NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM newsletter

Vol.1 No.3 January 2007

More hardwork needed to make India Polio-Free

Progress under | NRHM

Institutional arrangements

- State Health Missions constituted in all States/UTs.
- State launch along with 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 29 states. Rest in process.

ASHA

- Total 3 lakh ASHA selected till date (1.28 lakh in 2005-06 and 1.8 lakh in 2006-07).
- ASHA trained: 2.05 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 1452 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 68513 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.
- 8080 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.
- 129 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 1117 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 624 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

- 299 Mother NGOs appointed for 410 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.

(as on 1.1.2007)

NRHM has boosted immunization coverage

More hardwork needed to make India Polio-Free

In pursuance to the World Health Assembly resolution of 1988, Pulse Polio Immunization (PPI) Programme was started in India from 1995 to eradicate polio from India. Significant success has been achieved in reducing number of polio cases in the country. As against 1600 cases in 2002 total cases declined gradually to only 66 cases in 2005. The geographical spread also declined from 159 districts in 2002 to 35 districts in 2005. Polio virus was eliminated in 33 of 35 states/UTs.

Of the 3 types of polio causing viruses, type 2 polio virus was eliminated in 1999. Type 3 virus has been geographically restricted to few districts of Moradabad region of Western UP. The on going circulation of polio virus is predominantly due to polio type 1 virus. However, significant success has been made in reducing the number of genetic families of polio virus in circulation from 8 in 2004 to 3 in 2006.

Polio Situation in year 2006

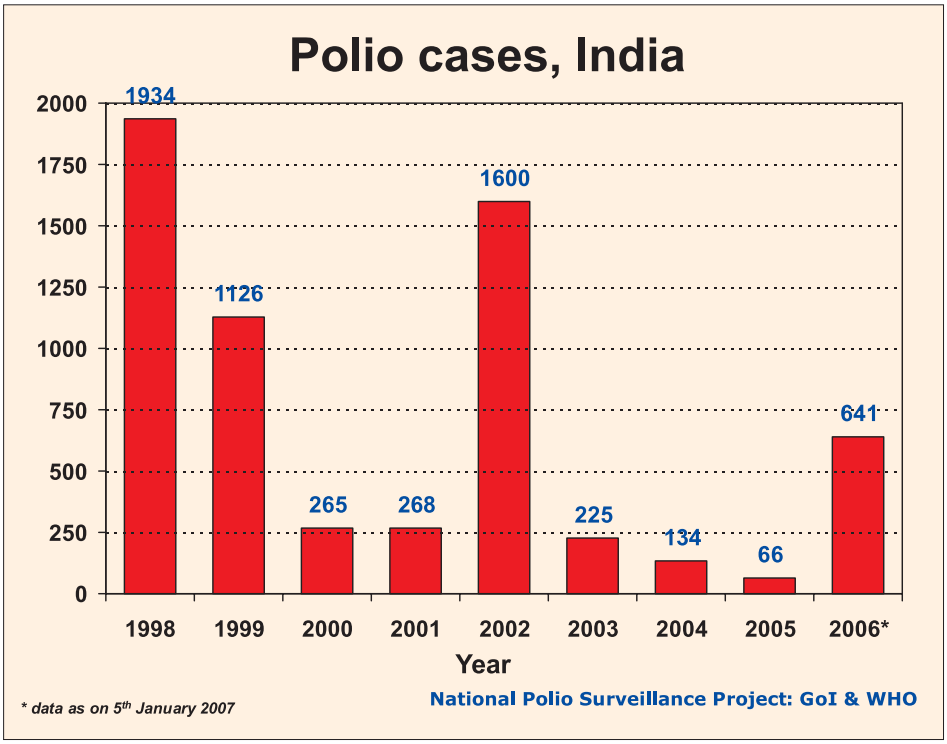
Due to an outbreak in Moradabad & J.P. Nagar in Western UP in early 2006, the polio virus circulation spread throughout Western UP and then to Central and Eastern U.P districts and other States like Madhya Pradesh, Uttaranchal, Chandigarh, Haryana, Maharashtra, Punjab, Himachal Pradesh, Jammu and Kashmir, Rajasthan which were free from indigenous transmission for the last two years. Polio virus from endemic districts in North-Central Bihar (East Champaran, Patna) spread to Southern districts of the State and infected several districts in Eastern UP, Gujarat, Mumbai, Haryana, Jharkhand.

So far 641 polio cases have been detected in 2006, out of which 519 from Uttar Pradesh, 57 from Bihar and remaining cases are from States of Uttaranchal, Haryana, Delhi, Punjab, Maharashtra, Gujarat, Madhya Pradesh, Jharkhand, West Bengal, Chandigarh, Assam, Jammu & Kashmir, Rajasthan & Himachal Pradesh.

The continuing polio circulation in UP and Bihar poses a threat for spread to other States and UTs in the country because of large scale movement of population to other parts of the country. It has also become a major global concern as polio cases reported from DR Congo, Angola, Namibia, Bangladesh and Nepal have come from Uttar Pradesh and Bihar.

Reasons for the outbreak in West UP.

The reasons for recurrence of polio in Western UP in 2006 were evaluated by WHO/UNICEF in April 2006. The increase in polio cases was due to a large percentage of children (nearly about 12%) missed from vaccination during the polio immunization campaigns conducted in the later part of 2005 and early 2006. This resulted in a large number of children not receiving polio vaccine during these rounds. Key factors contributing to reduced number of children immunized included:-



Cover Photo: President APJ Abdul Kalam giving Polio drops to a child at Rashtrapati Bhavan on 6th January 07. Secretary (Health & FW) Sh. Naresh Dayal is also seen.

- Inadequate or inconsistent State Government oversight for the polio eradication effort.
- Poor supervision of the implementation of the programme due to a large vacancies of medical officers at block / PHC level
- Lack of efforts to educate the underserved community for acceptance of polio vaccine.
- Poor sanitation and hygiene condition with high density of population in the Moradabad region favour continuing circulation of polio virus.

Response to the outbreak

Increased programmatic focus has been given in UP and Bihar :-

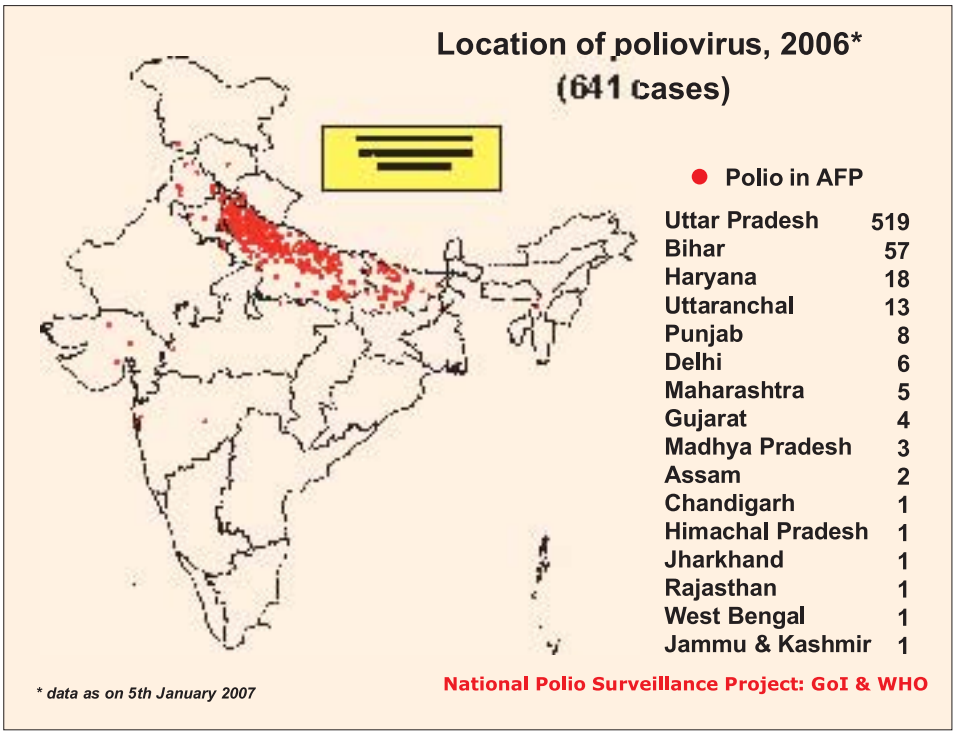
- Union Health Minister, GoI, met with Health Ministers of polio affected States in Delhi in late September, 2006 to discuss critical next steps
- Increasing government ownership through better involvement of State and District administrative machinery.
- Deploying high level officials from UP and Bihar to monitor PPI activities.
- Increased focus on mechanisms to reduce missed children in West UP
- Improving vaccination team performance by re-training vaccinators and supervisors to improve their interpersonal communication skills.
- Improving community participation by expanding the social mobilization network by increased deployment of social mobilization coordinators in West UP districts.
- Involving ASHA as member of vaccination team and made them responsible for mobilization of missed children and vaccinate them on monthly health day.
- Pilot in Moradabad for administration of birth dose of mOPV1 to all new born within 72 hours of the birth

In many areas, the above actions had a positive impact on the quality of the polio campaigns conducted during June and Nov 2006. The percentage of missed children has been reduced during these rounds. While the trend is positive, it is important that these efforts are sustained and maintained uniformly and consistently all across West UP and Bihar for the next 4-5 immunization rounds. If this is done the polio transmission can be stopped in India during 2007. This will require the highest level of Political and Administrate commitment in the States of UP and Bihar.

In the States where poliovirus is re-introduced (Haryana, Punjab, Chandigarh, MP, Maharashtra, Jharkhand, Uttaranchal, Himachal Pradesh, Jammu& Kashmir, Assam, Delhi, Gujarat and Rajasthan), it is important to conduct high quality activity to prevent establishment of the polio virus circulation in these States.

The India Expert Advisory Group (IEAG) on Polio reviewed the Polio situation during 11-12 December 06 and remains confident that wild polio virus will be eradicated from India. Population immunity against wild polio virus very high due to improvement in Supplementary Immunization Activities (SIA) quality, use of monovalent polio vaccine 1 (mOPV1) and every effort should be made to interrupt transmission of wild polio virus in 2007 through implementation of the appropriate strategies. It has recommended for implementing following strategy of Supplementary Immunization Activities (SIA) during 2007:-

- 2 National Immunization Days (NID) rounds in January and February 2007
- Up to 6 Sub National Immunization Days (SNID) rounds (2 in the first half of the year and up to 4 in the second half of the year) covering whole of UP and Bihar with other areas if required.
- mOPV should be used in the highest risk areas and tOPV in remaining areas.
- Supplementary Immunization Activities (SIA) should be carried out in response to the detection of wild polio virus in polio free areas.
- Undertaking an Inactivated Polio Vaccine (IPV) pilot project consisting of 2 rounds of IPV immunization as a supplement to mOPV1 Supplementary Immunization Activities (SIA) in 2 endemic blocks starting in 2nd quarter of 2007.



Background

Despite the wide availability of a number of contraceptive methods, unplanned and unwanted pregnancies persist. In India, 21 percent pregnancies are unplanned and 6.5 million induced abortions are carried out every year. Situations such as unprotected sex, improper use of regular contraceptives, failure of barrier methods, sexual violence and miscalculation of fertile period often leads to an unwanted pregnancy. In all such situations, emergency contraception will give women a last chance to prevent unwanted pregnancy. Reduction of unwanted pregnancies would protect a large number of women from undergoing the trauma of induced abortions, as well as reduce morbidities and deaths from abortions and pregnancy related complications. Emergency Contraceptive Pills (ECP)are hormonal pills that prevent pregnancy following an unprotected sexual intercourse, if taken within 72 hours. The hormone used in ECP is the same as used in Oral Contraceptive Pills (OCP) but in higher doses.

This write up is written in simple language to explain what are emergency contraceptive pills, when and how it should be used, its effectiveness and limitations. It is hoped that the article will be of particular use for ANMs, pharmacists, and village doctors who carry the major burden of educating community about family planning use and help women in achievin

Points to remember and emphasize during counselling

- ECP is for emergency use only. It is not a regular family planning method.
- If ECP is used frequently for preventing pregnancy, it is less effective than Pills/ Injection/ Condom/ IUD.
- ECP must be taken within 72 hours of unprotected intercourse. The earlier the better.
- The interval between the two doses should be 12 hours.
- After taking ECPs, if menstruation delays for more than one week of the expected date, go for pregnancy test.
- ECP is not an abortion pill. It cannot dislodge implanted foetus from the uterus.

ECP is not a regular Family Planning Method

It is important to recognize that ECP is NOT a regular family planning method. If used frequently for preventing pregnancy, it is less effective than Pills/IUD/Condom. Hence ECP should be used only as back up support to prevent pregnancy if unprotected sex has already occurred. Even when ECP is used only occasionally as back-up support, out of 100 women who will use it, 15 women will become pregnant.

Women should be told that ECP does not bring on menses immediately. Most women will have their menstruation on time or slightly early or 2-3 days late than the expected date. If period is delayed for more than one week of the expected date of menstruation, women should go for pregnancy test.

ECP cannot induce abortion

It is equally important to know that ECP is NOT an abortifacient. ECP cannot cause abortion. If a woman is pregnant or egg has been fertilised, use of ECP neither causes abortion nor will it harm the foetus or cause any birth defects. ECP should not be used for inducing abortion; it will not work.

Initiating or resuming regular contraception after ECP

As mentioned earlier, ECP is not a regular contraceptive method. It is only 85 percent effective in preventing pregnancy. Hence, it

Figure1: Contraceptive Options after Emergency Contraceptive Treatment

After taking two doses of ECP:

Methods	How to start
Condom Users	• Use Condom for every sexual encounter
OCP Users	•Continue using the rest of the OCPs, one tablet daily up to the beginning of the menstrual bleeding ***and*** •Start a new packet of OCP at the first day of the next cycle. **OR** •Stop using OCPs ***and*** •Use condoms till the beginning of the menstrual period ***and*** •Start a new packet of OCP at the first day of the next cycle.
Injectable Users	• Use condoms till beginning of the next menstrual period and • Take injection on the first day of the next menstrual cycle.
Non-users of Family Planning Methods	• Use condom till beginning of the next menstrual period and • Adopt any other Family Planning Method within 7 days of beginning the menstrual period • OR • Continue using condom as the Family Planning Method

Reducing Maternal Mortality in the State of Gujarat through Public Private Partnerships

The Chiranjeevi Yojana

Dr. Amarjit Singh

**Secretary (Family Welfare) and Commissioner (Health), Gujarat India.*

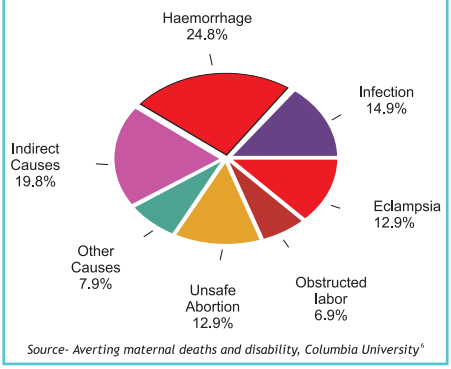
The Government of Gujarat after considering the cost effectiveness of various options settled for an innovative model of public private partnership - a programme for outsourcing the deliveries to private Gynaecologists called ***'Chiranjeevi Yojna'***, that is "Long life". The scheme has been initiated in the five most deprived districts in the state, involving private sector specialists for maternity services, primarily for socio economically weaker sections. These five border districts have sizable tribal and SC/ ST population and are also 'backward' in terms of overall development.

The Association of Obstreticians & Gynecologists and Federation of Gynecological Societies of India, Gujarat Chapter offered services for conducting deliveries. The rates were fixed in consultation with the NGOs working in the area and the Association of Obstreticians and Gynecologists to ensure reasonableness. The following issues were kept in mind in fixing the rates.

1. The rates were fixed for a package of 100 deliveries considering 85% normal deliveries and likelihood of complications in the remaining 15% cases. Based on evidence it was assumed that 7% of the complicated cases would require caesarian sections.
2. The rates were fixed for a package of 100 deliveries, so that there was no temptation for any doctor to do more cesarean surgeries.

3. The reimbursement was to be made directly to the gynecologists for the expectant BPL women. The scheme was kept simple; the BPL women were not expected to carry anything except her BPL card, which is widely available for all BPL families in Gujarat. *This was expected to take care of the first delay.*
4. Two hundred rupees were to be paid as transportation allowance to enable the pregnant women to come from remote village to the place of clinic. This was to be paid by the concerned doctor directly to the women and ultimately reimbursed by the government to the doctor. *This provision was made to address the second delay.*

Causes of Maternal Death



Source- Averting maternal deaths and disability, Columbia University[5]

5. Similarly a sum of Rupees fifty was provided for the TBA or person accompanying the expectant mother to ensure that somebody known to the lady was there at the time of the delivery.

The details of the charges can be seen at Annexure A. As can be seen, the average comes to Rs.1,795/- for one delivery or approximately US $ 4000 for 100 deliveries. It was decided to cover the 5 worst affected districts in the State, in the first phase. For the purpose, the five districts with the highest MMR were selected.

Based on the 2004 district level health survey, it was estimated that there would be 2,54,548 births in these districts. Since the Chiranjeevi Scheme was made available for only BPL women, it was expected that 58,637

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HEALTH & FAMILY WELFARE AT IITF '06

Facade of the Health & Family Welfare pavilion.

Union
vi

Song & Drama group performing at the pavilion.

Ministers interacting with the Press at the pavilion.

The Health & Family Welfare pavilion at the India International Trade fair 2006, won the Gold medal for its beautiful display among all the Pavilions of Central Ministries at the fair.

Health Minister Dr. A. Ramadoss siting a stall at the pavilion.

Children using touchscreen interactive computer at the pavilion.

Learn through Play: Snakes & Ladders game let children learn some important health tips.

Display at the pavilion.

births, at the rate of 25% of BPL population, would take place in these districts amongst BPL families.

Steps to popularize the scheme

The scheme was given a wide publicity. MoUs were signed with the doctors who were willing to participate in this scheme. At this stage no selection was made. The basic idea was to get large number of O&G doctors enrolled in this scheme in the first instance. Once the scheme is operational, the accreditation of doctors is proposed to be taken on hand and quality checks put in place.

The following other steps were taken to popularize the scheme:

- District level FOGSI members workshops organized for orientation on Chiranjeevi scheme and enrollment of doctors on the panel.
- The state Health Minister wrote letters about the scheme to presidents of district and talukas panchayats in 5 districts.
- District level advocacy workshops for presidents of district and taluka panchayats, Block Health Officers and Chiranjiv panel doctors organized in each district.
- In each district IEC activities were undertaken. Awareness was also created through the Gram sabhas .
- Rupees 15000/ advance was given to each obstetrician. Similarly, steps were taken to ensure that there was no delay in reimbursement to doctors.
- Regular interaction with Chiranjeev Panel doctors by the Chief District Health Officers

Preliminary results

The actual implementation of the scheme was started in late December. 2005. The scheme really got functional in early January, 2006. The district wise performance under the scheme, in the last 8 months can be seen in the table below:

The table shows that out of the 250 doctors that were available in the districts 158 doctors, (63%) of the available doctors have enrolled under the scheme. This is in sharp

Lessons from successful MMR reduction programmes

The experience of developed countries in this regard is instructive. The MMR of UK during the period 1920-1930 was around 440 i.e. at the same level as that of developing countries today. However, 1940 onwards when they initiated surgical improvements, ensured availability of blood as well as skilled birth attendants, there was a steep fall in the MMR in UK. Similar, is the case in Sri Lanka. Ensuring the availability of trained birth attendants, backed by trained Obstreticians and Gynecologists has brought down the MMR to less than 100 from 1970 onwards.

Therefore, it is clear from the international experience that in case of complications during pregnancy and child birth, even trained TBAs or nurses cannot do much at home, unless they are backed by trained O& G experts.

The evidence further shows that mounting maternal deaths are attributable to 3 major delays (deciding, reaching and receiving):

1. Delay in decision to seek care
2. Delay in reaching care
3. Delay in receiving care.

The first delay occurs because of poor economic conditions; as the families cannot afford to take the expectant mothers to trained O&G experts. There are instances where people are severely impoverished in trying to do so. They have to sell their livestock, property or ornaments and even go bankrupt in the process at times. The National Rural Health Mission document has also stated the fact that curative services favour the rich, for every rupee spent on the poorest 20% population, Rs. 3 is spent on the richest quintile. Over 25% of hospitalized Indians are pushed below the poverty line because of hospital expenses. This has been a major hurdle in the path of the poor seeking timely reproductive health care.

The second delay occurs because of poor road network and lack of availability of transportation.

Finally, delay occurs because of the poor facilities at government hospitals, poorly trained personnel with indifferent and unwelcoming attitudes. Because of these factors the MMR has remained at a high and there has been no improvement in the same in the last decade.

contrast with 8-10 O&G professionals available in the government sector in these five districts earlier. Many more gynecologists are available in the five districts to the poor under the Chiranjeevi scheme.

On an average each doctor has conducted 116 deliveries under the scheme. In the best performing district that is Panchmahals, each of the doctors has earned on an average more than Rs 2,00,000, in four months only, which is a decent earning in India by any economic criteria. More so when this is entirely an additional income for them as the BPL families were not a part of their clientele earlier.

The initial results are encouraging; however, there are miles to go. At the State level only 38% of the expected deliveries in these 5 districts have been covered under the scheme, which means that a large number of BPL expectant mothers are still uncovered. Vigorous efforts are required to ensure that the remaining BPL women also make use of this scheme. The results show;

1. There is surge of demand which has been responded to effectively by the private practitioners.
2. There is considerable check on un-wanted cesarean sections.
3. There is only one maternal death reported, amongst 22,263 mothers, who have delivered under the scheme.
4. Only 28 newborns have died because of various reasons.

However, on the flip side, a number of issues have come up. The major issue is to ensure availability of safe blood in the remote areas so that blood can be provided to expectant mothers in case of need.

It was also found that some doctors are still expecting additional funds from BPL families. There were also cases when the transportation allowance has not been paid.

Non BPL families are also being attended to. This though, is not a major cause for worry. Non BPL low income women can also be covered under this scheme provided they get a certificate of being poor from their village headman/primary teacher.

However, the number of deliveries done by the ANMs in the sub centres as well as in the homes has gone down. This issue needs to be analyzed and addressed.

Future Plan

The state Government is now interested in extending this scheme to the entire State. Several consultations have been launched in this regard. The following issues have come up:

1. The Government should make arrangements to ensure that the expectant mothers could stay in the hospital or at the place of delivery for one more day after delivery so that any complications that may have arisen can be attended to.
2. Keeping in view the poor hygiene in the rural area, it has been suggested that one week's supply of sanitary pads should be made available to the women after the delivery.
3. Additional incentive to the TBA accompanying the expectant mother.

BPL Population	Load	Cost Incurred (in INR)@1795/delivery
Performance under the scheme (5 district)	Deliveries under the scheme=11,146	Rs 20 million
Beneficiaries covering 5 districts	Estimated Births=58,637	Rs 100 million
Beneficiaries covering whole of Gujarat State	Estimated Births =3,00,000	Rs 540 million

Districts Covered	Total O&G doctors in the district	Enrolled under the scheme	Total Deliveries under the scheme
Banaskantha	50	52*	4361
Dahod	16	15*	4040
Kachchh	47	20	2628
Panchmahal	29	20	7061
Sabarkantha	73	46	4173
Total	**215**	**158**	**22263**

Currently she is paid only Rs. 50 which may not be enough incentive for her to bring the patient to the trained gynecologist. She may still have the temptation to do the delivery herself and earn more money.

4. Similarly there is a possibility of providing services such as sterilizations, IUD insertions, as an extended package of services.[13]
5. This contract could also be used for checking for RTI, STI, and HIV AIDS. The O&G doctors could be properly trained in counseling skills to counsel HIV/AIDS patients effectively.
6. Low patient turn out in district Kachchh needs to be analyzed. A major cause may be large distances. Therefore, it has been suggested to increase the allowance for transportation.
7. General Practitioner/Midwifery based delivery model could be studied and implemented, wherein the GP and midwifes are allowed to provide basic EmOC to the patients and only if required, refer patients to higher referrals.
8. Still birth rate, peri-natal mortality and number of cases referred should be monitored so as to limit the chances of unnecessary C-Sections and referrals.
9. Post Natal visits should also be added to find out satisfaction level of the beneficiaries

Implications

The initial results show that the Chiranjeevi Scheme is a viable option for the parts of Gujarat for making skilled birth attendants and specialists available in the remote rural areas in collaboration with private sector.

This PPP model could be effectively used for attaining the Millennium Development Goals for reduction of maternal and child mortality.[11,13]

There is a possibility of using this intervention for encouraging checking for RTI/STI, HIV/ AIDS, as well as Pap smear for cancer of the cervix.

The scope to include FP services in this scheme as an additional package of services is also an opportunity.

Prima facie this scheme appears to be an effective use of funds under the RCH programme, than investing more and more resources in the Government health infrastructure without commensurate results.

Annexure A

Service Charges	% patients	Unit charge	Cost
Normal delivery	85	800	68000
Complicated cases			
Eclampsia		1000	
Forceps/vacuum/breech	3	1000	3000
Episiotomy		800	
Septicemia	2	3000	6000
Blood transfusion	3	1000	3000
Cesarean (7%)	7	5000	35000
Predelivery visit	100	100	10000
Investigation	100	50	5000
Sonography	30	150	4500
NICU support	10	1000	10000
Food	100	100	10000
Dai	100	50	5000
Transport	100	200	20000
			179500

NRHM has boosted immunization coverage

NABADIH | Endearing people to make job simple & easy

Nikita Sinha
IEC Consultant, Jharkhand

Nabadih Primary Health Centre in Bokaro district is like any other PHC in rural Jharkhand - located in hilly and jungle area populated by the tribals mostly. Though it is only 70 kms. away from Bokaro city, but it is actually far away from modern life. Most of the tribals at Nabadih are Santhals and Mundas, the main language being Santhali and Khortha. The health workers working at this PHC are Jodho Mahato and Sukhdev Singh (Health workers), Mahadev Dey (Family Planning worker), Arjun Pandit and Rama Shanker Prasad (Vaccinators), and Jivlal Murmu (Health Assistant). Most of them joined the service in the seventies. Those days, the Health Workers recount, nobody understand what was health care. "They only thought the injections we give were for Vasectomy.

The hilly terrain of this PHC area is very difficult to cover. There are few roads. The health workers mostly have to walk through the jungles to reach households in villages. Even the villages are clusters of 5 10 houses spread over a distance of 1-2 kms. which have to be covered mostly by foot. Another challenge the health workers face is the naxalite movement in this area. Sometimes, the health department vehicle, mistaken for a police jeep is also attacked. Recently, a health department vehicle narrowly escaped a landmine blast. Despite these difficulties, the health workers of Nabadih execute their programme quite systematically. When they started their work in Nabadih, the local people hardly understood the importance of healthcare. It was a hard task

convincing the locals about primary health care benefits. But these health workers worked hard to learn the local dialects, communicated with them and slowly and steadily they were endeared by the community. Their outstanding work has been recognized by CMO of Bokaro as well as the Health Secretary of Jharkhand State. Jodho Mahato is a cancer patient since 2003 but his services to patients and general public remain uninterrupted by his personal tragic disease. The health workers of Nabadih have done a simple job which many other health personnel fail to do: they have endeared the people and made this job easy and simple.

Letters

Dear Sir,

Only recently I came to know about this NRHM Newsletter from one of the social workers. I read "Immunization is priceless for a healthy young India". I got lots of information. I am Jude working for "REAP" (Reach Education Action Programme), a private organization. We organise different programmes for children and women too. We have many self help groups for women in different villages. I want to create awareness programmes on various topics like cleanliness, on food, clothing, health and hygiene, saving water, saving electricity, etc. for these women. I do not have sufficient material to create awareness, After reading your NRHM Newsletter, I thought may be you have information on different topics. Even if you have charts on various topics will do for me. Please send us NRHM Newsletter regularly.

Jude Benjamin,
Reach Education Action Programme (REAP),
502, Bali Towers, Station Road,
Kalwa (W), Thane Distt. 400 605

Dear Sir,

Our organization has been working for the welfare of poor and downtrodden sections of the society for last 20 years in entire Uttar Dinajpur, Dakshin dinajpur & partly of Darjeeling districts of West Bengal. As a Mother NGO of RCH-II recently, we had ASHA project under NRHM. For this reason, I had a newsletter of NRHM. We found it is very useful to us. Therefore, I request you to send this newsletter to the given address on regular basis.

Narayan Mazumdar,
Joint Secretary,
St. John Ambulance Association, District Centre,
Birnagar, Raiganj,
Uttar Dinajpur 733 134
West Bengal

Dear Sir,

CARDS is a voluntary organization working for the empowerment of rural poor in remote rural areas of Nellore district for the past 5 years. We came to know that your esteemed organization is publishing NRHM Newsletter and we are herewith requesting that kindly send the above books to enable us to equip ourselves and to improve our knowledge levels as well as quality of work.

Shri D. Sudhakar Rao,
Secretary,
Community Awareness and Rural Development Society (CARDS),
23/1242, Beside Post Office,
Akkanna Vari Street, Fathe Khan Pet,
Nellore 524 003
Nellore District, A.P.

Dear Sir,

I got a copy of the NRHM Newsletter and read it in detail. The write-ups in the Newsletter are very useful regarding implementation of the rural health programme. Therefore, I request you to kindly send me a copy of the Newsletter.

Shri Mahendra Singh Baghel,
(Former Panchayat Member)
Village Chilkora,
P.O. Quarsi, Zilla Aligarh (U.P)
PIN 202002

Dear Sir,

We have read one of your NRHM Newsletters. We are NGOs working for family welfare activities and rural health development programme. So we request you to please enroll our NGO's name in the mailing list for getting regular copies of the English Newsletter.

The Minister,
Jankalyan Charitable Trust,
Opp. Aradhana Cinema,
Highway Road,
Khedbrahma 383255 Gujarat

Primary Prevention : UIP

Dear Sir,

First of all I like to congratulate you for inviting suggestions to improve UIP. I am 37 years old doctor, a gynaecologist by qualification and am working on Public Health as a Block Medical Officer (Bandipur BPHC, Barrackpore, Block II, 24, Paraganas (N), West Bengal) for last 1 year. As we all know NRHM has changed the concept of attaining cent percent target of CNAA to covering each and every under 5 children and pregnant mother under the umbrella of UIP. As such "tracing of drop outs and defaulters" is a very popular and common terminology to all of us working with public health programmes. But I think 'tracing of drop-outs' is something like secondary prevention. Then the question arises what should be the measures that are equivalent to primary prevention! In my block, under the leadership of Block Health and Family Welfare Samiti, we have practised that concept of 'Primary Prevention' with good results and I like to put it step by step and it is as follows:-

1. **BHFWS** - Under the joint leadership of Sabhapati of Panchayat Samiti, Block Development Officer and B.M.O. this is the ideal platform for planning, implementation and monitoring. These three heads should work with good knowledge and understanding and coordination with each other and also with all PRI members, ANM, AWW, SHGs, NGO and link persons. They should have joint visits to sub-centres, OR sessions and last Saturday meetings at GP headquarters. The purpose should be expansion of programmes and the strategies for its implementation, assessment and making solutions of need gaps and monitoring also.

2. **Last Saturday meetings at G.P. Hqrs.**- This is the platform where all ANMs and HA(M), AWW, ICDS Supervisors, GP Supervisors and Panchayat members meet to share information and make strategies for community based approach.
ANMs and HA(M)s may be asked to submit microplan of RI for the coming month in advance and also the field visit schedule for the coming month. The microplan should consist of the following::-

- Date of Sessions of RI - S/C based/ OR based - Immunization hours - place of immunization in case of OR.
- Name of beneficiaries i.e. under 5 years children and pregnant women.
- Guardian's name and specific address
- Name of the specific antigen and its dose (i.e. 1st/2nd/3rd/Booster).

This list in hand and following the field visit schedule, put in advance ANM - one team comprising of ANM or HA(M), AWWs, Panchayat members of that particular area, and link persons should visit door to door in the said community and give information regarding negative RI to particular guardians and also do IEC. For this purpose there should be one or more teams with adequately motivated members in the jurisdiction of each Sub-Centre.

3. **Role of link persons** - Generally the S/C based sessions take place on Wednesdays and the OR sessions on Thursday. The link persons may be asked to visit the ANM at S/C on every Monday. The ANM should handover a copy of list containing the names of under 5 years children and pregnant women, who are supposed to attend the coming Wednesday's/Thursday's session, to the link persons for proper motivation and mobilization of the beneficiaries. The link persons should also be present during the session. During the session, if the ANM feels that the attendance of beneficiaries is not satisfactory. She should at once send the link persons for another round of motivation and mobilization. So that all the supposed beneficiaries receive their due antigen on the same day.

4. **Follow up** - with the list of beneficiaries in hand, the ANM, after completion of the session should have a check whether all supposed beneficiaries have received their due antigen or not, and make a list of left outs if there is any. If above strategy is meticulously followed, there is very little chance of having any left out or drop out. Still if there be any, the number should be much less and that can be followed up by further home-visits on the same day by ANMs and immunization on spot as we do during IPPI programmes.

Dr. Chandan Banerjee,
Block Medical Officer ofHealth,
Bandipur BPHC, Barrackpore,
Block II, 24, Paraganas (N),
West Bengal.

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ATTENTION

DOCTORS, CLINICS AND PUBLIC

The Pre-conception and Pre-natal Diagnostic Techniques (PC & PNDT) Act, 1994 is being Implemented in the country which prohibits sex selection and regulates pre-natal diagnostic techniques to prevent their misuse for sex determination leading to female foeticide. The Act prohibits the following:

- Conducting of pre-natal diagnostic techniques in units /clinics not registered under the Act. The registration is renewable after every five years.
- Determination of Sex of the foetus and its communication to the concerned pregnant woman or her relatives or any other person.
- Conducting of any test on a woman or man or both or on any tissue, embryo, conceptus, fluid or gametes from either or both of them for the purpose of ensuring or increasing the probability that the embryo will be of a particular sex.
- Sale of ultrasound machines or any other equipment capable of detecting the sex of the foetus to units /clinics not registered under the Act.
- Advertisements for the sex determination tests in any form such as notice, circular, label, wrapper, or any other document including advertisements through the internet or any other media in electronic or print form and also including any visible representation made by means of any hoardings, wall painting, signal, light sounds, smoke or gas.

⇒ Any person, clinic, hospital, company, firm, or association of individuals who violate the above provisions is punishable with imprisonment upto 5 years and fine upto Rs One lakh.

⇒ This will also lead to suspension of registration of the doctor by the State medical council if the charges are framed by the court and till the case is disposed off and on conviction for removal of name from the register of the Council for a period of five years for the first offence and permanently for the subsequent offence.

i) The chief Medical Officer (Appropriate Authority) of the concerned District ii) Director Family Welfare of the concerned State /UT *with a copy* Director (PNDT), Ministry of Health and Family Welfare Government of India, Nirman Bhawan New Delhi-110001.

Telefax: 011-23061089. Email: pndt@nic.in *Visit our website: www.mohfw.nic.in*

बेटी बचाओ
save the girl child

Sex test of foetus is illegal

Designed and issued by Ministry of Health & Family Welfare, Government of India