imperative that the programme is clear about the budget it has before embarking on the creation of a strategic design for the behavioural change process.

3. Designing a Communications Strategy

The communications strategy must specify clear cut **objectives.** It must in clear terms state what it wants to achieve through the communications/ BCC strategy. While framing objectives, one has to specify the issues/ health needs that would be addressed by the campaign in clear terms. Once the objectives of the campaign is finalised, a conceptual framework should be developed. **A conceptual framework** details the path the campaign is supposed to take as per the ground realities and the situational analysis that was done earlier. It details how programme activities are expected to contribute to the objectives.

The programme managers will **need to identify the various communication tools and channels** that they will need to engage to reach out to various segments including policy makers, service providers, primary audiences and secondary audiences.

Messages can be delivered through mass media, eg: television or radio spots, articles in newspapers, periodicals or through brochures, posters, flip charts, comics, or in- person by health workers, peer educators,

Displays such as Republic Day Tableau make an impression in the mind of beneficiaries

counsellors and trained personnel. Messages can also be communicated through musical, dramatic performances and community events. It is important to judge which media reaches your target audience the most.

Broadly, the communication channels can be grouped under three basic categories: (a) Interpersonal channels (b) Community based channels and (c) Mass media channels It is important to understand that how particular channels can help achieve particular goals. Each medium has its own advantages and disadvantages and various media may suit various circumstances as per the profile of the target audience. Once the communication channels have been identified and a media mix/ matrix is ready, programme managers will have to **develop a creative brief** for the benefit of the implementation team.

The implementation plan should reflect how the BCC strategy would be implemented.The implementation plan should be based on the activities, timelines for implementation of the BCC intervention, available budget at hand and roles and responsibilities of various stakeholders. The implementation plan should also include **monitoring and evaluation strategies** as they are the key to assess the success of any campaign.

4. Development and pretesting of materials

The analysis / formative research and the strategic plan that has been created guide the development of concepts, messages and materials. The tone of the messages could vary as per the profile of the target audience. It could be entertaining or humorous or empowering or even authoritative. Once the messages are developed they should be pretested in the community and among the intended target audience and revised as per feedback.

5. Implementation

A structured and well thought out Implementation plan calls for detailed timelines with planned activities, responsibilities, budget for utilisation, staffing and manpower and audience responses.

6. Monitoring and Evaluation

Monitoring takes place during the implementation of the programme. A proper monitoring strategy enables programme managers to examine if the plan is moving in the right direction. It helps authorities to track programme activities, outputs, reach of the programme and check costs of implementation.

Evaluation of the programme is necessary for measuring the impact and success of BCC interventions. It helps assess program achievements and how well the programme has met its objectives. It also helps to understand shortfalls and discrepancies

SNIPPETS

Bill seeks to regulate wombs-for-rent

New Delhi: A woman acting as surrogate mother in India cannot be less than 21 or over 35 years. Also she cannot give more than five live births, including her own children.

With India fast emerging as a rent-a-womb hotspot, the Union Health Ministry has now finalized the Assisted Reproductive Technologies (ART) Regulation Bill 2010, which has been sent to the Law Ministry for its approval.

Times of India 27th January 2011

One-third of adolescent girls under-nourished in India

New Delhi: The number of adolescent girls (in the age group of 11-18 years), constituting 17 per cent of the total female population, is 8.3 crore, according to the National Family Health Survey.

The female literacy rate is only 53.87 per cent. Thus, they have considerable "unmet needs" in terms of education, health and nutrition, it said.

The Assam Tribune, Guwahati 24th January 2011

3 popular drugs face ban for serious side-effects

After the recent ban on nimesulide, India is looking to clamp down on three other controversial drugs Gatifloxacine. Tegaserod and Deanxit. All these drugs are used extensively in the country, under different brand names, and they cumulatively do a business of around Rs. 70 crore annually.

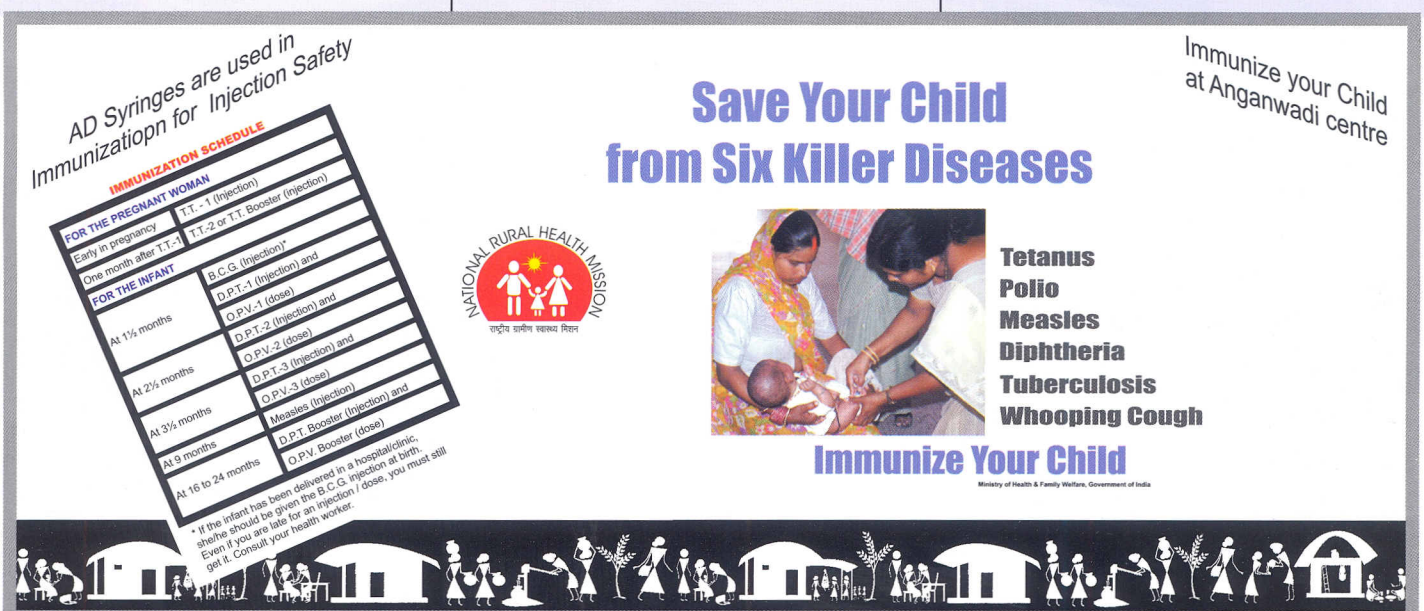
TIO 8.2.2011

Government bans use of plastics for packaging tobacco products

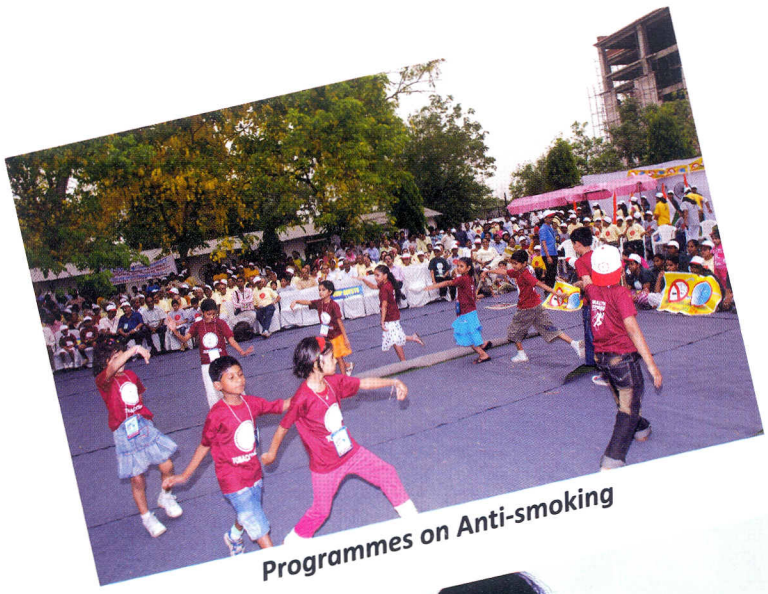
The environment ministry today issued a notification banning the use of plastics for packaging gutka and other tobacco products. The new notification that replaces the earlier Recycled Plastics Manufacture and Usage Rules, 1999 (amended in 2003), also states no carry bags shall be made available free of cost to consumers. The municipal authority may determine the minimum price for plastic carry bags, the ministry said in a statement.

In addition, packaging of foodstuffs in recycled plastics or compostable plastics has been banned. Recycled carry bags shall confirm to specific Bureau of Indian Standards (BIS), the ministry specified.

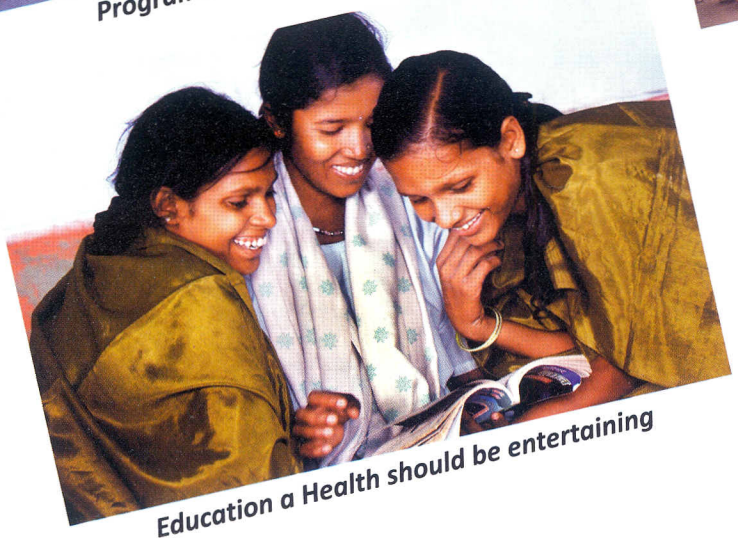
Business Standard 8.2.2001



Communication Ac



Programmes on Anti-smoking



Education a Health should be entertaining

Population ru

Drawing competition on Health issues

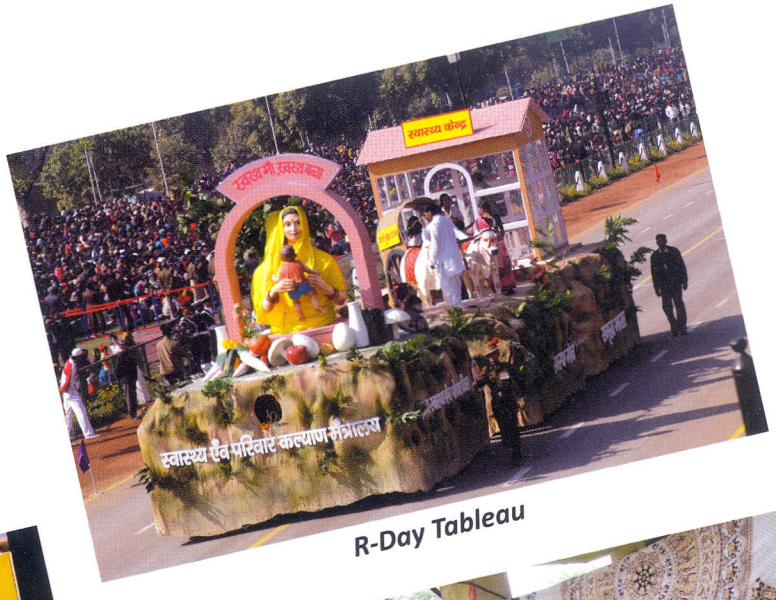
Activites at Anganwadi Centre

tivities under NRHM

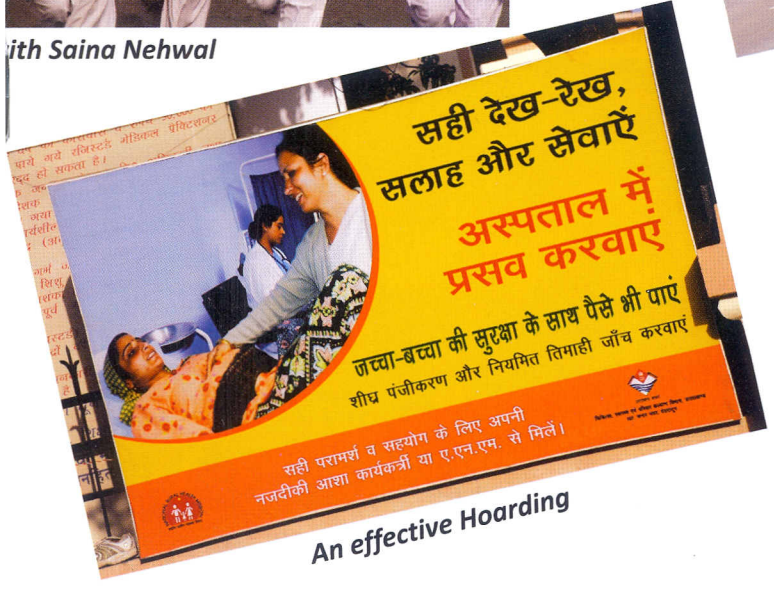
Beneficiaries must be satisfied

Song & Drama troupe's show

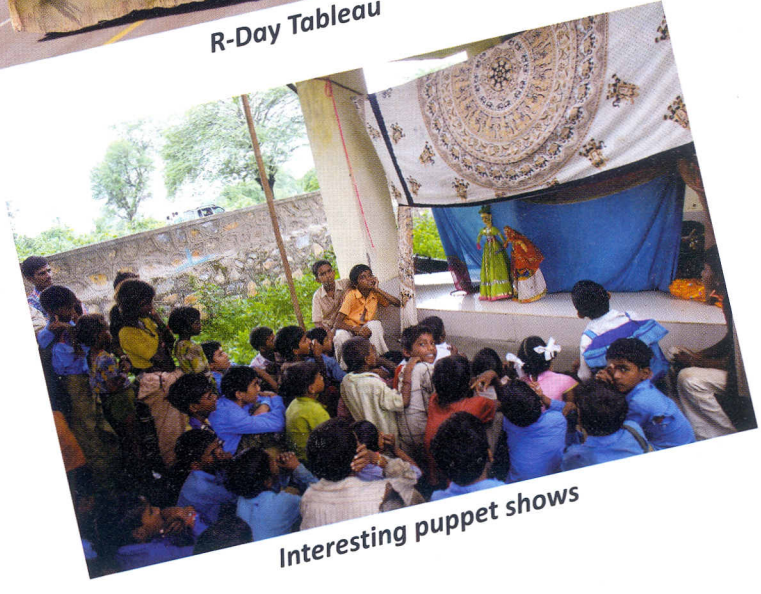
ith Saina Nehwal



R-Day Tableau



An effective Hoarding



Interesting puppet shows

PROGRAMME FOR MENSTRUAL HYGIENE LAUNCHED

The government of India has launched a new innovative programme for the promotion of menstrual hygiene among adolescent girls in rural areas of the country. The programme is targeted at adolescent girls in the age group of 10-19 years residing in rural areas to make sure that they gather adequate knowledge and information about the use of sanitary napkins, high quality safe napkins are made available to them and they are made aware of environmentally safe disposal practices.

In India, menstruation and menstrual practices are clouded by taboos and Socio-cultural restrictions for women as well as adolescent girls. Limited access to products for sanitary hygiene, and lack of safe sanitary facilities have been major barriers.Anecdotal evidence suggests that the lack of access to menstrual hygiene (which includes sanitary napkins, toilets in schools, availability of water, privacy and safe disposal) could constrain school attendance and possibly contribute to local infections during this period. Therefore the need for creating awareness and increasing access to the requisite sanitary infrastructure related to menstrual hygiene is important.

The main focus of the programme is to increase awareness among adolescent girls on menstrual hygiene, build self-esteem and increase access to and use of high quality sanitary napkins by adolescent girls in rural areas . The other focus is to ensure safe disposal of sanitary napkins in an environment friendly manner.

The overall implementation of the programme is based on two key strategies :

- Demand generation through ASHA and other community mechanisms such as Women's Group/Kishori Mandals. An additional mechanism for in-school youth would be that of the APE through the life skills courses for Classes IX and XI.
- Supply side intervention through ensuring a supply of a product (sanitary napkin) which is reasonably priced and of high quality.

The first phase of the programme will cover 150 districts of the country in selected states reaching out to a population of 2.14 crore girls in the target group. The following criteria are being suggested to the states for selection of districts where this intervention may be taken up (a) Existing adolescent health programme in place (b)Strong APE intervention (Adolescent health programme) (c)Active Self-Help Group (SHG) federations (d) Effective ASHA training and support systems.

In the selected districts, the states would cover approximately 70% of the adolescent girl population because of the varying ages of onset of menarche between 10-12 years. The programme will be components through a variety of intervention. The various components of the programme include :

1.Community based health education and outreach in the target population to promote menstrual health

a. Outreach through ASHA/other community mechanisms

The outreach to adolescent girls will be through:

- Monthly meeting to be convened by ASHA at the Anganwadi Center or Panchayat Bhavan for adolescent girls in the target age group. The monthly meeting can also be held with the Kishori Samooh or the Adolescent Resource Center proposed under the SABLA scheme Rajiv Gandhi Scheme for Empowerment of Adolescent

Girls (RGSEAG) by the Ministry of Women and Child Development (MWCD).

- Monthly meeting will be complemented by household visits to promote menstrual hygiene among girls who are unable to attend the monthly meeting and motivate attendance for future meetings.

The meeting will be focus on issues of menstrual hygiene and also serve as a forum for supplying sanitary napkins to the girls. In addition, other issues that impact adolescent health such as: early marriage, nutrition, gender issues, knowledge of contraceptive choices, understanding of Sexually Transmitted Infection(STI) including HIV and the consequences of high risk behaviour, improving self-esteem and negotiation skills will be discussed.

b. outreach through schools

Another channel for promotion of menstrual hygiene for school going adolescents could be the APE/School Health Promotion and the nodal school teachers.

2. Ensuring regular availability of sanitary napkins to the adolescents

a. In the community

At the community level, the ASHA will be responsible for ensuring an adequate supply of sanitary napkins to adolescent girls who require them. The monthly meetings would be the key forum to facilitate this regular supply. States are free to select other mechanisms for reaching the adolescent girls in order to provide them with sanitary napkins which may be better suited to the local context.

b. In the school

Based on existing data, it can be assumed that approximately 45% of the rural adolescent girl population is in school and the remaining is out of school. Thus, health education and supply and distribution of sanitary napkins both can be done through the mechanisms of the AEP/School Health Programme.

3. Sourcing and procurement of sanitary napkins

The requirement of sanitary napkins for each selected district is based on 70% of the total population of adolescent girls in the age group 10-19 years. These guidelines stipulate that each pack of sanitary napkins will contain six napkins.

The sanitary napkins shall be sourced through enabling manufacture by SHGs in states and under various national and state programmes under Women and Child Development Corporations.

Procurement will also be done through a competitive bidding process States will need to put into place uniform standards for production and quality checks to ensure safety of the product in line with the prescribed standards. This would require that the state involves local technology institutions for material testing and Research and Development (R&D) by establishing quality testing labs and ensuring quality measures for infection prevention during manufacture.

4. Training of ASHA in menstrual hygiene

ASHA training

Asha workers will be divided into three batches of 35 each. The training duration for a batch is about four hours. The three batches of ASHA will be trained at the block level by a team of two district trainers, who belong to that block.The ASHA will be given a copy of the flipbook and reading material, and the trainers will be given the trainer module in addition. The reading material and trainer module can also be used to train SHGs and AWW.

5. Behaviour Change Communication

A communication strategy and a kit targeted at adolescent girls and gatekeepers and influencers (mothers, teachers, women members of PRI and VHSC) will be developed at the national level for translation and adaptation at state levels. The mechanisms for Behaviour Change Communication (BCC) will include Interpersonal Communication (IPC) use of Flipcharts and Leaflets, and Health Camps.

6. Safe disposal of sanitary napkins

Safe disposal of sanitary napkins is an integral part of the programme, particularly given the consequences for the environment. Safe disposal communication will be one of the core components of the BCC training. At the community level, deep pit burial or burning are two options which could be considered after due environmental clearances are obtained. State could consider installing incinerators in school.

HOW TO BE AN EFFECTIVE VILLAGE HEALTH WORKER

A village health worker is a person who helps and lead family and neighbours towards better health. Often she of he has been selected by the other villagers as someone who is especially able and kind.

Some village health workers receive training and help from an organized program, perhaps the Ministry of Health. Others have no official position, but are simply members of the community whom people respect as healers or leaders in matters of health. Often they learn by watching, helping, and studying on their own.

In the larger sense, a village health worker is anyone who takes part in making her/his village a healthier place to live.

This means almost everyone can and should be a health worker :

THE VILLAGE HEALTH WORKER LIVES AND WORKS AT THE LEVEL OF HER PEOPLE. HER FIRST JOB IS TO SHARE HER KNOWLEDGE.

- Mothers and fathers can show their children how to keep clean;
- Farm people can work together to help their land produce more food;
- Teachers can teach schoolchildren how to prevent and treat many common sicknesses and injuries;
- Schoolchildren can share what they learn with their parents;
- Midwives can counsel parents about the importance of eating well during pregnancy. breast feeding, and family planning.

HAVE COMPASSION
Kindness often helps more than medicine. Never be afraid to show your care.

Dear Village Health Worker,

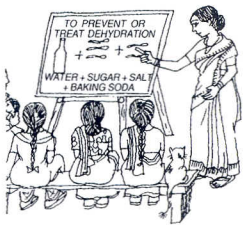
To make your village be a healthy place to live, you must also be in touch with their **human needs.** Your understanding and concern for people are just as important as your knowledge of medicine and sanitation.

Here are some suggestions that may help the health worker serve people's human needs as well as health needs :

1. BE KIND. A friendly word, a smile, a hand on the shoulder, or some other sign of caring often means more than anything else you can do. **Treat others as your equals.** Even when you are hurried or worried, try to remember the feelings and needs of others. Often it helps to ask yourself. "What would I do if this were a member of my own family ?"

Treat the sick as people. Be especially kind to those who are very sick or dying. And be kind to their families. Let them see that you care.

2. SHARE YOUR KNOWLEDGE. As a health worker, your first job is to teach. This means helping people learn more about how to keep from getting sick. It also means helping people learn how to recognize and manage their illnesses including the sensible use of home remedies and common medicines.



LOOK FOR WAYS TO SHARE YOUR KNOWLEDGE.

There is nothing you have learned that, if carefully explained, should be of danger to anyone. Some doctors talk about **self care** as if it

were dangerous, perhaps because they like people to depend on their costly services. But in truth, **most common health problems could be handled earlier and better by people in their own homes.**

3.RESPECT YOUR PEOPLE'S TRADITIONS AND IDEAS.

Because you learn something about modern medicine does not mean you should no longer appreciate the customs and ways of healing of your people. Too often the human touch in the art of healing is lost when medical science moves in. This is too bad, because....

If you can use what is best in modern medicine, together with what is best in traditional healing, the combination may be better than either one alone.

In this way, you will be adding to your people's culture, not taking away.

WORK WITH TRADITIONAL HEALERS AND MIDWIVES– NOT AGAINST THEM.

Learn from them and encourage them to learn from you.

Of course, if you see that some of the home cures or customs are harmful, you will want to do something to change this, But do so carefully, with respect for those who believe in such things. Never just tell people they are wrong. Try to help them understand WHY they should do something differently.

People are slow to change their attitudes and traditions, and with good reason. They are true to what they feel is right. And this we must respect.

Modern medicine does not have all the answers either. It has helped solve some problems, yet has led to other, sometimes even bigger ones. People quickly come to depend too much on modern medicine and its experts, to overuse medicines, and to forget how to care for themselves and each other.

So go slow and always have a deep respect for your people, their traditions, and their human dignity. Help them build on the knowledge and skills they already have.

4. KNOW YOUR OWN LIMITS.

No matter how great or small your knowledge and skills, you can do a good job as long as you know and work within your limits. This means : **Do what you know how to do.** Do not try things you have not learned about or have not had enough experience doing, if they might harm or endanger someone.

KNOW YOUR LIMITS.

But use your judgement.

Often, what you decide to do or not do will depend on how far you have to go to get more expert help.

For Example, a mother has just given birth and is bleeding more than you think is normal. if you are only half an hour away from a medical centre, it may be wise to take her there right away. But if the mother is bleeding very heavily and you are a long way from the health centre. you may decide to massage her womb or give misoprostal tablets even if you were not taught this.

Do not take unnecessary chances. But when the danger is clearly greater if you do nothing, do not be afraid to try something you feel reasonably sure will help.

Know your limits but also use your head. Always do your best to protect the sick person rather than yourself.

5. KEEP LEARNING. Use every chance you have to learn more. Study whatever books or

KEEP LEARNING – Do not let anyone tell you there are things you should not learn or know.

information you can lay your hands on that will help you be a better worker, teacher, or person.

Always be ready to ask questions to doctors, sanitation officers, agriculture experts, or anyone else you can learn from.

Never pass up the chance to take refresher courses or get additional training.

Your first job is to teach, and unless you keep learning more, soon you will not have anything new to teach others.

PRACTICE WHAT YOU TEACH
(or who will listen to you?)

6. PRACTICE WHAT YOU TEACH.

People are more likely to pay attention to what you do than what you say. As a health worker, you want to take special care in your personal life and habits, so as to set a good example for your neighbours.

Before you ask people to make latrines, be sure your own family has one.

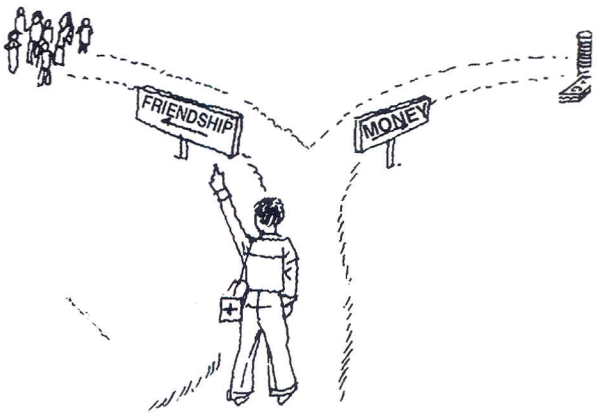
Also, if you help organize a work group for example, to dig a common garbage hole be sure you work and sweat as hard as everyone else.

A good leader does not tell people what to do. He sets the example.

7. WORK FOR THE JOY OF IT.

If you want other people to take part in improving their village and caring for their health, you must enjoy such activity yourself. If not, who will want to follow your example ?

Try to make community work projects fun. For example, fencing off the public water hole to keep animals away from where people take water can be hard work. But if the whole village helps do it as a 'work festival' perhaps with refreshments and music the job will be done quickly and can be fun. Children will work hard and enjoy it, if they can



WORK FIRST FOR THE PEOPLE – NOT THE MONEY
(People are worth more)

turn work into play.

Your may or may not be paid for your work. But never refuse to care, or care less, for someone who is poor or cannot pay.

This way you will win your people's love and respect. These are worth far more than money.

8. LOOK AHEAD AND HELP OTHERS TO LOOK AHEAD.

A responsible health worker does not wait for people to get sick. He tries to stop sickness before it starts. He encourages people to take action now to protect their health and well-being in the future.

Many sicknesses can be prevented. Your job, then, is to help your people understand the causes of their health problems and do something about them.

Most health problems have many causes, one leading to another. To correct the problem is a lasting way. You must look for and deal with the **underlying causes.** You must get to the root of the problem.

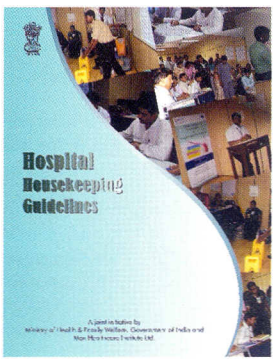
For example, in many villages diarrhea is the most common cause of death in small children. The spread of diarrhea is caused in part by lack of cleanliness (poor sanitation and hygiene). Your can do something to correct this by digging latrines and teaching basic guidelines of cleanliness.

TRAINING TO UPGRADE QUALITY OF CARE IN SANITATION AND INFECTION CONTROL

The Ministry of Health & Family Welfare in partnership with Max Health Care Institute Limited has successfully completed a training programme for sanitation and infection control for the staff of Safdarjung Hospital, Ram Manohar Lohia Hospital and Lady Hardinge Medical College and Hospital in Delhi. The objective behind the exercise was to upgrade the quality of health care in these hospitals for the benefit of the general public. This programme was launched on the 9th of April, 2010 at the Safdarjung hospital by the then secretary of health K. Sujatha Rao.

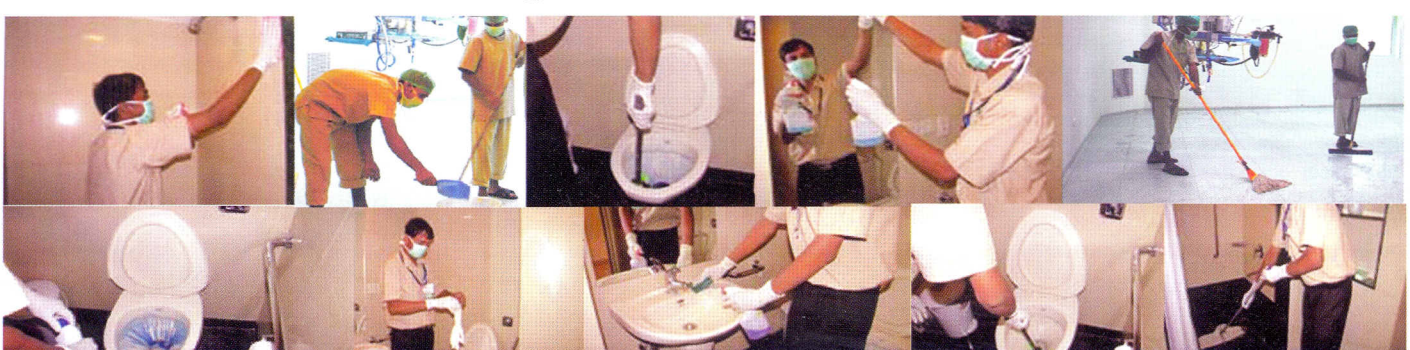
This initiative brought about the deployment of skilled trainers from departments like Nursing, Human Resources, Medical Quality & Housekeeping of Max Healthcare institute Ltd to these government hospitals to impart training to the staff. The training programme commenced on the 15th of April,2010 at the Safdarjung Hospital and was followed up by training of staff at Dr. Ram Manohar Lohia Hospital towards the end of June. Trainings were imparted to more than 500 personnels of these two hospitals in a phased manner for a period of 150 days.

Before the commencement of the training, a baseline audit to understand the existing procedures and sanitation standards being practiced in these hospitals was conducted for identifying the training needs. This was followed by 'Train the Trainer Programme' in which more than 70 supervisory staff of each of these hospitals including some nursing personnel and sanitation staff were trained in Leadership Development and Technical Areas of Sanitation and Infection Control. This was followed by training of 400 ground level staff at these hospitals with the help of technical modules.



A Hospital Housekeeping Guidelines, giving step-by-step instructions, have been brought out which will be helpful to all public sector hospitals- in the Centre or states- as a reference material.

The response from the various categories of staff selected for the training was overwhelming. The management of these hospital also played a key supportive role in facilitating the training and taking the agenda forward. The training programme spared no efforts to address the sanitation and housekeeping needs of these two hospitals with the latest advances in medical care. The medical superintendents and support staff of these two hospitals are now ensuring that these learning's are followed by regular in house trainings and the best practices learnt are being put to use for attaining excellence in cleanliness and infection control.



Dear Sir,

I am working as an Assistant Professor in the Department of Community Medicine at Sree Mookambiga Institute of Medical Sciences, Kulasekharam, Kanyakumari district. I used to read the NRHM Newsletter from our departmental library and found they are very much informative and thought provoking. I would be very happy and thankful if you include me in the mailing list.

Dr. D. Pethuru, M.B.B.S.; M.D., (Comm. Med).,
No:1, S.N.V. Nagar, High Ground,
Tirunelveli- 627 011.

Dear Sir,

I shall appreciate greatly if you could kindly send me your web edition of the Newsletter.
Email : hdkhanna@yahoo.co.in

Prof. H. D. Khanna,Head,
Department of Biophysics,
Institute of Medical Sciences,
Banaras Hindu University,
Varanasi.Contact No.: 09450710446

Dear Sir

I am working as Block Medical Officer of Health, West Bengal. I request you to kindly send a copy of NRHM news letter (English) regularly through mail.

Dr. Sudipta Bhattacharjee, MBBS, DPH
BMOH, BASIRHAT-II,
24 - Parganas (N)
WEST BENGAL.,
Mobile: 9830114103

Dear Sir,

I have read your NRHM Newsletter. I found it useful and informative. I am working as AYUSH Medical Officer. So kindly include my name in the mailing list for sending NRHM Newsletter (Oriya version) regularly.

Dr. Tuni Moharana,
Office of the Shree Purushottam Ayur. Building,
Near Gandhi Chhak,
At/Post Balugaon, Distt. Khurda,
Pin 752 030 (Orissa)

Dear Sir,

The other day I was going through the NRHM magazine and found it to be very useful. It will be of help if you could include my name in the subscription list.

Dr. Manoj Agarwala,
Marwari Para,
Sambalpur,
Odisha 0 768 001.

Dear Sir,

I am working as a Block Public Relation Officer of BPHC Vamanpuram, under NRHM in Kerala. I would like to get the web edition of the Newsletter. I would request you to include me in your mailing list to get the Newsletter regularly.

Ms. Eliz Rose k.a.,
Email : elizroseka@yahoo.co.in

Dear Sir,

I am Dr. Sugunamma working as a Medical Officer in Sivananda Community Care Centre, Kukatpally, Hyderabad. We want NRHM newsletter regularly. Please send me the details regarding "how to get this news letter".

Medical Officer,
Sivananda Community Care Center
Kukatpally, Hyderabad
Ph. 04023156605

Dear Sir,

General Hospital Channapattana is a 100 bedded Hospital working under the Department of Health & Family Welfare, Govt. of Karnataka in Ramanagara Distt. Karnataka. We found NRHM Newsletter very informative and useful for spreading the message of NRHM. Hence, I request you to include our name in your mailing list.

Dr. B.N. Dhanya Kumar,
MBBS, MD, DGO, PGDHHM Depp (Italy),
General Hospital, Channapattana 571 501
Distt. Ramanagara, Karnataka.

Dear Sir,

I am working as AYUSH Medical Officer in Community Health Centre, Betalghat, Nainital (Uttarakhand). I read your NRHM Newsletter regularly and found the same very informative and useful. So kindly include my name in the mailing list for sending NRHM Newsletter (English version) regularly.

Dr. Shailendra Dagar, MBBS,
AYUSH Medical Officer,
Community Health Centre,
Betalghat, Nainital (Uttarakhand)

Dear Sir,

I have read NRHM Newsletter and found it very useful for our nursing students to update their knowledge. As we are running DGNM Nursing Course at our Shri G.H. Patel School of Nursing, Anand, please enroll us in your mailing list.

Ms. Raksha Parmar,
Vice Principal,
Shri G.K. Patel School of Nursing,
Karamsad – 388325
Distt. Anand (Gujarat)

Dear Sir,

I am the Managing Director of Shreeya College of Nursing, Dharwad. This College is catering the medial and health knowledge information to the students of B.Sc. Nursing and also paramedical sciences. This newsletter is very useful for the students and faculty members. Hence I request you to send one copy of the NRHM Newsletter regularly.

Dr. Satish Y. Irkal,
Shreeya College of Nursing,
Irkal Complex, Opp. District Court,
P.B. Road, Dharwad 580 008, Karnataka

Dear Sir,

I have been working as Lab. Technician in HMRI (104) Mobile Service, Kadapa District in Andhra Pradesh since last 2 years. I read your newsletter at my head office. The matter which you publish is very useful. I want to have your NRHM Newsletter on a regular basis. Kindly put me on your mailing list.

Shri S. Vara Prasad,
Lab. Technician,
H.No. 16/1013, Masapeta,
Kadapa 516001, Andhra Pradesh

Dear Sir,

I am working as a Principal in ANM School in Kollam, Kerala. I have read the NRHM Newsletter. I found this newsletter very useful and informative to our students. Kindly add our name in your mailing list.

Mrs. Margaret Raju,
Principal,
CSI School of Nursing,
L.M.S.Boys' Brigade Hospital,
Kundara, Kollam

Dear Sir,

We shall be highly obliged if you kindly enroll our name in your mailing list for sending the NRHM Newsletter regularly as the same is very informative and useful.

Principal,
ANM Training Centre,
S.N.R. Hospital,
Kolur Town, Kolur 563 101
Karanataka

Dear Sir,

I recently read a copy of the NRHM Newsletter & found it to be very informative & useful. I am posted at a peripheral primary health centre in Jhargram sub-division of West Bengal as medical officer in charge. I have to implement various national health programmes & other activities under NRHM. Therefore, I will be highly obliged if you kindly arrange to include my name & mailing address in your mailing list for sending me the English version of your newsletter & also the previous editions.

Dr. Abhirup Sinha,
Medical Officer-in-charge, Jamirapal P.H.C. (W.B. Health Service),
E/476, A-Block, P.O.-Sonari JAMSHEDPUR-831011, JHARKHAND

Dear Sir,

I am working for medical & health services in the villages for the last 25 years. NRHM is giving very good services in the villages. The NRHM Newsletter is very good services for health services. Kindly put my name in you mailing list.

Dr. C.P. Kushwaha,
Nehar Kothi Road,
Attri Nagar, Attarara,
Janpad Banda,
Uttar Pradesh

Dear Sir,

I am working as Health Supervisor. NRHM Newsletter is very useful to Health professionals. Kindly put my name in your mailing list.

Mr. Rajama Mahendra MPHS (M),
Primary Health Centre,
Ganded
Ranga Reddy distt.
Andhra Pradesh

Dear Sir,

I will be grateful if you please include my name in your mailing list and send me your NRHM Newsletter regularly. I have completed my graduation in Public Health (DPH).

Dr. S.K. Khadar Valli,
MBBS, DDVL,DPH, MIPHA,
15/68, Brundavanam,
Nellore Distt. 524 001
Andhra Pradesh

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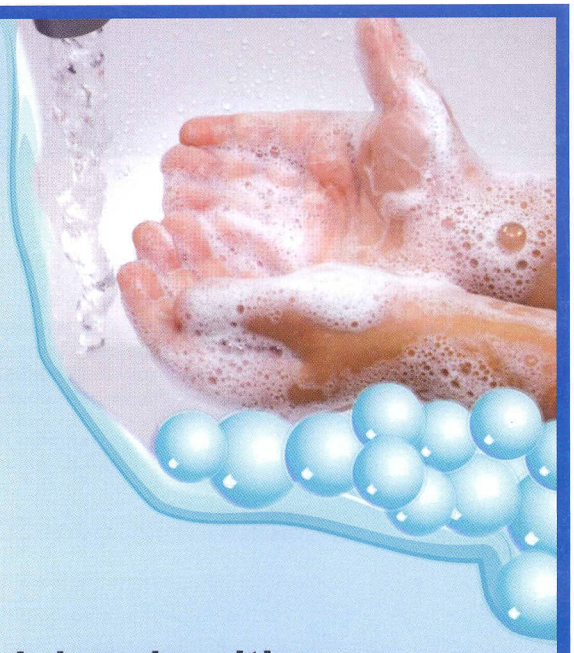
Make Hand Wash a Healthy Habit

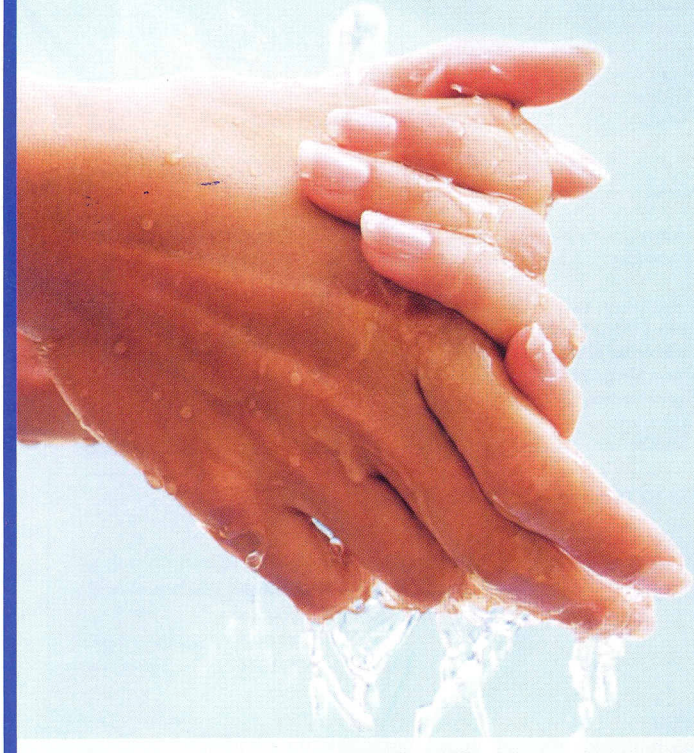


* Wash hands with soap before taking food

* Wash hands with soap after using toilet

* Wash hands after visiting a sick person

* Wash hands with soap after handling waste



Hand wash fights germs & prevents infections