No. 0. 11019/2/77-Trg.
MINISTRY OF HEALTH & FAMILY WELFARE
(RURAL HEALTH DIVISION)

WORKSHOP OF CENTRAL TRAINING INSTITUTES FOR TRAINING OF TRAINERS UNDER COMMUNITY HEALTH WORKERS SCHEME.

25th to 27th July 1977

WORKSHOP SCHEDULE

MONDAY 25.7.77

9.30-10.00 a.m.	- Registration	
10-10.30 a.m.	- Inaugural Session	
	Chairman : Shri J.S.Bali, Addl. Secretary.	
	1. Welcome Address -	Dr. P.P.Goel, D.G.H.S.
	2. Inaugural Address -	Sh. Rajeshwar Prasad, Health Secretary.
	3. Remarks	- Shri J.S.Bali, Addl. Secretary.
	4. Vote of Thanks	- Dr. B.C.Ghoshal, ADG(RH).
10.30-10.45 a.m.	- Tea Break.	
10.45-11.30 a.m.	- Plenary Session (1)	Community Health Workers Scheme - Sh. C.R.Krishnamurthy, JS(K).
11.30-1.00 p.m.	- Plenary Session (2)	Training Strategy for Community Health Workers Scheme - Dr. R.M.Varma, D.D.G.(RH)
1.00-2.00 p.m.	- Lunch Break.	
2.00-5.00 p.m.	- Group Work (1) - (3 groups)	
	Course for trainers under Community Health Workers Scheme:	
	1) Training objectives	
	2) Training Schedule and distribution of hours.	

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TUESDAY 26.7.77

9.30-11.30 a.m. - Plenary Session (3) -

Chairman : Dr.M.D.Saigal, Dy. Comm.(Tr.& Str.).

Presentation of group reports followed by general discussion and finalisation.

11.30-11.45 a.m. - Tea Break.

11.45-1.00 p.m. - Group Work (2) - (7 groups).

Development of Training Calendar for Central Training Institutes for 1977-78.

1.00-2.00 p.m. - Lunch.

2.00-5.00 p.m. - Group Work (3) - (3 groups)

Development of Lesson Plans.

WEDNESDAY 27.7.77

9.30-12.30 p.m. - Plenary Session (4)

Chairman : Dr. P.P.Goel, D.G.H.S.

Presentation of group reports followed by general discussion and finalisation.

1) 10.00-10.30 a.m. - Training Calendar.

2) 10.30-12.30 p.m. - Lesson Plans.

12.30-1.30 p.m. - Closing Session -

Chairman : Shri C.R.Krishnamurthy, J.S.(K)

1) Presentation of Reports of workshop by one of the participants.

2) Chairman's Remarks - Shri C.R.Krishnamurthy, JS(K).

3) Concluding Remarks - Shri Rajeshwar Prasad, Health Secretary.

4) Vote of Thanks - Dr.R.M.Varma, D.D.G.(RH)

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Ministry of Health & Family Welfare
Rural Health Division
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COURSE FOR COMMUNITY HEALTH WORKERS

LEARNING OBJECTIVES

At the end of the course the trainee should be able to do the following:

Unit 1 PRIMARY HEALTH CARE IN RURAL AREAS

1. State the aims and advantages of the Multipurpose Workers Scheme and the Community Health Workers Scheme.
2. Describe the relationship of the Multipurpose Workers Scheme and the Community Health Workers Scheme in the delivery of health services at village level.
3. Describe the tasks to be performed as a Community Health Worker and the responsibilities of the Community Health Workes in the various programmes of health and family welfare.

Unit II CONTROL OF COMMUNICABLE DISEASES

1. Define the terms 'health', 'disease' 'communicable disease' and 'epidemic'.
2. Describe the methods of disease transmission, and the factors affecting the spread of disease.
3. Describe the method of transmission of malaria.
4. Discuss briefly the habits of the malaria mosquito.
5. Identify cases of malaria.
6. Make thick & thin blood films.
7. Despatch blood films for laboratory examination.
8. Give presumptive treatment for malaria to fever cases.
9. Keep the necessary records of cases from whom blood films are taken and to whom presumptive treatment is given.

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10. Assist in spraying and larvicidal operations and get the community to cooperate in these operations.

11. Educate the community about malaria and how to prevent it.

12. Describe the method of transmission of smallpox.

13. Distinguish between the rash of chickenpox and that of smallpox.

14. Describe what is primary vaccination and the course of a successful 'take'.

15. Collect information about infants requiring primary vaccination and inform the Health Worker (Male/Female).

16. Educate the community about the importance of primary vaccination and how to care for the vaccination site.

17. To enumerate ~~Identify~~ the signs and symptoms associated with the following communicable disease:

    1. ~~Cholera~~ Gastroenteritis.
    2. ~~Typhoid~~
    3. ~~Hepatitis~~ jaundice
    4. Influenza
    5. Tuberculosis
    6. Diphtheria
    7. Whooping cough
    8. Conjunctivitis and Trachoma
    9. Leprosy
    10. Meningitis
    11. Tetanus
    12. Poliomyelitis

18. Take precautions to prevent the spread of the communicable diseases enumerated in objective 17.

19. Educate the community about the prevention and control of the communicable diseases enumerated in objective 17.

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Unit III ANATOMY & PHYSIOLOGY

1. Describe the general structure and function of the body.
2. Indicate the position of the important organs in the body and describe briefly the functions of the following:

   i. Skin
   ii. Bones, joints and muscles
   iii. Digestive system
   iv. Respiratory system
   v. Circulatory system
   vi. Excretory system
   vii. Reproductive system
   viii. Sense organs
   ix. Nervous system.

3. Give a simple explanation of how the functions of the various parts of the body are affected in disease or injury.

Unit IV ENVIRONMENTAL SANITATION AND PERSONAL HYGIENE

1. Explain the terms 'environmental sanitation' and 'personal hygiene'.
2. Describe the sources of drinking water in rural areas.
3. List the characteristics of a sanitary well.
4. Describe the ways in which drinking water can be polluted.
5. State the diseases carried by polluted water.
6. Outline briefly the principle of chlorination of water.
7. Chlorinate wells with bleaching powder.
8. Keep a record of the wells chlorinated.

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9. Describe the following:

i. Soakage pit
ii. Kitchen garden
iii. Compost pit
iv. Sanitary latrine
v. Smokeless chulha

10. Assist in the construction of the facilities enumerated in objective 9.

11. Educate the community about:

i. Safe drinking water
ii. Hygienic methods of disposal of liquid waste
iii. Hygienic methods of disposal of solid waste
iv. Home sanitation
v. Kitchen gardens
vi. Sanitary latrines
vii. Smokeless chulhas
viii. Food hygiene
ix. Control of insects, rodents and stray dogs
x. Personal hygiene

12. Give treatment for head lice.

Unit V FAMILY WELFARE

1. Explain the concept of family welfare.
2. Describe the objectives of prenatal, natal, postnatal and child care.
3. Discuss the causes of neonatal tetanus and its prevention.
4. List the maternal and child health care services available in the village, at the Subcentre and at the Primary Health Centre.
5. Educate the community about how to keep mothers

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and children healthy and when to seek treatment for ailments.

6. Explain ~~Define~~ the terms 'immunization' and 'immunity'.

7. List the diseases against which immunizations are available in rural areas.

8. Assist the Health Worker(Male/Female) during immunization programmes.

9. Educate the community about immunization.

10. Discuss the goals of the family planning programme.

11. Discuss the advantages of the small family norm.

12. Define the term 'eligible couple'.

13. Structure and fn. of reproductive system.

13. Discuss the use, advantages and limitations of the following methods of preventing conception:

✓ i. Intra-uterine device
✓ ii. Oral contraceptives
iii. Foam tablets
iv. Jellies and creams
v. Rhythm method
✓ vi. Tubectomy
✓ vii. Nirodh
viii. Withdrawal
✓ ix. Vasectomy.

14. Identify couples willing to use a family planning method.

15. Explain ~~Define~~ the term 'Medical Termination of Pregnancy'(MTP).

16. Describe briefly the provisions of the MTP Act (1971).

17. Describe the available facilities for family planning services and MTP.

18. Educate the community about contraceptive methods and MTP.

19. Explain. ~~Define~~ the term 'depot holder'.

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20. List the responsibilities of a depot holder.

21. Keep the necessary records relating to nirodh distribution.

22. Define the terms 'nutrition' and 'malnutrition' .

23. Identify the signs and symptoms of malnutrition in pre-school children.

24. List the conditions in the family which are likely to be associated with malnutrition.

25. Identify anaemia in mothers and children.

26. Identify the signs of Vitamin A deficiency, especially in children.

27. Assist the Health Worker(Male/Female) in the distribution of iron and folic acid and vitamin A.

28. Discuss the importance of breast feeding and the introduction of supplementary weaning foods.

29. Educate the community about nutritious diets for mothers and children.

Unit VI VITAL EVENTS AND RECORDS & REPORTS

1. Define the terms 'vital events', 'birth rate' and 'death rate'.
2. Discuss the reasons for registration of births and deaths.
3. Describe the system of registration of births and deaths followed in his/her own State.
4. Maintain the required registers.
5. Maintain a daily diary.

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Unit VII COMMUNICATION

1. Give a simple definition of communication.
2. Describe the common barriers which can interfere with communication and the ways in which these barriers can be avoided.
3. Identify opportunities for health education.
4. Demonstrate how to work with community leaders.
5. Identify community resources and utilize them for health programmes.
6. Discuss health topics with individuals and with informal groups.
7. Assist the Health Workers in conducting mass meetings, film shows and exhibitionson health topics.
8. Select and use simple visual aids for health education.
9. List the common rumours, doubts and misconceptions regarding health and family welfare programmes and discuss ways of dealing with them.

Unit VIII PRIMARY MEDICAL CARE

1. Defins the terms 'primary medical care', 'accident' and 'first aid'.
2. List the principles of giving first aid.
3. give first aid in the following emergencies:
   - i. Drowning
   - ii. Electric shock
   - iii. Heat stroke
   - iv. Snake bite
   - v. Scorpion sting
   - vi. Insect stings

vii. Dog bite
viii. Wounds
ix. Sprains and dislocations
x. Fractures
xi. Burns and scalds
xii. Shock
xiii. Bleeding

4. Demonstrate how to give artificial respiration and mouth to mouth respiration.

5. Demonstrate the various uses of triangular and roller bandages.

6. Improvise and apply a splint and a tourniquet.

7. Give simple treatment and advice for the following conditions:

i. Fever
ii. Headache and joint pains
iii. Backache and joint pains
iv. Cough and cold
v. Diarrhoea
vi. Vomiting
vii. Pain in the abdomen
viii. Constipation
ix. Toothache
x. Earache
xi. Sore eyes
xii. Boils, abscesses and ulcers
xiii. Scabies and ringworm

8. Indicate when to refer cases to the Subcentre or Primary Health Centre in the conditions listed in objectives 3 and 7.

9. Carry out the following procedures:

i. Take the patient's history
ii. Examine the patient
iii. Take the patient's temperature
iv. Apply a cold compress
v. Apply hot fomentations
vi. Give a steam inhalation
vii. Prepare a gargle and a mouth-wash
viii. Prepare rehydration mixture
ix. Measure & dispense medicines
x. Administer oral drops to children
xi. Apply ear drops
xii. Apply eye drops
xiii. Clean and dress an ulcer.

10. Keep the necessary records of drugs dispensed.

11. Demonstrate the arrangement and cleaning of the kit bag and the care of its contents.

12. List the uses, dosage and method of administration of each of the medicines included in the kit bag.

Unit IX NERVOUS & MENTAL ILLNESS

1. Recognize the signs and symptoms of nervous and mental illness and refer cases early.
ii. Give immediate assistance in psychiatric emergencies.
iii. Educate the community about mental illness.

Unit X FIELD WORK

1. Carry out all the tasks relating to his activities as a Community Health Worker.

MINISTRY OF HEALTH & FAMILY WELFARE
RURAL HEALTH DIVISION

TRAINING COURSE FOR COMMUNITY HEALTH WORKERS - SCHEDULE

DAY	10.00AM - 11.00AM	11.05AM - 12.00NOON	12.00Noon - 1 P.M.	1.00PM - 2.00PM	2.05 P
1	1st Week Registration (BEE)	Inauguration of Course Panchayat chief (CMO of Dist.)	B R E A K	Pre-Course Evaluation 1. Precourse test 2. Expectations (MO PHC/BEE)	Obje of C (
2	I-1 Introduction to Multipurpose Workers Scheme & Community Health Workers Scheme (Lect.- Disc.) (MO PHC)		L U N C H	I-2 Job Responsibilities Community Health Wor (~~Panel Disc.~~) Discussions. (BEE, ~~H.M/San. Insp. & Ha~~	

DAY	10.00AM - 11.00PM	11.05AM - 12.00Noon	12.00Noon - 1 P.M.	1.00PM - 2.00PM	.05P
3	VIII-1 Introduction to Primary Medical Care (1) 1. What is primary medical care 2. History taking (symptoms) 3. How to examine a patient 4. What to look for (signs) (Pract.Dem. in clinic) (MO PHC)			III-1 Anatomy & Physiol 1. General body structu 2. Skin, bones, joints, muscles (Lect.- Dem.) (HAF/LHV &/or HAM/San.In	
4	VIII-3 Attendance at PHC (1) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)			III - 2 Anatomy & Physs 1. Digestive system 2. Respiratory syster (Lect.-Dem.) (HAF/LHV &/or HAM/San.I	

ay	10AM to 11AM	11.05AM to 12 noon	12 noon to 1PM	1PM to 2PM	2.05PM
	2ND WEEK II-2 Malaria (1) 1. Transmission of Malaria 2. Malaria Mosquito 3. Identification of Malaria 4. Role of C.H.W. (Lect. - Disc.) (MOPHC & HAM/Mal. Insp.)		B R E A K	III-3 Anatomy & Physic 1. Circulatory syste 2. Excretory system (Lect. - Dem.) (HAF/LHV and/or HAM/S Ins	
6	II-4 Malaria (3) 1. Treatment of malaria 2. Records and reports 3. Larviciding & spraying 4. Health education (Lect. - Disc. - Dem.) (MOPHC & HAM/Mal. Insp.)		L U N C H	II-5A Malaria(4) 1. Preparation of blood films (Pract.) (Lab. Tech. & HAM/Mal. Insp.)	II-6 1. 2. ((M T

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1 PM	1PM to 2 PM	2.05
7	VIII-4 Attendance at PHC (2) 1. Out patient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MOPHC, HAF/LHV & HAM/San.Insp.)	II-7 Smallpox (1) 1. Transmission of smallpox 2. Identification of smallpox 3. Prevention of smallpox 4. Role of CHW (Lect. - Disc.) (MOPHC)	B R E A K	III-4 Anatomy & Phys 1. Reproductive sys 2. Sense Organs 3. Nervous System (Lect. - Dem.) (HAF/LHV & HAM/San.	
8	II-9 Smallpox (3) 1. Vaccination (Dem.-Pract. in clinic or village) (HAM/Vac.Super. & HWM/Vaccinator)		L U N C H	II-10 Small-pox (4) 1. Education for vacci-nation (Group Disc.) (BEE & HAM/ Vac. Super.)	II-11 1. H a) M b) S (R (BE Vac.

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1 PM	1PM to 2 PM	2
	3RD WEEK				
9	II-12 Other Communicable Diseases (1) 1. Diarrhoea 2. Vomiting 3. Jaundice a) Identification b) Precautions to limit spread c) Health education (Lect. - Dem. - Disc.) (MOPHC & BEE)		B R E A K	IV-I Introduction ... tation & Pers... Water supply 1. Definition of 2. Sources of wa 3. Safe drinking (Lect. - Di (HAM / San. I	
10	II-13 Other Communicable Diseases (2) 1. Fever with/without rigors 2. Rash 3. Cough and cold a) Identification b) Precautious to limit spread c) Health education (Lect. - Disc. - Dem.) (MOPHC & BEE)		L U N C H	IV-2 Water: Wells ... Chlorination 1. Characteristi... sanitary well 2. Pollution of ... water 3. Principles of ... tion (Lect. - Dem. - (HAM / San. In	

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1PM	1PM to 2PM	2.0
11	II-14 Other Communicable Diseases (3) 1. Eye infection 2. Leprosy a) Identification b) Precautions to limit spread c) Health education (Lect. - Disc. - Dem.) (MOPHC & BEE)		BREAK	IV-4 Water: Water-borne diseases & health education 1. Diseases transmitted by polluted water 2. Health education (Group Disc.) (HAM/San. Insp.)	IV- 1. 2.
12	II-15 Other Communicable Diseases (4) 1. Stiffness of neck 2. Lockjaw 3. Paralysis or weakness of limbs a) Identification b) Precautions to limit spread c) Health education (Lect. - Disc. - Dem.) (MOPHC & BEE)		LUNCH	IV-5B Chlorination of wells (2) 1. Health educatio 2. Chlorination of (Prect.) (HAM/San. Insp. &	

DAY	10.00AM - 11.00AM	11.05AM - 12.00Noon	12.00Noon - 1 P.M.	1.00PM -
	4TH WEEK			
13	VIII-5 Attendance at PHC (3) 1. Outpatient Clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)		BREAK	V-1 Mater Child Hea 1. Concep family 2. Prenat & post care 3. Health ion (Lect.- (HAF/LHV
14	VIII-6 Attendance at PHC (4) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)		LUNCH	V-2 Matern Child Heal 1. Neonata tetanus 2. Child H care 3. Facilit materna child h care 4. Health ion (Lect.- (HAF/LH

DAY	10.00AM - 11.00AM	11.05AM -12.00Noon	12.00Noon to 1 P.M.	1.00PM - 2.00PM	2.05
15	VIII-7 Attendance at PHC (5) 1. Outpatient Clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)	VIII-22 First Aid(1) 1. Definition of terms 2. Principles of first aid 3. Treatment for bleeding 4. Tourniquet (Lect.-Dem.-Pract.) (MO PHC)	B R E A K	V-3 Immunization 1. Definition of terms 2. Diseases against which immunizations are available 3. Role of C.H.W. 4. Health education (Lect.-Disc.) (MO & BEE)	IV-1 1. Ha ur di ex 2. Ch is sa la 3. Co an sa la (Lec Dis (BDO San.
16	VIII-8 Attendance at PHC (5) 1. Outpatient Clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAM/LHV & HAM/San.Insp.)	VIII-23 First Aid(2) 1. Treatment for shock 2. Electric Shock 3. Mouth-to-mouth respiration 4. Heatstroke (Lect.-Dem.-Pract.) (MO PHC)	L U N C H	V-4 Maternal & Child Healt Health Education 1. How to keep mothers hea 2. How to keep children he (Role Play) (BEE and HAF/LHV)	

Day	10AM to 11AM	11.05AM to 12noon	12 noon to 1PM	1PM to 2PM	2.05PM t
	TH WEEK				
17	VIII-9 Attendance at PHC (7) 1. Out patient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MOPHC, HAF/LHV & HAM/San.Insp.)	VIII-24 First Aid (3) 1. Drowning 2. Artificial repiration (Lect.-Dem.-Pract.) (MOPHC)	B R E A K	V-5 Family Planning (1) 1. Goals of F.P. Programme 2. Advantages of small family 3. Eligible couples (Lect.-Disc.) (BEE)	IV-12 Home tion less and Hyg 1. Chara tics thy h 2. Advan smoke chulh 3. Const of sm chulh 4. Food (Lect.-D (HAM/San
18	VIII-10 Attendance at PHC (8) 1. Out patient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MOPHC, HAF/LHV & HAM/San.Insp.)	VIII-25 First Aid(4) 1. Burns and Scalds 2. Wounds 3. Dressing & bandaging (Lect.-Dem-Pract.) (MOPHC)	L U N C H	V-6 Family Planning (2) 1. Methods of F.P. a) I.U.D. b) Oral contraceptives c) Foam tablets d) Jellies e) Rhythm f) Tubectomy 2. Facilities for F.P. services for women (Lect.-Q-A) (MOPHC)	V-7 Famil Plan 1. Methods a) Niro b) With c) Vase 2. Facili F.P. s for me 3. Medica tion o pregna (Lect.-Q. (MOPH

Day	10AM to 11AM	11.05AM to 12noon	12 noon to 1PM	1PM to 2PM	2.05PM to
19	VIII-11 Attendance at PHC (9) 1. Out patient clinic 2. Treatment room 3. Wards (Pract.-Dem.-in clinic) (MOPHC, HAF/ LHV & HAM/ San. Insp.)	VIII-26 First Aid (5) 1. Fractures 2. Sprains and dislocations 3. Splints 4. Bandaging (Lect.-Dem.-Pract.) (MOPHC)	B R E A K	V-8 Family Planning(4) 1. Education for F.P. & MTP 2. Identification and referral of couples for F.P. & MTP (Group Disc.) (BEE)	IV-15 Pers Hygi 1. What i sonal 2. Care o a) Teeth b) Hair c) Skin d) Eyes 3. Persona habits health (Group Dis (HAF / LHV
20	VIII-12 Attendance at PHC(10) 1. Out patient clinic 2. Treatment room 3. Wards (Pract.-Dem.-in clinic) (MOPHC, HAF/ LHV & HAM/ San. Insp.)	VIII-27 First Aid (6) 1. Snake bite 2. Dog bite 3. Scorpion sting 4. Insect sting (Lect.-Dem.-Pract.) (MOPHC)	L U N C H	V-9 Family Planning(5) 1. Responsibilities of depot holder 2. Records of nirodh distribution 3. Role of CHW in F.P. Programme (Lect.-Disc.) (BEE)	IV-17 Envi menta Sanit & Per Hygie Healt Educa 1. Educatio Environm Sanitati 2. Educatio Personal Hygiene (Role Pl (BEE, HAM Insp. & H LHV)

DAY	10.00AM - 11.00AM	11.05 - 12.00Noon	12.00Noon to 1 P.M.	1.00PM - 2.00PM
21	6TH WEEK VIII-13 Attendance at PHC (11) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)	VIII-28 First Aid-Revision 1. Bandaging 2. Splints 3. Tourniquet 4. Dressing (Pract.) (MO PHC & HAF/LHV)	B R E A K	V-10 Nutrition (1) 1. Definition of terms 2. Identification of malnutrition, anaemia and Vitamin A deficiency 3. Conditions associated with malnutrition (Lect.-Disc.) (MO PHC)
22	VIII-14 Attendance at PHC (12) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)	VIII-29 Treatment of Minor Ailments(1) 1. Fever a) Causes b) History c) Examination d) Treatment & advice e) Referral (Lect.-Dem.) (MO PHC)	L U N C H	V-12 Nutrition (2) 1. Role of CHW in distribution of iron & folic acid & Vitamin A 2. Breast feeding 3. Supplementary weaning foods 4. Nutrition education (Lect.-Disc.) (HAF/LHV)

DAY	10.00AM to 11.00AM	11.05AM to 12.00Noon	12.00Noon to 1 P.M.	1.00PM to 2.00PM	2.
23	VIII-15 Attendance at PHC (13) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San. Insp.)	VIII-31 Treatment of Minor Ailments (3) 1. Headache 2. Backache 3. Joint pains a) Causes b) History c) Examination d) Treatment & advice e) Referral (Lect.-Dem.) (MO PHC)	BREAK	VIII-32 Care of Kit Bag 1. Contents 2. Arrangement 3. Cleaning 4. Replenishment (Dem.-Practs.) (HAF/LHV)	VII Rec 1. 2. 3. (D
24	VIII-16 Attendance at PHC (14) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San. Insp.)	VIII-33 Treatment of Miror Ailments (4) 1. Cough 2. Cold a) Causes b) History c) Examination d) Treatment & advice e) Referral (Lect.-Dem.) (MO PHC)	LUNCH	VII-2 Working with the Community 1. Working with community leaders 2. Using community resources (Disc.-Dem.) (BEE & HAM/ San. Insp.)	VI of 1. 2. (

DAY	10.00AM to 11.00PM	11.05AM to 12.00Noon	12.00Noon to 1 P.M.	1.00PM to 2.00PM	2.05PM t
	7TH WEEK				
25	VIII-17 Attendance at PHC (15) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)	VIII-35 Treatment of Minor Ailments (6) 1. Diarrhoea 2. Vomiting a) Causes b) History c) Examination d) Treatment & advice e) Referral (Lect.-Dem.) (MO PHC)	B R E A K	VIII-36 Dispensing & Administering Drugs (1) 1. Administration of medicines 2. Dosage for various age groups (Lect.-Dem.) (MO PHC)	VII-3 Tal Meetings 1. Indivi talks 2. Group meetin 3. Mass m film s exhibi Role o (Disc.-D (BEE)
26	VIII-18 Attendance at PHC (16) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)	VIII-38 Treatment of Minor Ailments (8) 1. Pain in abdomen 2. Constipation a) Causes b) History c) Examination d) Treatment & advice e) Referral (Lect.-Dem.) (MO PHC)	L U N C H	VIII-39 Dispensing & Administering Drugs (2) 1. Measuring & dispensing medicines 2. Precautions in measuring, dispensing & administering medicines (Lect.-Dem.) (HAF/LHV & Compounder)	V-14 Nut 1. Nutri educa (Role (BEE

AY	10.00AM to 11.00AM	11.05AM to 12.00Noon	12.00Noon to 1 P.M.	1.00PM to 2.00PM	2.05
7	VIII-19 Attendance at PHC (17) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)	VIII-41 Treatment of Minor Ailments (9) 1. Toothache 2. Earache 3. Sore eyes a) Causes b) History c) Examination d) Treatment & advice e) Referral (Lect.-Dem.) (MO PHC)	B R E A K	VII-4 Educational Aid 1. Types of simple aids av 2. Use of aids in health e (Lect.-Dem.-Prac (BEE)	
28	VIII-20 Attendance at PHC (18) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)	VIII-43 Treatment of Minor Ailments (11) 1. Boils & abscesses 2. Ulcers a) Causes b) History c) Examination d) Treatment & advice e) Referral (Lect.-Dem.) (MO PHC)	L U N C H	VII-5 Rumours & Misconceptions 1. Types of rumours, doubts & misconceptions regarding Health and Family Welfare programmes 2. How to deal with these (Group disc.) (BEE)	VIII- of M 1. P a f 2. C w u (Pra (HAF San.

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1PM	1PM to 2PM	2.
	8TH WEEK				
29	VIII-21 Attendance at PHC (19) 1. Out patient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MOPHC, HAF/LHV & HAM/San.Insp.)	VIII-45 Treatment of Minor Ailments (13) 1. Scabies) 2. Ringworm) a) Cause b) Predisposing conditions c) Identification d) Treatment and Advice e) Referral (Lect.-Dem.) (MOPHC)	B R E A K	IX-1 Nervous & Mental Illness 1. Recognition of signs & symptoms 2. Psychiatric emergencies 3. Educating the community (Lect.-Dem.-Disc.) (MOPHC)	V
30	II-16 Communicable Diseases - Revision 1. Identification 2. Preventive measures 3. Control measures (Q & A - Disc.) (MOPHC, HAF/LHV, HAM/Male counterparts)	IV-18 Environmental Sanitation & Personal Hygiene - Revision 1. Environmental sanitation 2. Personal hygiene (Q & A - Disc.) (HAM/San.Insp.)	L U N C H	VII-6 Conducting a Group Discussion 1. Conducting group discussions on topics related to health and family welfare (Role play) (BEE, HAM/San. Insp. & HAF/LHV)	

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1PM	1PM to 2PM
31	VIII-47 Primary Medical Care - Revision 1. First Aid 2. Treatment of Minor Ailments 3. Procedures (Q & A - Disc.) (MOPHC, HAF/LHV, HAM/Male counterparts)			X-1 F I E Actual pract Note: Kit bag wi Community (HWM & HWF sup male and femal
32	V-15 Family Welfare - Revision 1. Maternal and Child Health Care 2. Immunization 3. Family Planning 4. Nutrition (Q & A - Disc.) (MOPHC, HAF/LHV)			X-2 F I E L Actual prac (HWM & HWF supe or male and fem

Day	10AM to 11AM	1105AM to 12 noon	12 noon to 1PM	1PM to 2PM
33	9TH WEEK X-3 F I E L D W O R K Actual practice of all activities (HWM & HWF supervised by HAM & HAF or male and female counterparts)			X-4 F I Actual pr (HWM & HWF male and f
34	X-5 F I E L D W O R K -do-			X-6 F I
35	X-7 F I E L D W O R K -do-			X-8 F I
36	X-9 F I E L D W O R K -do-			X-10 F I E

Day	10AM to 11AM	11.05AM to 12noon	12 noon to 1PM	1PM to 2PM	2
37	X-11 F I E L D W O R K Actual practice of all activities (HWM & HWF supervised by HAM & HAF or male and female counterparts)		B R E A K	X-12 F I E Actual pra (HWM & HWF s and female c	
38	X-13 F I E L D W O R K -do-			X-14 F I E	
39	X-15 Group Reports (1) 1. Presentation of report of field work by each group: a) Activities conducted b) Learning experiences c) Problems faced d) Solutions found (MOPHC, BEE, HAM/Male counterparts, HAF/LHV, HWM/Male counterparts, HWF/ANM)		L U N C H	X-16 Group Repor Presentation	
40	Post - course Evaluation 1. Post-course test 2. Suggestions (MOPHC/BEE)			Valedictory Sessi 1. Report of Cou 2. Report by trai 3. Remarks of CM 4. Vote of thanks (CMO of Dist. &	

MINISTRY OF HEALTH & FAMILY WELFARE
RURAL HEALTH DIVISION

TRAINING COURSE FOR COMMUNITY HEALTH WORKERS - SCHEDULE

DAY	10.00AM - 11.00AM	11.05AM - 12.00NOON	12.00Noon - 1 P.M.	1.00PM - 2.00PM	2.05 P
1	1st Week Registration (BEE)	Inauguration of Course Panchayat chief (CMO of Dist.)	B R E A K	Pre-Course Evaluation 1. Precourse test 2. Expectations (MO PHC/BEE)	Obje of C (I
2	L-1 Introduction to Multipurpose Workers Scheme & Community Health Workers Scheme (Lect.- Disc.) (MO PHC)		L U N C H	L-2 Job Responsibilities Community Health Wor (Panel ~~Disc.~~ Discussions. (BEE, ~~H.N/San. Insp. & H~~	

DAY	10.00AM - 11.00PM	11.05AM - 12.00Noon	12.00Noon - 1 P.M.	1.00PM - 2.00PM	.05P
3	VIII-1 Introduction to Primary Medical Care (1) 1. What is primary medical care 2. History taking (symptoms) 3. How to examine a patient 4. What to look for (signs) (Pract.Dem. in clinic) (MO PHC)			III-1 Anatomy & Physiol 1. General body structu 2. Skin, bones, joints, muscles (Lect.- Dem.) (HAF/LHV &/or HAM/San.In	
4	VIII-3 Attendance at PHC (1) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)			III - 2 Anatomy & Phys 1. Digestive system 2. Respiratory syste (Lect.-Dem.) (HAF/LHV &/or HAM/San.	

ay	10AM to 11AM	11.05AM to 12 noon	12 noon to 1PM	1PM to 2PM	2.05PM
	2ND WEEK II-2 Malaria (1) 1. Transmission of Malaria 2. Malaria Mosquito 3. Identification of Malaria 4. Role of C.H.W. (Lect. - Disc.) (MOPHC & HAM/Mal. Insp.)		B R E A K	III-3 Anatomy & Physic 1. Circulatory syste 2. Excretory system (Lect. - Dem.) (HAF/LHV and/or HAM/S Ins	
6	II-4 Malaria (3) 1. Treatment of malaria 2. Records and reports 3. Larviciding & spraying 4. Health education (Lect. - Disc. - Dem.) (MOPHC & HAM/Mal. Insp.)		L U N C H	II-5A Malaria(4) 1. Preparation of blood films (Pract.) (Lab. Tech. & HAM/Mal. Insp.)	II-6 1. 2. ((M T

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1 PM	1PM to 2 PM	2.05P
7	VIII-4 Attendance at PHC (2) 1. Out patient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MOPHC, HAF/LHV & HAM/San.Insp.)	II-7 Smallpox (1) 1. Transmission of smallpox 2. Identification of smallpox 3. Prevention of smallpox 4. Role of CHW (Lect. - Disc.) (MOPHC)	B R E A K	III-4 Anatomy & Physi 1. Reproductive syst 2. Sense Organs 3. Nervous System (Lect. - Dem.) (HAF/LHV & HAM/San.	
8	II-9 Smallpox (3) 1. Vaccination (Dem.-Pract. in clinic or village) (HAM/Vac.Super. & HWM/Vaccinator)		L U N C H	II-10 Small-pox (4) 1. Education for vacci-nation (Group Disc.) (BEE & HAM/ Vac. Super.)	II-11 1. He ed fo a) Ma b) Sm (Ro (BEE Vac.

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1 PM	1PM to 2 PM	2
9	3RD WEEK II-12 Other Communicable Diseases (1) 1. Diarrhoea 2. Vomiting 3. Jaundice a) Identification b) Precautions to limit spread c) Health education (Lect. - Dem. - Disc.) (MOPHC & BEE)		B R E A K	IV-I Introduction tation & Pers Water supply 1. Definition of 2. Sources of wa 3. Safe drinking (Lect. - Di (HAM / San. I	
10	II-13 Other Communicable Diseases (2) 1. Fever with/without rigors 2. Rash 3. Cough and cold a) Identification b) Precautious to limit spread c) Health education (Lect. - Disc. - Dem.) (MOPHC & BEE)		L U N C H	IV-2 Water: Wells Chlorination 1. Characteristic sanitary well 2. Pollution of water 3. Principles of tion (Lect. - Dem. - (HAM / San. In	

Day	10AM to 11AM	11.05AM to 12 noon	12 noon to 1PM	1PM to 2PM	2.0
11	II-14 Other Communicable Diseases (3) 1. Eye infection 2. Leprosy a) Identification b) Precautions to limit spread c) Health education (Lect. - Disc. - Dem.) (MOPHC & BEE)		BREAK	IV-4 Water: Water-borne diseases & health education 1. Diseases transmitted by polluted water 2. Health education (Group Disc.) (HAM/San. Insp.)	IV- 1. 2.
12	II-15 Other Communicable Diseases (4) 1. Stiffness of neck 2. Lockjaw 3. Paralysis or weakness of limbs a) Identification b) Precautions to limit spread c) Health education (Lect. - Disc. - Dem.) (MOPHC & BEE)		LUNCH	IV-5B Chlorination of wells (2) 1. Health education 2. Chlorination of (Prect.) (HAM/San. Insp. &	

DAY	10.00AM - 11.00AM	11.05AM - 12.00Noon	12.00Noon - 1 P.M.	1.00PM - 2.
13	4TH WEEK VIII-5 Attendance at PHC (3) 1. Outpatient Clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)		B R E A K	V-1 Matern Child Heal 1. Concept family 2. Prenata & postn care 3. Health ion (Lect.- (HAF/LHV)
14	VIII-6 Attendance at PHC (4) 1. Outpatient clinic 2. Treatment room 3. Wards (Pract.-Dem. in clinic) (MO PHC, HAF/LHV & HAM/San.Insp.)		L U N C H	V-2 Materna Child Healt 1. Neonatal tetanus 2. Child He care 3. Faciliti maternal child he care 4. Health ed ion (Lect.-Di (HAF/LH

COM H 7.4

AGENDA ITEM No.I(i)

RURAL HEALTH SCHEME.

The draft plan of Rural Health Scheme was discussed in the Health Minister's Conference held in New Delhi on 28th and 29th April, 1977. On the basis of the consensus arrived at the meeting, the State Governments were requested to send their approach papers. 23 States/ Union Territories while sending their approach paper have accepted the draft plan of Health Care Services in rural areas proposed by the Government of India. Out of these 23 States, Punjab have accepted to use only Dais. Two States i.e. Kerala and Tamilnadu have not agreed to the draft plan and instead have submitted plans of their own for acceptance. Replies from the six States/Union Territories have not been received so far. A statement indicating the names of the States who have accepted the draft plan, submitted plans of their own for acceptance and the States/ Union Territories from which the replies have not been received so far is at Annexure 'I'.

In pursuance of the decision of Health Ministers' meeting, it has been decided to introduce the scheme from the 2nd October, 1977, the birth Anniversary of Mahatma Gandhi. It is proposed to have a detailed discussion on the following points in order to arrive at consensus:

I. Area of Implementation.

During this year the scheme is proposed to be launched in

i. All Primary Health Centres of Districts where the Multipurpose Workers-Scheme has already been implemented (list of districts given in Annexure 'II'.)

ii. In one Primary Health Centre each from the remaining districts of the country. States have been requested to select one Primary Health Centre from each of the districts where the scheme is to be launched from 2nd October, 1977. The selection of Primary Health Centres should preferably be completed by first week of August, 1977 keeping in view the following:

a. Primary Health Centres having two doctors atleast.

b. Preference to tribal/backward/hilly areas.

...contd...

c. Primary Health Centres covered by Integrated Child Development Scheme. (Annexure 'III').

d. Primary Health Centre covered by Integrated Rural Development Scheme.

e. Primary Health Centres which have effective local Self Government Organisations.

f. Primary Health Centres which have active community participation as for example Mahila Mandal etc.

g. Primary Health Centres which have enthusiastic Voluntary Organisations working in Health and related sectors.

It would be useful to consult the Panchayats/ Organisations, Rural Development Organisations prior to selection of Primary Health Centre.

II. Number of Community Health Workers to be trained.

It is proposed to have one Community Health Worker for every one village (on average of 1000 Population). However, where the population of a village is less than one thousand, either 2-3 neighbouring villages may be grouped together or if the villages are not very close to each other, one Community Health Worker may be selected from each village, even if the population of the village is less than one thousand. In villages with more than one thousand population, the number of Community Health Workers may be more, so as to have one worker for about one thousand population. If the States feel the necessity of selecting more than one Community Health Worker from a village where the population is not more than one thousand they can do so considering the local circumstances.

III. Selection of Community Health Workers.

The Health Worker at community level would not be a Government functionary, but Government will only assist the programme of the community to help themselves. If the community feels that a person selected and trained by Government does not fulfil their requirements at a later stage, they would be at liberty to change him/her. Depending upon local conditions, the community can choose any person who has correct aptitude and willingness to serve the community from the village level itself. However, in order that the community is able to select the most suitable person, assistance and necessary guidance would have to be provided by the Primary Health Centre Doctor and staff. The following guidelines may be given to the Village Community in this regard:

i. Community Health Worker may be of either sex.

...cont'd...

ii. The person selected must be a permanent resident of that village itself, and may be from any vocation.

iii. He/She should be able to read and write. However, since the higher the level of education the better the quality of service that would be available, it is recommended that the person to be selected should have had formal education upto 6th Standard (Class).

iv. He should be social-service minded and be able to spare atleast 2/3 hours everyday for community health activities.

v. He should be physically active to serve atleast for a minimum period of three years as a Community Health Worker.

vi. Should be acceptable to all sections of the community.

vii. Should not belong to any group or political organisation of the village which may limit acceptability.

viii. Suitable relaxation may be permitted for Scheduled Castes/Scheduled Tribes.

ix. He/She may also be a practitioner of traditional medicine or Homeopathy.

With these guidelines, the Village Community may be requested to recommend 2-3 persons considered suitable by them to be Community Health Workers. The final selection may be made by the Medical Officers of the Primary Health Centre, jointly after consulting the Block Development Officer/ the Field Staff and the various Government Organisations (Village Level Worker, Basic Health Worker, F.P.(HA) and ANM etc.) working in the village.

As the training of the first batch of Community Health Workers will start from 2nd October, 1977, the Medical Officers of the selected Primary Health Centres should take the following action immediately:-

i. Select the first 20 villages from the Primary Health Centres (preferably villages covered under 2 Sub-Centres). At a time, villages under 2 Sub Centres may be taken in a cyclic manner.

ii. The Medical Officer should visit each of these villages himself along with the concerned field workers like F.P.(HA), Basic Health Worker and ANM and hold a whole day meeting to explain the whole concept of Community Health Workers to the Village Community and request them to select 2/3 persons who they feel would be suitable for being trained as Community Health Workers.

iii. It may be desirable to depute either Block Extention Educator/ Sanitary Inspector to attend the meeting for which the selection is to be made. His presence should be more as an observer to guide the selection process than to influence the selection in any way.

...contd...

While explaining the utility and process of selection of the CHW, the village community may be informed that:

i. The CHW(though he/she may get some monthly honorarium) will not be a Government Servant. His/her activities will have to be looked after by the community itself.

ii. Continuance of CHW will depend on favourable reports from the community. On receiving adverse reports from the village, Government would discontinue recognising the CHW and providing any facility.

iii. As training the CHW costs money, Government will not train another CHW from the village before three years. However, if the village wants to change the CHW before this period, either the villagers will have to bear the training cost, or no stipend will be paid to the new CHW during the training period. In view of this, the villagers may be advised to be very cautious while selecting the CHW and recommending his/her name.

The whole process of selection of First Batch of Community Health Worker must be completed by the end of August, 1977.

IV Scheduling of Training Programme.

After the process of selection of the first batch of Community Health Worker is over, a meeting of the selected Health Workers may be called to finalise the training programme particularly regarding:

i. training time,

ii. days on which the training should be arranged.

iii. as most of the persons selected for Community Health Worker training would be having some vocation of their own, it is necessary that time and days of the training are finalised in consultation with them.

The suggested training schedule given may be modified according to the suitability of the trainee - Community Health Workers.

V Training Programme.

It is suggested that the Training Programme for Community Health Workers may be arranged at the Primary Health Centres or at Sub-Centres where the necessary physical facilities are available

...cont..

In one batch about 20 Community Health Workers should be taken for training, as between 80-120 Community Health Workers would be required to undergo training from each Primary Health Centre, it would be desirable and convenient if Community Health Workers from the areas of two adjacent sub-centres are taken in one batch and trained together in a central place. This may be either a sub-centre or a Chaupal or the PHC. Each Primary Health Centre may have to run 5-8 training courses for training the required number of Community Health Workers.

VI Contingency.

The contingency amount to make the training needs is being sanctioned separately. A sum of Rs.5000 per Primary Health Centre has already been sanctioned for meeting the contingency expenditure under the Multi Purpose Workers Scheme. The Budget Head of account is 'Demand No.49 Medical & Public Health -Major Head 282- B.P.H- Sanitation and Water Supply. B.1.P.H. and Sanitation B.1(5)-Training- B.1.(5)(2)(3)-Training and Employment of Multi-purpose Workers Scheme'. As the physical facilities and educational aids required for the training of Community Health Workers and Dais to a great extent would be common, it is also suggested that the contingency expenditure sanctioned under the Dais training and under Multi Purpose Workers Scheme is pooled. This would help in providing better facilities and at the same time avoid any duplication and wasteful expenditure.

The training period for Community Health Workers would be of 200 Hours duration spread over 10-12 weeks. It is suggested that training programme may be conducted for four days in a week and 5 Hours every day. However, the details may be modified according to the convenience of the trainees, keeping in mind that the total training is to be completed within three months. The detailed training curriculum has been worked out and will be sent separately. The hours of training should be so arranged that trainees may come in the morning and return to their villages in the evening. However, there is no objection if the trainees want to stay overnight and if the facilities for overnight stay can be provided. The expenditure for this purpose will have to be provided by the trainees from the stipends given to them. The Primary Health Centres role in this respect will be limited to assist in making these arrangements.

The ultimate objective is to provide one community Health Worker and one trained Dai in every village (sanction for Dais Training Programme has already been issued. The suggested training plan for the community Health Worker has been worked out, so that the training programme for Community Health Workers and Dais can be undertaken simultaneously (4 days a week for Community Health Workers and 2 Days a week for Dais) at Primary Health Centres, for four days when the Community Health Workers would come at the Primary Health Centre for training, the Dais would have their field training with the A.N.M.S.

The training team for the Community Health Worker would consist of Medical Officers of the Primary Health Centres, Sanitary Inspectors, Block Extension Educator, Malaria Inspectors and Lady Health Visitors. The various subjects to be covered by these functionaries have been indicated in the training curriculum. Medical Officer in charge of the Primary Health Centre would be in charge of the training programme which will be planned and conducted under the guidance of a District Level Medical Officer assigned for this purpose (in districts where MPW Scheme has not been implemented). In district where MPW Scheme has been implemented, the District Level Officers will guide the training programme in a given number of Primary Health Centres.

VII - Stipends.

Community Health Workers will get a stipend during the training period. This may be paid to them either in a lump sum at the end of the training or in suitable instalments. This may be either weekly, fortnightly or monthly whichever way is feasible. The Medical Officer of Primary Health Centre should see that the stipends are given in time in order to avoid any repercussions in the programme. If the sanction does not reach the Primary Health Centre in time, the payment of stipends may be made from contingency fund that he has with him. Howevery, no stipend would be paid to a candidate who leaves the training in the middle.

VIII - Additional Medical Officer

It is proposed to appoint a third Medical Officer in the Primary Health Centres, sanction for which is being issued separately. While doing so the State Governments may if they so desire, appoint a Qualified Doctor other than Allopathy, like Homoeopathy, Ayurvedic, Unani etc. wherever that particular system of medicine is in vogue and is popular. In order that the training programme is conducted under the direct supervision of a Medical Officer, States are requested to take advance action for the recruitment of the additional doctor required under the scheme, so that the doctor is in position by the middle of September, 1977.

In view of this training programme, the present duties of the Medical Officers of the Primary Health Centres would need some revision, so that training becomes a part of their regular duties. It is suggested that as long as the third doctor is not posted, each of the two Medical Officers of the Primary Health Centre may devote two days for the training programme and three days in conducting Primary Health Centre Services and one day for field visit every day. When the third doctor is posted, then the days would be 2 days PHC, 2 days Training Programme and two days for Field visit.

IX - Training of Trainers.

It is considered necessary that before the training is launched, the leaders of the training team undergo a short orientation training to understand the training strategy and training methodology. For these purpose it is proposed that one District Level Medical Officer (to be incharge of the training programme) and the Medical Officer Incharge of the Primary Health Centre selected for the implementation of the scheme during the 1st year from all the Districts (other than those where MPW Scheme has been implemented) are given orientation training at the Central Training Institutes for six days. The details of this training programme will be sent separately and the States are requested to depute the required number of officers for each course. A statement shown allocation of States with the name of the districts to the seven Central training Institutes is at annexure - IV.

In the first batch, 15 - 20 districts will be taken up in each of the seven Central Training Institutes for imparting training to District Level Officer and Primary Health Centre Medical Officers. A statement indicating the names of the districts to be taken in the first course by Seven Central Training Institutes is at Annexure V. This is, however, subject to changes according to the convenience of the State Governments.

The training team would be provided with lessons, plans to ensure that the training is to the point and purposeful. These lessons, plans are being prepared and would be sent to the all concerned shortly.

X - Medicinal Kit.

After completing the training, each Community Health Worker would be provided a kit containing simple medicines and remedies from all systems as for example Allopathic, Ayurvedic, Homoeopathic, Unani, Sidha, The kit will also have educational aids, During their visits they will carry with them the kit. In addition to the Allopathic medicines, they will carry those medicines which are acceptable to the community of that region as per example Ayurvedic, Homoeopathic, Unani or Sidha.

It is also suggested that the appointment of the third doctor could be linked with the medicines acceptable in that region. In case of need the existing pfactitioners of that region may also be associated with the training programme. Contents of the kit may be seen at Annexure VI.

XI - Supply of Medicines.

Each Community Health Worker will be given an initial supply of medicines after the training is completed followed by quarterly supply of medicines to replenish the contents of the kit. It is proposed to have a Central supply to maintain the continuity of supply of medicines and to ensure that there is no break down. This supply may go from the Centre or from the State level. The quarterly supply of medicines to the Community Health Worker will be given in a package which he/she may collect every quarter from the Primary Health Centre Medical Officer. States are required to finalise the list of medicines (Allopathy, Ayurvedic, Homoeopathic, Unani or a combination of them) which they would like to be used by the Community Health Workers. A list of the medicines drawn up by G.of I of the various systems which can be used by the Community Health Workers may be seen at Annexure VII.

XII - Manuals.

i) Community Health Workers Manual.

The Manual for the Community Health Worker has been prepared. A few copies have been printed and are being circulated in the meeting. This manual is being printed in the English and Hindi versions. The various chapters in this Manual are loose bound with three screws so that changes, improvements etc can be effected easily. For the Hindi-Speaking States, this Manual can be used as it is. For the non-Hindi Speaking States, the English version of the Manual will have to be immediately translated into the regional languages and printed in the Off-Set Press or in the State Government Press or in a Private Press so that they are ready by the middle of October, 1977 for use. In case the states are short of funds, for the printing of Manuals, they may please inform the Government of India so that immediate action may be taken in the matter. Advances from UNICEF can be arranged for this purpose.

ii) Manual for Trainers

The manual for trainers is being prepared and would be sent to all the concerned before the training of Community Health Workers starts.

The training team would be provided with lesson plans to ensure that the training is to the point and purposeful. These lesson plans are being prepared and would be sent to all concerned in due course of time.

ANNEXURE-I

The following States/UTs have accepted the draft plan on Health Care Services in Rural Areas proposed by the Government of India:-

1. Andhra Pradesh
2. Assam
3. Gujarat
4. Madhya Pradesh
5. Maharashtra
6. Nagaland
7. Orissa
8. Punjab (to use only Dais)
9. Rajasthan
10. Sikkim
11. Uttar Pradesh
12. West Bengal
13. Andaman & Nicobar Island.
14. Arunachal Pradesh
15. Chandigarh
16. Dadra & Nagar Haveli
17. Delhi
18. LakshadWeep
19. Pondicherry
20. Tripura
21. Manipur
22. Mizoram
23. Goa, Daman & Diu.

2. The following States have not agreed to the draft plan on Health Care Services in rural areas proposed by the Govt. of India and have instead submitted plans of their own for acceptance:-

Kerala and Tamil Nadu.

3. Replies from the following States/UTs. have not been received so far:-

1. Bihar 2. Haryana 3. Himachal Pradesh
4. Karnataka 5. J&K 6. Meghalaya

ANNEXURE - II

List of Districts where the training Programme has been completed and the Scheme is being implemented.

.....

sr. No.	Name of the State/UT	Sr. No.	Districts where training programme has been implemented.
1.	2.	3.	4
1.	Andhra Pradesh	1.	East Godawari
		2.	Nellore
		3.	Nalgonda
		4.	Chittoor
2.	Assam		
3.	Bihar		
4.	Gujarat	5.	Rajkot
		6.	Ahmedabad
		7.	Baroda
		8.	Jamnagar
		9.	Surat
		10.	Kheda
		11.	Dangs
		12.	Gandhinagar
5.	Haryana	13.	Mohindergarh
		14.	Ambala
6.	Himachal Pradesh		
7.	Karnataka		
8.	Madhya Pradesh		
9.	Maharashtra	15.	Kholapur
		16.	Ratnagiri
		17.	Wardha
		18.	Amravati
		19.	Akila
10.	J & K.		
11.	Kerela.		

cont'd...

1.	2.	3.	4.
12.	Punjab	20. 21.	Rupnagar Kapurthala
13.	Manipur		
14.	Mizoram		
15.	Orissa		
16.	Rajasthan		
17.	Tripura		
18.	Uttar Pradesh	22. 23. 24. 25. 26. 27. 28.	Lucknow Allahabad Meerut Agra Varanasi Jhansi Gonda
19.	Tamil Nadu		
20.	West Bengal.		

List of ICDS Project Areas/Blocks.

Sl. No.	Name of the State.	Nature of Project Area	Name of the Block selected
(1)	(2)	(3)	(4)
1.	Andhra Pradesh	Rural-1 Tribal-1	Kambadur Utnoor
2.	Assam	Rural-1	Dhakukhana
3.	Bihar	Rural-2	Manigachi Tarapur
		Tribal-1	Barajamda
4.	Gujarat	Tribal-1	Chhotaudepur (Tejghar PHC are
5.	Haryana	Rural-1	Kathura
6.	Himachal Pradesh	Tribal-1	Pooh
7.	Jammu & Kashmir	Rural-1	Kangan
8.	Karnataka	Rural-1	T.Narasipur
9.	Kerela	Rural-1	Vengara
10.	Madhya Pradesh	Rural-1 Tribal-1	Singroli Tokapal
11.	Maharashtra	Tribal-1 Urban-1	Dharni Bombay (a group of slums)
12.	Manipur	Rural-1	Umkhrul
13.	Meghalaya	Tribal-1	Songsak

(1)	(2)	(3)	(4)
14.	Nagaland	Tribal-1	Zaluke
15.	Orissa	Tribal-1	Subdega
16.	Punjab	Rural-1	Nurpur Bedi
17.	Rajasthan	Tribal-1	Garhi
18.	Tamil Nadu	Urban-1	Madras(a group selected
		Rural-2	Thalli Gandhigram
19.	Tripura	Rural-1	Chawmanu
20.	Uttar Pradesh	Rural-3	Shankargarh Dalmau Jawan
21.	West Bengal	Rural-1 Urban-1	Man Bazar Ward No.79 & 85 Kidderpore Area.
22.	Sikkim	Rural-1	Gyalzing and Nam
23.	Delhi	Urban-1	A group of slums Jama Masjid, Mati Mahal, Turkman Gate, Ajmeri Gate Areas.

COMMUNITY HEALTH WORKER SCHEME

Allocation of States with districts to Cen
Training Institutes

1.	2.	3.	4.	5.
Sl. No.	Name of C.T.I.	Name of the State	No. of districts in the State	No. of districts where MPW Scheme fully implemente
1.	C.H.E., New Delhi	Haryana	11	2
		Bihar	31	-
		Orissa	13	-
2.	N.I.F.P., New Delhi.	U.P.	55	7
		Delhi	1	-
3.	R.H.T.C., Najafgarh, New Delhi.	J&K	10	-
		Punjab	12	2
		Chandigarh	1	-
		H.P.	13	-
4.	P.H.I. Nagpur	Maharashtra	26	5
		Rajasthan	26	-
5.	F.P.T. & R.C. Bombay	M.P.	45	-
		Gujarat	19	8
6.	G.I.R.H. Tamil Nadu	A.P.	21	4
		Tamil Nadu	14	-
		Karnataka	19	-
		Kerela	11	-
		Pondicherry	1	-
		Goa, D&Diu	3	-
		D&N Haveli	1	-

1.	2.	3.	4.	5.
7.	A.I.I.H.&PH, Calcutta.	Assam	10	-
		West Bengal	16	-
		Manipur	5	-
		Meghalaya	2	-
		Arunachal	5	-
		Nagaland	3	-
		Mizoram	3	-
		Andeman Nicobar	1	-

ANNEXURE V

Allocation of districts to CTI's for training of trainers in the First course and number of districts to be taken in the subsequent courses during First Phase

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Central Training Institutes	States	Name of the distt. to be taken in the first course.	No. of the distt. to be taken in the second course.	No. of the distt. to be taken in the third course	No. of distt to be taken in the fourth course
1.	2.	3.	4.	5.	6.
F.P.Trg. & Research Centre Bombay.	M.P.	1. Balaghat 2. Betul 3. Bastar 4. Bhind 5. Bilaspur 6. Challarpur 7. Datia 8. Guna	15	14	12
	Gujarat	9. Amreli 10. Banaskanter 11. Baraoch 12. Bhavanagar 13. Bulsar 14. Janagarh 15. Mehsana			
Institute of Rural Health Gandhigram.	A.P.	1. Adilabad 2. Anantapur 3. Sri Kakulam	18	17	16
	T.Nadu	4. Arcot(North) 5. Chinglepet 6. Tinenelvelli			
	Karnataka	7. Bellanj 8. Coorg 9. Darwar			
	Kerala	10. Allappey 11. Cannanore 12. Malapuran			
	Pondi-Cherry	13. Pondicherry 14. Goa			
	Goa-Daman Dadra Haveli	15. D&N Haveli.			
C.H.E.B. New Delhi	Haryana	1. Bhiwani 2. Gurgaon 3. Karnal 4. Rohtak	14	13	12
	Bihar	5. Begusarai 6. Bhagalpur 7. Bhojpur 8. Champaran East 9. Champaran West 10. Dumka			

---2/-

1.	2.	3.	4.	5.	6.
	Orissa	Bolangir Dhenkanal Ganjam Mayurganj Sundargarh			
National Institute of Health & Family Planning	U.P.	1. Aligarh 2. Almorah 3. Azamgarh 4. Bahriach 5. Bullandshahr 6. Rae Bareilly 7. Sultan Pur 8. Mirzapur 9. Kheri 10. Mathura 11. Jaunpur 12. Nainital 13. Rampur 14. Lalitpur	11	10	10
	Delhi	15. Delhi.			
A.I.I. H. & PH., Calcutta	West Bengal	1. Bankura 2. Burdwan 3. Coach Behar 4. Malda 5. Midnapur	10	10	10
	Assam	6. Cachar 7. Dibrugarh 8. Kampup 9. Nowgong			
	Manipur	10. Central Manipur			
	Arunachal Pradesh	11. Garo Hills			
	Nagaland	12. Tirap 13. Kohima			
	Mizoram	14. Lunghi			
	A & N	15. Andaman & Nicobar.			
R.H.T.C. Najafgarh	J & K	1. Anantnag 2. Baramula 3. Jammu 4. Udhampur	8	6	5
	Punjab	5. Amritsar 6. Bhatinda 7. Faridkot 8. Gurdaspur 9. Ludhiana 10. Patiala.			

cont'd..

13. Sulphacetamide eye and ear drops 10%
14. Sulphanilamide skin ointment
15. Sulphonamide dusting powder
16. Monthol and eucalyptus oil ointment
17. Whitfield ointment

Additional material to be kept with selected membere of thecommunity

1. Blaching powder in pots with cover.

Annexure VII

Medicinal kits (Provisional) to be carried by Community Health Workers.

A. For Internal use:

1. Aspirin, phenacetin and Caffeine (APC) Tablets
2. Chloroquin Tablets
3. Magnesium Prydroxide Tablets
4. Ph. Stralyl Sulphathiazole Tablets
5. Cough Linctus
6. Triple - Sulpha Tablets
7. Rehydration Powder.

B. For External use :

1. Antiseptic lotion
2. Salicylic Ointment
3. Pot. Permanganate Crystals
4. Sulphanamide Eye & Ear drops 10 p.c.
5. Sulphonamide dusting Skin ointment
6. Sulphonamide dusting powder
7. Totracycline Eye ointment

C. First Aid :

1. Methylated Spirit
2. Tincture benzoin Co
3. Tincture Iodine
4. Zinc Boric dusting powder
5. Cotton
6. Gauge
7. Bandages
8. Adhesive Plasters

D. Instruments

1. Scissors
2. Clinical oral thermometer

E. Health Education Material :

1. Flip Chart on Health & Family Welfare
2. Set of Contraceptives for demonstration
3. Manual.

List of some of the effective Ayurvedic Medicines for inclusion in the medicinal Kit

1. Tribhuvana keerti Mishrana
2. Jatiphaladi Mishrana
3. Lashunadi Vati
4. Sankhodara Mishrana
5. Chandra Prabhavati
6. Jatyadi Tail (for external use)
7. Karpoora Rasa
8. Lavana Bhaskara Churna
9. Sukhavirechani
10. Lavanga Taila.

(Proposed by Adviser Indigenous Systems of Medicine).

Medicinal Kits (Provisional) to be carried by Community Health Workers

Sl.No.	Name of Drug	Potency
A.	MEDICINES FOR INTERNAL USE ONLY	
1.	Aconite Nap	6X
2.	Arsenic Alb.	30
3.	Baptisia	3X
4.	Belladona	6,30
5.	Bryonia	30
6.	Cascara Sagrada	q.
7.	China	6,30
8.	Chammomilla	30
9.	Colocynth	6,200
10.	Cynodon Dac	6 X
11.	Euphrasia	30
12.	Eupatorium Perf	30
13.	Hepar S-ulph	30
14.	Ipecac	30
15.	Lachasis	30
16.	Lycopodium	30
17.	Merc. bin-iodide	30,6
18.	Merc. Sol.	30,200
19.	Mellilotus	30
20.	Nux Vomica	30
21.	Podophyllum	30
22.	Pulsatilla	30
23.	Rhus tox	30
24.	Sepia	30, 6X
25.	Sulphur	30, 6X
26.	Staphysagria	200
B.	MEDICINES FOR EXTERNAL USE ONLY (q indicates 'Mother Tinchure')	
1.	Calendula	Ointment for wounds
2.	Cantharia	Ointment for burns
3.	Euphrasia Eye Drops	q for toothache
4.	Plantago	Q for toothache
5.	Kreosote	
C.	BIO-CHEMIC MEDICINES (FOR INTERNAL USE)	
1.	Calcarea Fluor	12 X
2.	Calcarea Phos.	3X,12 X
3.	Calcarea Suplh.	12X
4.	Ferrum Phos	1X, 12X
5.	Kali Mur	6X, 12X
6.	Kali Phos	12X, 30X
7.	Kali Sulph	12X
8.	Mag. Phos	12X
9.	Nat. Mur.	12X
10.	Nat. Phos	6X, 12X
11.	Nat. Sulph.	6X, 12X, 30X
12.	Silicea	12X

LIST OF THE EFFECTIVE UNANI MEDICINES FOR INCLUSION IN THE MEDICIN

For Oral use

Sl.No.	Name of the Medicine	Indication	Contra indication	D Adult
1.	Habb-e Bukhar	Fever, Body pain & Headache.	Nil	1 pill T.
2.	Habb-e-Mubarak	Fever	Nil	1 pill B.
3.	Sufoof Ghutki	Diarrhoea (Infants & Child)	Nil	-
4.	Habb-e Raj	Diarrhoea	Nil	2 pills
5.	Habb-e-Surfa.	Cough & Cold	Nil	2 pills
6.	Qurs Mulayyan	Constipation	Contra indicated in infants & children.	2 to 4 tablets
7.	Habb-e-Usara-e-Rew-and.	Constipation (Infants & Children)	Nil	-
8.	Araq Ajeeb	Pain in abdomen, Vomitting. (Note: May also be sued locally for Headache & Toothache).	NIL	3 to 5 d 4 hourly
9.	Habb-e-Kabid Naus hadari	Pain in abdomen & indigestion	Not advis-able in infants.	2 pills after m

10.	Habb-e-Zahar Mohra.	Diarrhoea & Vomitting.	Nil	2 pills T.D.S.	½ to 1 pill T.D.S. acco to age.
11.	Qutoor-e-Ramad	Sore eye	Nil	1 to 2 drops thrice a day t be instilled in the affecte eye.	
12.	Marham Kharis-h	Ringworm, Scabies.	Nil	For local application.	

1	2	3	4	5	6
	Chandigarh	11.Chandigrh			
	Himachal Pr.	12.Chamba			
		13.Kangra			
		14.Kinaur			
		15.Sirmaur			
Public Health Institute					
Nagpur	Maharashtra	1.Ahmednagar			
		2.Aurangabad			
		3.Bhandra	12	10	10
		4,Bhir			
		5,Buldhana			
		6.Chanda			
		7.Dhulia			
	Rajasthan	8.Ajmer			
		9.Alwar			
		10.Banswara			
		11,Barmer			
		12.Bharatpur			
		13.Bundi			
		14.Bikaner			
		15.Chittorgarh.			

Annexure VI

CONTENTS OF KIT FOR COMMUNITY HEALTH WORKER

1. Slides (5) in slide box
2. Cloth for cleaning slides
3. Hagedorn needle
4. Pencil
5. Clinical oral thermometer
6. Graduated medicine glass
7. Scissors
8. Cotton Wool
9. Gauze
10. Roller bandage
11. Traingular bandage
12. Adhesive plaster
13. Soap dish and soap
14. Towels (2)
15. Nirodh Packets (50)
16. Suitable containers for drugs (17)
17. Forms for reporting of blood smears
18. Franked envelopes addressed to the Primary Health Centre
19. Exeecise book (200 pages)
20. Diary
21. Health Education Materials (flip chart on family Welfare, set of contraceptives)
22. Manual for Community Health Worker
23. Kit beg
24. Razor blade

MEDICINES TO BE CARRIED BY COMMUNITY HEALTH WORKER

For internal use

1. Aspirin, Phelacetin and Caffeine (APC) tables
2. Chloroquine tables
3. Cough mixture
4. Magnesium Hydroxide tablets
5. Kaolin Powder
6. Rehydrtaion mixture

For external use

1. Methyl salicylate ointment
8. Antiseptic lotion
9. Bnzyl bensoate enulsion
10. Mercurochrome 2%
11. Methylated spirit
12. Potassium Permanganate Crystals

ACTIVITIES OF COMMUNITY HEALTH WORKER

Note: A Community Health Worker will be expected to cover the population of a village or, if the village is a large one, a population of about 1,000. He/She will receive technical guidance from the Health Worker (Male/Female).

After training, the Community Health Worker will be able to carry out the following activities:

1. Malaria

- 1.1 Identify fever cases.
- 1.2 Make thick and thin blood films of all fever cases.
- 1.3 Send the slides for laboratory examination.
- 1.4 Administer presumptive treatment to fever cases.
- 1.5 Keep a record of the persons given presumptive treatment.
- 1.6 Inform the Health Worker (Male) of the names and addresses of cases from whom blood slides have been taken.
- 1.7 Assist the Health Worker (Male) and the spraying teams in spraying and larvicidal operations.
- 1.8 Educate the community on how to prevent malaria

2. Smallpox

- 2.1 Identify cases of fever with rash and report them to the Health Worker (Male).

2.2 Inform the Health Worker of infants aged zero to one year requiring primary vaccination as follows:

2.2.1 In the intensive area inform the Health Worker (Female).

2.2.2 In the twilight area inform the Health worker (Male).

2.3 Assist the Health Worker (Male/Female) in arranging for primary vaccination.

2.4 Follow up cases who have been given primary vaccination.

2.5 Educate the community about the importance of primary vaccination.

3. Communicable Diseases

3.1 Inform the Health Worker (Male) immediately an epidemic occurs in his/her area.

3.2 Take immediate precautions to limit the spread of disease.

3.3 Educate the community about the prevention and control of communicable diseases.

3.4. Symptomatic TB cases should be referred to Hth.

4. 3. Environmental Sanitation and Personal Hygiene

4.1 Chlorinate drinking water sources at regular intervals.

4.2 Keep a record of the number of wells chlorinated.

4.3 Assist the Health Worker (Male) in arranging for the construction of the following:

4.3.1 Soakage pits

4.3.2 Kitchen gardens

4.3.3 Compost pits

4.3.4 Sanitary latrines

4.3.5 Smokeless chulhas.

4.4. Educate the community about the following:

4.4.1 Safe drinking water

4.4.2 Hygienic methods of disposal of liquid waste

4.4.3 Hygienic methods of disposal of solid waste

4.4.4 Home sanitation

4.4.5 Kitchen gardens

4.4.6 Advantages and use of sanitary latrines

4.4.7 Advantages of smokeless chulhas

4.4.8 Food hygiene

4.4.9 Control of insects, rodents and stray dogs.

4.5 Educate the community about the importance of personal hygiene.

5. Immunization

5.1 Assist the Health Worker (Male/Female) in arranging for immunization.

5.2 Educate the community about immunization against diphtheria, whooping cough, tetanus, smallpox, tuberculosis, poliomyelitis, cholora and typhoid.

6. Family Planning

6.1 Spread the message of family planning to the couples in his/her area and educate them about the desirability of the small family norm.

6.2 Educate the people about the methods of family planning which are available.

6.3 Act as a depot holder, distribute nirodh to the couples, and maintain the necessary records of nirodh distributed.

6.4 Inform the Health Worker (Male/Female) of those couples who are willing to accept a family planning method so that he/she can make the necessary arrangements.

6.5 Educate the community about the availability of services for Medical Termination of Pregnancy (MTP).

7. Maternal and Child Care

7.1 Advise pregnant women to consult the Health Worker (Female) or the trained dai for prenatal, natal and postnatal care.

7.2 Advise pregnant women to get immunized against tetanus.

7.3 Educate the community about the availability of maternal and child care services and encourage them to utilize the facilities.

7.4 Educate the community about how to keep mothers and children healthy.

8. Nturition

8.1 Identify cases with signs and symptoms of malnutrition among pre-school children (one to five years) and refer them to the Health Worker (Male/Female).

8.2 Identify cases with signs and symptoms of anaemia in pregnant and nursing women and children and refer them to the Health Worker (Male/Female) for treatment.

8.3 Assist the Health Worker (Male/Female) in administering vitamin A solution as prescribed to children from one to five years of age.

8.4 Teach families about the importance of breast feeding and the introduction of supplementary weaning foods.

8.5 Educate the community about nutritious diets for mothers and children.

9. Vital Events

9.1 Report all births and deaths in his/her area to the Health Worker (Male).

9.2 Educate the community about the importance of registering all births and deaths.

10. First Aid in Emergencies

10.1 Give emergency first aid for the following conditions, refer these cases to the Primary Health Centre as necessary and inform the Health Worker Male/Female:

10.1.1 Drowning
10.1.2 Electric Shock
10.1.3 Heat Stroke
10.1.4 Snake bite
10.1.5 Scorpion sting
10.1.6 Insect stings
10.1.7 Dog bite
10.1.8 Accidents
10.1.9 Procedures in dealing with accidents.

? Burns

10.2 Keep a record of first aid given to each patient.

11. Treatment of Minor Ailments

11.1 Give simple treatment for the following signs and symptoms and refer cases beyond his/her competence to the Subcentre or Primary Health Centre:

11.1.1 Fever
11.1.2 Headache
11.1.3 Backache and pain in the joints
11.1.4 Cough and cold

11.1.5 Diarrhoea

11.1.6 Vomiting

11.1.7 Pain in the abdomen

11.1.8 Constipation

11.1.9 Toothache

11.1.10 Earache

11.1.11 Sore eyes

11.1.12 Boils, abscesses and ulcers

11.1.13 Scabies and ringworm.

11.2 Keep a record of the treatment given to each patient.

12. Nervous and mental illness

deleted

12.1 Recognize signs and symptoms of nervous and mental illness and refer these cases to the Health Worker.

12.2 Give immediate assistance in psychiatric emergencies.

12.3 Educate the community about mental illness.

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Madan Kathayan

MEETING OF HEALTH MINISTERS/HEALTH SECRETARIES OF STATES/UNION TERRITORIES TO BE HELD ON THE THURSDAY THE 28th and FRIDAY THE 29th JULY, [illegible] IN THE COMMISSION ROOM 'H' - VIGYAN BHAWAN NEW DELHI

Meeting of State Health Ministers/
Health Secretaries etc. to be held
on 28th & 29th July,1977.

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(Commission Room 'H', Vigyan Bhavan, New Delhi)

PROGRAMME

Thursday - July 28,1977

11.00 a.m. to 1.00 pm	Meeting of Health Secretaries, Directors of Health Services, State Family Welfare Officers, Directors of Indian Medicine etc., to be presided over by Union Health Secretary.
1.00 p.m..to 2.00 p.m.	Working lunch at Vigyan Bhavan
2.00 p.m. to 5.30 p.m.	Further discussion

Friday - July 29,1977

	Meeting of State Health Ministers/ Health Secretaries/Directors of Health Services/State Family Welfare Officers/Directors of Indian Medicines and special invitees.
9.00 a.m. to 10.00 a.m.	Inauguration Welcome by Union Minister of Health and Family Welfare Inaugural speech by P.M . Vote of thanks by Secretary.
10.00 a.m. to 10.30 a.m.	Coffee break
10.30 a.m. to 1.00 p.m.	Discussion on agenda items
1.00 p.m. to 3.00 p.m.	Lunch break(Lunch by Union Health Minister at Vigyan Bhavan).
3.00 p.m. to 5.30 p.m.	Further discussion.

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Meeting of State Health Ministers/Health Secretaries etc. to be held on 28th & 29th July, 1977.

(Meeting with State Health Ministers will be held on 29.7.77.)

(Commission Room 'H', Vigyan Bhavan, New Delhi.)

A G E N D A

Item No.I : (i) Rural Health Scheme
(ii) Multipurpose Workers Scheme

Item No.II: Family Welfare Programme - new approach

(i) Suggested levels of performance and its implications;
(ii) Voluntary sterilisation programme including MTP as a health measure;
(iii) Place of conventional methods including oral pills, IUD etc. in the Family Welfare Programme;
(iv) Role of Voluntary Organisations and of the Organised Sector;
(v) Family Welfare Field Workers and his supervision;
(vi) Progress in respect of MCH Scheme;
(vii) Media efforts and the new motivational directions of Family Welfare Programme;
(viii) Family Welfare and Maternal & Child Health Programme policy in ICDS blocks and Tribal Areas.

Item No.III: Integrated Ayurvedic Course.

Agenda Item No.I

(i) Rural Health Scheme

(ii) Multipurpose Workers Scheme.

AGENDA ITEM No.I(i)

RURAL HEALTH SCHEME

The draft plan of Rural Health Scheme was discussed in the Health Minister's Conference held in New Delhi on 28th and 29th April, 1977. On the basis of the consensus arrived at the meeting, the State Governments were requested to send their approach papers. 23 States/ Union Territories while sending their approach paper have accepted the draft plan of Health Care Services in rural areas proposed by the Government of India. Out of these 23 States, Punjab have accepted to use only Dais. Two States i.e. Kerala and Tamilnadu have not agreed to the draft plan and instead have submitted plans of their own for acceptance. Replies from the six States/Union Territories have not been received so far. A statement indicating the names of the States who have accepted the draft plan, submitted plans of their own for acceptance and the States/ Union Territories from which the replies have not been received so far is at Annexure 'I'.

In pursuance of the decision of Health Ministers' meeting, it has been decided to introduce the scheme from the 2nd October, 1977, the birth Anniversary of Mahatma Gandhi. It is proposed to have a detailed discussion on the following points in order to arrive at consensus:

I. Area of Implementation.

During this year the scheme is proposed to be launched in

i. All Primary Health Centres of Districts where the Multipurpose Workers-Scheme has already been implemented (list of districts given in Annexure 'II'.

ii. In one Primary Health Centre each from the remaining districts of the country. States have been requested to select one Primary Health Centre from each of the districts where the scheme is to be launched from 2nd October, 1977. The selection of Primary Health Centres should preferably be completed by first week of August, 1977 keeping in view the following:

a. Primary Health Centres having two doctors atleast.

b. Preference to tribal/backward/hilly areas.

...contd...

c. Primary Health Centres covered by Integrated Child Development Scheme. (Annexure 'III').

d. Primary Health Centre covered by Integrated Rural Development Scheme.

e. Primary Health Centres which have effective local Self Government Organisations.

f. Primary Health Centres which have active community participation as for example Mahila Mandal etc.

g. Primary Health Centres which have enthusiastic Voluntary Organisations working in Health and related sectors.

It would be useful to consult the Panchayats/ Organisations, Rural Development Organisations prior to selection of Primary Health Centre.

II. Number of Community Health Workers to be trained.

It is proposed to have one Community Health Worker for every one village (on average of 1000 Population). However, where the population of a village is less than one thousand, either 2-3 neighbouring villages may be grouped together or if the villages are not very close to each other, one Community Health Worker may be selected from each village, even if the population of the village is less than one thousand. In villages with more than one thousand population, the number of Community Health Workers may be more, so as to have one worker for about one thousand population. If the States feel the necessity of selecting more than one Community Health Worker from a village where the population is not more than one thousand they can do so considering the local circumstances.

III. Selection of Community Health Workers.

The Health Worker at community level would not be a Government functionary, but Government will only assist the programme of the community to help themselves. If the community feels that a person selected and trained by Government does not fulfil their requirements at a later stage, they would be at liberty to change him/her. Depending upon local conditions, the community can choose any person who has correct aptitude and willingness to serve the community from the village level itself. However, in order that the community is able to select the most suitable person, assistance and necessary guidance would have to be provided by the Primary Health Centre Doctor and staff. The following guidelines may be given to the Village Community in this regard:

i. Community Health Worker may be of either sex.

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ii. The person selected must be a permanent resident of that village itself, and may be from any vocation.

iii. He/She should be able to read and write. However, since the higher the level of education the better the quality of service that would be available, it is recommended that the person to be selected should have had formal education upto 6th Standard (Class).

iv. He should be social-service minded and be able to spare atleast 2/3 hours everyday for community health activities.

v. He should be physically active to serve atleast for a minimum period of three years as a Community Health Worker.

vi. Should be acceptable to all sections of the community.

vii. Should not belong to any group or political organisation of the village which may limit acceptability.

viii. Suitable relaxation may be permitted for Scheduled Castes/Scheduled Tribes.

ix. He/She may also be a practitioner of traditional medicine or Homeopathy.

With these guidelines, the Village Community may be requested to recommend 2-3 persons considered suitable by them to be Community Health Workers. The final selection may be made by the Medical Officers of the Primary Health Centre, jointly after consulting the Block Development Officer/ the Field Staff and the various Government Organisations (Village Level Worker, Basic Health Worker, F.P.(HA) and ANM etc.) working in the village.

As the training of the first batch of Community Health Workers will start from 2nd October, 1977, the Medical Officers of the selected Primary Health Centres should take the following action immediately:-

i. Select the first 20 villages from the Primary Health Centres (preferably villages covered under 2 Sub-Centres). At a time, villages under 2 Sub Centres may be taken in a cyclic manner.

ii. The Medical Officer should visit each of these villages himself along with the concerned field workers like F.P.(HA), Basic Health Worker and ANM and hold a whole day meeting to explain the whole concept of Community Health Workers to the Village Community and request them to select 2/3 persons who they feel would be suitable for being trained as Community Health Workers.

iii. It may be desirable to depute/either Block Extention Educator/ Sanitary Inspector to attend the meeting for which the selection is to be made. His presence should be more as an observer to guide the selection process than to influence the selection in any way.

...contd...

While explaining the utility and process of selection of the CHW, the village community may be informed that:

i. The CHW(though he/she may get some monthly honorarium) will not be a Government Servant. His/her activities will have to be looked after by the community itself.

ii. Continuance of CHW will depend on favourable reports from the community. On receiving adverse reports from the village, Government would discontinue recognising the CHW and providing any facility.

iii. As training the CHW costs money, Government will not train another CHW from the village before three years. However, if the village wants to change the CHW before this period, either the villagers will have to bear the training cost, or no stipend will be paid to the new CHW during the training period. In view of this, the villagers may be advised to be very cautious while selecting the CHW and recommending his/her name.

The whole process of selection of First Batch of Community Health Worker must be completed by the end of August, 1977.

IV Scheduling of Training Programme.

After the process of selection of the first batch of Community Health Worker is over, a meeting of the selected Health Workers may be called to finalise the training programme particularly regarding:

i. training time,

ii. days on which the training should be arranged.

iii. as most of the persons selected for Community Health Worker training would be having some vocation of their own, it is necessary that time and days of the training are finalised in consultation with them.

The suggested training schedule given may be modified according to the suitability of the trainee - Community Health Workers.

V Training Programme.

It is suggested that the Training Programme for Community Health Workers may be arranged at the Primary Health Centres or at Sub-Centres where the necessary physical facilities are available

...cont...

In one batch about 20 Community Health Workers should be taken for training, as between 80-120 Community Health Workers would be required to undergo training from each Primary Health Centre, it would be desirable and convenient if Community Health Workers from the areas of two adjacent sub-centres are taken in one batch and trained together in a central place. This may be either a sub-centre or a Chaupal or the PHC. Each Primary Health Centre may have to run 5-8 training courses for training the required number of Community Health Workers.

VI Contingency.

The contingency amount to make the training needs is being sanctioned separately. A sum of Rs.5000.00 per Primary Health Centre has already been sanctioned for meeting the contingency expenditure under the Multi Purpose Workers Scheme. The Budget Head of account is 'Demand No.49 Medical & Public Health -Major Head 282- B.PH- Sanitation and Water Supply. B.1.P.H. and Sanitation B.1(5)-Training- B.1.(5)(2)(3)-Training and Employment of Multi-purpose Workers Scheme'. As the physical facilities and educational aids required for the training of Community Health Workers and Dais to a great extent would be common, it is also suggested that the contingency expenditure sanctioned under the Dais training and under Multi Purpose Workers Scheme is pooled. This would help in providing better facilities and at the same time avoid any duplication and wasteful expenditure.

The training period for Community Health Workers would be of 200 Hours duration spread over 10-12 weeks. It is suggested that training programme may be conducted for four days in a week and 5 Hours every day. However, the details may be modified according to the convenience of the trainees, keeping in mind that the total training is to be completed within three months. The detailed training curriculum has been worked out and will be sent separately. The hours of training should be so arranged that trainees may come in the morning and return to their villages in the evening. However, there is no objection if the trainees want to stay overnight and if the facilities for overnight stay can be provided. The expenditure for this purpose will have to be provided by the trainees from the stipends given to them. The Primary Health Centres role in this respect will be limited to assist in making these arrangements.

The ultimate objective is to provide one Community Health Worker and one trained Dai in every village (sanction for Dais Training Programme has already been issued. The suggested training plan for the Community Health Worker has been worked out, so that the training programme for Community Health Workers and Dais can be undertaken simultaneously (4 days a week for Community Health Workers and 2 Days a week for Dais) at Primary Health Centres, for four days when the Community Health Workers would come at the Primary Health Centre for training, the Dais would have their field training with the A.N.M.S.

The training team for the Community Health Worker would consist of Medical Officers of the Primary Health Centres, Sanitary Inspectors, Block Extension Educator, Malaria Inspectors and Lady Health Visitors. The various subjects to be covered by these functionaries have been indicated in the training curriculum. Medical Officer in charge of the Primary Health Centre would be in charge of the training programme which will be planned and conducted under the guidance of a District Level Medical Officer assigned for this purpose (in districts where MPW Scheme has not been implemented). In district where MPW Scheme has been implemented, the District Level Officers will guide the training programme in a given number of Primary Health Centres.

VII - Stipends.

Community Health Workers will get a stipend during the training period. This may be paid to them either in a lump sum at the end of the training or in suitable instalments. This may be either weekly, fortnightly or monthly whichever way is feasible. The Medical Officer of Primary Health Centre should see that the stipends are given in time in order to avoid any repercussions in the programme. If the sanction does not reach the Primary Health Centre in time, the payment of stipends may be made from contingency fund that he has with him. Howevery, no stipend would be paid to a candidate who leaves the training in the middle.

VIII - Additional Medical Officer

It is proposed to appoint a third Medical Officer in the Primary Health Centres, sanction for which is being issued separately. While doing so the State Governments may if they so desire, appoint a qualified Doctor other than Allopathy, like Homoeopathy, Ayurvedic, Unani etc. wherever that particular system of medicine is in vogue and is popular. In order that the training programme is conducted under the direct supervision of a Medical Officer, States are requested to take advance action for the recruitment of the additional doctor required under the scheme, so that the doctor is in position by the middle of September, 1977.

In view of this training programme, the present duties of the Medical Officers of the Primary Health Centres would need some revision, so that training becomes a part of their regular duties. It is suggested that as long as the third doctor is not posted, each of the two Medical Officers of the Primary Health Centre may devote two days for the training programme and three days in conducting Primary Health Centre Services and one day for field visit every day. When the third doctor is posted, then the days would be 2 days PHC, 2 days Training Programme and two days for Field visit.

IX - Training of Trainers.

It is considered necessary that before the training is launched, the leaders of the training team undergo a short orientation training to understand the training strategy and training methodology. For these purpose it is proposed that one District Level Medical Officer (to be incharge of the training programme) and the Medical Officer Incharge of the Primary Health Centre selected for the implementation of the scheme during the 1st year from all the Districts (other than those where MPW Scheme has been implemented) are given orientation training at the Central Training Institutes for six days. The details of this training programme will be sent separately and the States are requested to depute the required number of officers for each course. A statement shown allocation of States with the name of the districts to the seven Central training Institutes is at annexure - IV.

In the first batch, 15 - 20 districts will be taken up in each of the seven Central Training Institutes for imparting training to District Level Officer and Primary Health Centre Medical Officers. A statement indicating the names of the districts to be taken in the first course by Seven Central Training Institutes is at Annexure V. This is, however, subject to changes according to the convenience of the State Governments.

The training team would be provided with lessons, plans to ensure that the training is to the point and purposeful. These lessons, plans are being prepared and would be sent to the all concerned shortly.

X - Medicinal Kit.

After completing the training, each Community Health Worker would be provided a kit containing simple medicines and remedies from all systems as for example Allopathic, Ayurvedic, Homoeopathic, Unani, Sidha. The kit will also have educational aids, During their visits they will carry with them the kit. In addition to the Allopathic medicines, they will carry those medicines which are acceptable to the community of that region as per example Ayurvedic, Homoeopathic, Unani or Sidha.

It is also suggested that the appointment of the third doctor could be linked with the medicines acceptable in that region. In case of need the existing practitioners of that region may also be associated with the training programme. Contents of the kit may be seen at Annexure VI.

XI - Supply of Medicines.

Each Community Health Worker will be given an initial supply of medicines after the training is completed followed by quarterly supply of medicines to replenish the contents of the kit. It is proposed to have a Central supply to maintain the continuity of supply of medicines and to ensure that there is no break down. This supply may go from the Centre or from the State level. The quarterly supply of medicines to the Community Health Worker will be given in a package which he/she may collect every quarter from the Primary Health Centre Medical Officer. States are required to finalise the list of medicines (Allopathy, Ayurvedic, Homoeopathic, Unani or a combination of them) which they would like to be used by the Community Health Workers. A list of the medicines drawn up by G.of I of the various systems which can be used by the Community Health Workers may be seen at Annexure VII.

XII - Manuals.

i) Community Health Workers Manual.

The Manual for the Community Health Worker has been prepared. A few copies have been printed and are being circulated in the meeting. This manual is being printed in the English and Hindi versions. The various chapters in this Manual are loose bound with three screws so that changes, improvements etc. can be effected easily. For the Hindi-Speaking States, this Manual can be used as it is. For the non-Hindi Speaking States, the English version of the Manual will have to be immediately translated into the regional languages and printed in the Off-Set Press or in the State Government Press or in a Private Press so that they are ready by the middle of October, 1977 for use. In case the states are short of funds, for the printing of Manuals, they may please inform the Government of India so that immediate action may be taken in the matter. Advances from UNICEF can be arranged for this purpose.

ii) Manual for Trainers

The manual for trainers is being prepared and would be sent to all the concerned before the training of Community Health Workers starts.

The training team would be provided with lesson plans to ensure that the training is to the point and purposeful. These lesson plans are being prepared and would be sent to all concerned in due course of time.

ANNEXURE-I

The following States/UTs have accepted the draft plan on Health Care Services in Rural Areas proposed by the Government of India:-

1. Andhra Pradesh
2. Assam
3. Gujarat
4. Madhya Pradesh
5. Maharashtra
6. Nagaland
7. Orissa
8. Punjab (to use only Dais)
9. Rajasthan
10. Sikkim
11. Uttar Pradesh
12. West Bengal
13. Andaman & Nicobar Island.
14. Arunachal Pradesh
15. Chandigarh
16. Dadra & Nagar Haveli
17. Delhi
18. LakshadWeep
19. Pondicherry
20. Tripura
21. Manipur
22. Mizoram
23. Goa, Daman & Diu.

2. The following States have not agreed to the draft plan on Health Care Services in rural areas proposed by the Govt. of India and have instead submitted plans of their own for acceptance:-

Kerala and Tamil Nadu.

3. Replies from the following States/UTs. have not been received so far:-

1. Bihar 2. Haryana 3. Himachal Pradesh
4. Karnataka 5. J&K 6. Meghalaya

ANNEXURE - II

List of Districts where the training Programme has been completed and the Scheme is being implemented.

.....

sr. No.	Name of the State/UT	Sr. No.	Districts where training programme has been implemented.
1.	2.	3.	4
1.	Andhra Pradesh	1.	East Godawari
		2.	Nellore
		3.	Nalgonda
		4.	Chittoor
2.	Assam		
3.	Bihar		
4.	Gujarat	5.	Rajkot
		6.	Ahmedabad
		7.	Baroda
		8.	Jamnagar
		9.	Surat
		10.	Kheda
		11.	Dangs
		12.	Gandhinagar
5.	Haryana	13.	Mohindergarh
		14.	Ambala
6.	Himachal Pradesh		
7.	Karnataka		
8.	Madhya Pradesh		
9.	Maharashtra	15.	Kholapur
		16.	Ratnagiri
		17.	Wardha
		18.	Amravati
		19.	Akila
10.	J & K.		
11.	Kerela.		

cont'd...

1.	2.	3.	4.
12.	Punjab	20.	Rupnagar
		21.	Kapurthala
13.	Manipur		
14.	Mizoram		
15.	Orissa		
16.	Rajasthan		
17.	Tripura		
18.	Uttar Pradesh	22.	Lucknow
		23.	Allahabad
		24.	Meerut
		25.	Agra
		26.	Varanasi
		27.	Jhansi
		28.	Gonda
19.	Tamil Nadu		
20.	West Bengal.		

List of ICDS Project Areas/Blocks.

Sl. No.	Name of the State.	Nature of Project Area	Name of the Block selected
(1)	(2)	(3)	(4)
1.	Andhra Pradesh	Rural-1 Tribal-1	Kambadur Utnoor
2.	Assam	Rural-1	Dhakukhana
3.	Bihar	Rural-2	Manigachi Tarapur
		Tribal-1	Barajamda
4.	Gujarat	Tribal-1	Chhotaudepur (Tejghar PHC a
5.	Haryana	Rural-1	Kathura
6.	Himachal Pradesh	Tribal-1	Pooh
7.	Jammu & Kashmir	Rural-1	Kangan
8.	Karnataka	Rural-1	T.Narasipur
9.	Kerela	Rural-1	Vengara
10.	Madhya Pradesh	Rural-1 Tribal-1	Singroli Tokapal
11.	Maharashtra	Tribal-1 Urban-1	Dharni Bombay (a group of slums)
12.	Manipur	Rural-1	Umkhrul
13.	Meghalaya	Tribal-1	Songsak

(1)	(2)	(3)	(4)
14.	Nagaland	Tribal-1	Zaluke
15.	Orissa	Tribal-1	Subdega
16.	Punjab	Rural-1	Nurpur Bedi
17.	Rajasthan	Tribal-1	Garhi
18.	Tamil Nadu	Urban-1	Madras(a grou select
		Rural-2	Thalli Gandhigram
19.	Tripura	Rural-1	Chawmanu
20.	Uttar Pradesh	Rural-3	Shankargarh Dalmau Jawan
21.	West Bengal	Rural-1 Urban-1	Man Bazar Ward No.79 & 8 Kidderpore Are
22.	Sikkim	Rural-1	Gyalzing and N
23.	Delhi	Urban-1	A group of slu Jama Masjid, M Mahal, Turkman Gate, Ajmeri G Areas.

COMMUNITY HEALTH WORKER SCHEME

Allocation of States with districts to Cen Training Institutes

1.	2.	3.	4.	5.
Sl. No.	Name of C.T.I.	Name of the State	No. of districts in the State	No. of districts where MPW Scheme fully implemente
1.	C.H.E., New Delhi	Haryana	11	2
		Bihar	31	-
		Orissa	13	-
2.	N.I.F.P., New Delhi.	U.P.	55	7
		Delhi	1	-
3.	R.H.T.C., Najafgarh, New Delhi.	J&K	10	-
		Punjab	12	2
		Chandigarh	1	-
		H.P.	13	-
4.	P.H.I. Nagpur	Maharashtra	26	5
		Rajasthan	26	-
5.	F.P.T. & R.C. Bombay	M.P.	45	-
		Gujarat	19	8
6.	G.I.R.H. Tamil Nadu	A.P.	21	4
		Tamil Nadu	14	-
		Karnataka	19	-
		Kerela	11	-
		Pondicherry	1	-
		Goa, D&Diu	3	-
		D&N Haveli	1	-

1.	2.	3.	4.	5.
7.	A.I.I.H.&PH, Calcutta.	Assam	10	-
		West Bengal	16	-
		Manipur	5	-
		Meghalaya	2	-
		Arunachal	5	-
		Nagaland	3	-
		Mizoram	3	-
		Andeman Nicobar	1	-

ANNEXURE V

Allocation of districts to CTI's for training of trainers in the First course and number of districts to be taken in the subsequent courses during First Phase

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Central Training Institutes	States	Name of the distt. to be taken in the first course.	No.of the distt. to be taken in the second course.	No. of the distt. to be taken in the third course	No.of distt to be taken in the fourth course
1.	2.	3.	4.	5.	6.
F.P.Trg. & Research Centre Bombay.	M.P.	1. Balaghat 2. Betul 3. Bastar 4. Bhind 5. Bilaspur 6. Challarpur 7. Datia 8. Guna	15	14	12
	Gujarat	9. Amreli 10. Banaskanter 11. Baraoch 12. Bhavanagar 13. Bulsar 14. Janagarh 15. Mehsana			
Institute of Rural Health Gandhigram.	A.P.	1. Aditabad 2. Anantapur 3. Sri Kakulam	18	17	16
	T.Nadu	4. Arcot(North) 5. Chinglepet 6. Tinenelvelli			
	Karnataka	7. Bellanj 8. Coorg 9. Darwar			
	Kerala	10. Allappey 11. Cannanore 12. Malapuran			
	Pondi-Cherry	13. Pondicherry 14. Goa			
	Goa-Daman Dadra Haveli	15. D&N Haveli.			
C.H.E.B. New Delhi	Haryana	1. Bhiwani 2. Gurgaon 3. Karnal 4. Rohtak	14	13	12
	Bihar	5. Begusarai 6. Bhagalpur 7. Bhojpur 8. Champaran East 9. Champaran West 10. Dumka			

---2/-

1.	2.	3.	4.	5.	6.
	Orissa	Bolangir Dhenkanal Ganjam Mayurganj Sundargarh			
National Institute of Health & Family Planning	U.P.	1. Aligarh 2. Almorah 3. Azamgarh 4. Bahriach 5. Bullandshahr 6. Rae Bareilly 7. Sultan Pur 8. Mirzapur 9. Kheri 10. Mathura 11. Jaunpur 12. Nainital 13. Rampur 14. Lalitpur	11	10	10
	Delhi	15. Delhi.			
A.I.I. H. & PH., Calcutta	West Bengal	1. Bankura 2. Burdwan 3. Coach Behar 4. Malda 5. Midnapur	10	10	10
	Assam	6. Cachar 7. Dibrugarh 8. Kampup 9. Nowgong			
	Manipur	10. Central Manipur			
	Arunachal Pradesh	11. Garo Hills			
	Nagaland	12. Tirap 13. Kohima			
	Mizoram	14. Lunghi			
	A & N	15. Andaman & Nicobar.			
R.H.T.C. Najafgarh	J & K	1. Anantnag 2. Baramula 3. Jammu 4. Udhampur	8	6	5
	Punjab	5. Amritsar 6. Bhatinda 7. Faridkot 8. Gurdaspur 9. Ludhiana 10. Patiala.			

cont'd..

1	2	3	4	5	6
	Chandigarh	11.Chandigrh			
	Himachal Pr.	12.Chamba			
		13.Kangra			
		14.Kinaur			
		15.Sirmaur			
Public Health Institute					
Nagpur	Maharashtra	1.Ahmednagar			
		2.Aurangabad			
		3.Bhandra	12	10	10
		4,Bhir			
		5,Buldhana			
		6.Chanda			
		7.Dhulia			
	Rajasthan	8.Ajmer			
		9.Alwar			
		10.Banswara			
		11,Barmer			
		12.Bharatpur			
		13.Bundi			
		14.Bikaner			
		15.Chittorgarh.			

Annexure VI

CONTENTS OF KIT FOR COMMUNITY HEALTH WORKER

1. Slides (5) in slide box
2. Cloth for cleaning slides
3. Hagedorn needle
4. Pencil
5. Clinical oral thermometer
6. Graduated medicine glass
7. Scissors
8. Cotton Wool
9. Gauze
10. Roller bandage
11. Traingular bandage
12. Adhesive plaster
13. Soap dish and soap
14. Towels (2)
15. Nirodh Packets (50)
16. Suitable containers for drugs (17)
17. Forms for reporting of blood smears
18. Franked envelopes addressed to the Primary Health Centre
19. Exeecise book (200 pages)
20. Diary
21. Health Education Materials (flip chart on family welfare, set of contraceptives)
22. Manual for Community Health Worker
23. Kit beg
24. Razor blade

MEDICINES TO BE CARRIED BY COMMUNITY HEALTH WORKER

For internal use

1. Aspirin, Phelacetin and Caffeine (APC) tables
2. Chloroquine tables
3. Cough mixture
4. Magnesium Hydroxide tablets
5. Kaolin Powder
6. Rehydrtaion mixture

For external use

1. Methyl salicylate ointment
8. Antiseptic lotion
9. Enzyl bensoate emulsion
10. Mercurochrome 2%
11. Methylated spirit
12. Potassium Permanganate Crystals

13. Sulphacetamide eye and ear drops 10%
14. Sulphanilamide skin ointment
15. Sulphonamide dusting powder
16. Monthol and eucalyptus oil ointment
17. Whitfield ointment

Additional material to be kept with selected membere of thecommunity

1. Blaching powder in pots with cover.

Annexure VII

Medicinal kits (Provisional) to be carried by Community Health Workers.

A. For Internal use:

1. Aspirin, phenacetin and Caffeine (APC) Tablets
2. Chloroquin Tablets
3. Magnesium Prydroxide Tablets
4. Ph. Stralyl Sulphathiazole Tablets
5. Cough Linctus
6. Triple - Sulpha Tablets
7. Rehydration Powder.

B. For External use :

1. Antiseptic lotion
2. Salicylic Ointment
3. Pot. Permanganate Crystals
4. Sulphanamide Eye & Ear drops 10 p.c.
5. Sulphonamide dusting Skin ointment
6. Sulphonamide dusting powder
7. Totracycline Eye ointment

C. First Aid :

1. Methylated Spirit
2. Tincture benzoin Co
3. Tincture Iodine
4. Zinc Boric dusting powder
5. Cotton
6. Gauge
7. Bandages
8. Adhesive Plasters

D. Instruments

1. Scissors
2. Clinical oral thermometer

E. Health Education Material :

1. Flip Chart on Health & Family Welfare
2. Set of Contraceptives for demonstration
3. Manual.

List of some of the effective Ayurvedic Medicines for inclusion in the medicinal Kit

1. Tribhuvana keerti Mishrana
2. Jatiphaladi Mishrana
3. Lashunadi Vati
4. Sankhodara Mishrana
5. Chandra Prabhavati
6. Jatyadi Tail (for external use)
7. Karpoora Rasa
8. Lavana Bhaskara Churna
9. Sukhavirechani
10. Lavanga Taila.

(Proposed by Adviser Indigenous Systems of Medicine).

Medicinal Kits (Provisional) to be carried by Community Health Workers

Sl.No.	Name of Drug	Potency
A.	MEDICINES FOR INTERNAL USE ONLY	
1.	Aconite Nap	6X
2.	Arsenic Alb.	30
3.	Baptisia	3X
4.	Belladona	6,30
5.	Bryonia	30
6.	Cascara Sagrada	q
7.	China	6,30
8.	Chammomilla	30
9.	Colocynth	6,200
10.	Cynodon Dac	6 X
11.	Euphrasia	30
12.	Eupatorium Perf	30
13.	Hepar S-ulph	30
14.	Ipecac	30
15.	Lachasis	30
16.	Lycopodium	30
17.	Merc. bin-iodide	30,6
18.	Merc. Sol.	30,200
19.	Mellilotus	30
20.	Nux Vomica	30
21.	Podophyllum	30
22.	Pulsatilla	30
23.	Rhus tox	30
24.	Sepia	30, 6X
25.	Sulphur	30, 6X
26.	Staphysagria	200
B.	MEDICINES FOR EXTERNAL USE ONLY (q indicates 'Mother Tinchure')	
1.	Calendula	Ointment for wounds
2.	Cantharia	Ointment for burns
3.	Euphrasia Eye Drops	q for toothache
4.	Plantago	Q for toothache
5.	Kreosote	
C.	BIO-CHEMIC MEDICINES (FOR INTERNAL USE)	
1.	Calcarea Fluor	12 X
2.	Calcarea Phos.	3X,12 X
3.	Calcarea Sulph.	12X
4.	Ferrum Phos	1X, 12X
5.	Kali Mur	6X, 12X
6.	Kali Phos	12X, 30X
7.	Kali Sulph	12X
8.	Mag. Phos	12X
9.	Nat. Mur.	12X
10.	Nat. Phos	6X, 12X
11.	Nat. Sulph.	6X, 12X, 30X
12.	Silicea	12X

LIST OF THE EFFECTIVE UNANI MEDICINES FOR INCLUSION IN THE E

For Oral use

Sl.No.	Name of the Medicine	Indication	Contra indication	Ad
1.	Habb-e Bukhar	Fever, Body pain & Headache.	Nil	1 p
2.	Habb-e-Mubarak	Fever	Nil	1 p
3.	Sufoof Ghutki	Diarrhoea (Infants & Child)	Nil	-
4.	Habb-e Raj	Diarrhoea	Nil	2 p
5.	Habb-e-Surfa.	Cough & Cold	Nil	2 p
6.	Qurs Mulayyan	Constipation	Contra indicated in infants & children.	2 t tab
7.	Habb-e-Usara-e-Rew-and.	Constipation (Infants & Children)	Nil	-
8.	Araq Ajeeb	Pain in abdomen, Vomitting. (Note: May also be sued locally for Headache & Toothache).	NIL	3 t 4 h
9.	Habb-e-Kabid Naus hadari	Pain in abdomen & indigestion	Not advis-able in infants.	2 p afte

10.	Habb-e-Zahar Mohra.	Diarrhoea & Vomitting.	Nil	2 pills T.D.S.	¼ to 1 pi T.D.S. ac to age.
11.	Qutoor-e-Ramad	Sore eye	Nil	1 to 2 drops thrice a day be instilled in the affec eye.	
12.	Marham Kharis-h	Ringworm, Scabies.	Nil	For local application.	

MULTIPURPOSE WORKERS SCHEME

Introduction

One of the main aims of the Fifth Five Year Plan is to establish a health delivery system through a team of Multipurpose Workers. Initially, four vertical National Programmes namely, Family Welfare Nutrition, Malaria Eradication Programme and Small pox Eradication Programme were integerated. Recently, however, National Tuberculosis Control Programme and Leprosy Control Programme have also been included.

TRAINING

The Implementation of this scheme calls for an intensive training programme to train uni-purpose workers, into the techrique concepts and skills of the multi-purpose workers at all levels. The State level Officers are trained at NIHFW; the district level medical officers and key-trainers are being trained at seven Central Training Institutes and Medical Officers (PHC) and BEEs at Health and Family Welfare Training Centres whereas the other categories are being trained at PHCs. The progress upto 31st March, 1977 is as below :-

	Category	Progress (upto 31st March, 1977)
1.	State Level Officer-in-charge of Training Programme.	48
2.	Training (Officer of HFWTCs) (key-trainers).	261
3.	District Level Medical Officers.	532
4.	Medical Officers (PHC).	2777
5.	Block Extension Educators.	1148
6.	Block Health Supervisors (F).	874
7.	Health Supervisors (M).	2111
8.	Health Workers (F).	3566
9.	Health Workers (M).	5295

....2..

The district which have completed the training programme/likely to be completed by the end of the year are tabulated at Appendix I.

IMPLEMENTATION

A list of 70 districts was approved for implementation of the MPW Scheme during first phase. Some States requested for a change which was approved and a modified list of 80 districts was issued.

Recently it was proposed by some States that they may be allowed to take up more districts for training and implementation of MPW Scheme after the scheme has been fully implemented in the districts selected during first phase. List of 35 districts selected in the second phase has been circulated (Appendix II).

It was visualised that the implementation of the scheme will be monitered by Health and Family Welfare Training Centres/Rural Health Training Centres. Out of a total of 44 Health and Family Welfare Training Centres sanctioned at the beginning of the year, 43 were functioning, the one at Gaya had been closed down and shifted to Imphal. Sanction for two new H&FWTCs at Simla and Shillong have been issued. Thus, there are now 46 H&FWTCs.

Employment of Health Workers (F) and Health Assistant (F) under the Scheme:

The States of A.P., Gujarat, Harayana, Karnataka, M.P., Orissa, Punjab, Rajasthan and Tamil Nadu have sanctioned the posts of Female Health Workers (ANM) and Female Health Assistants (LHV)s under MPW Scheme. The total number of Health Workers sanctioned and employed under MPW Scheme so far by these States is 3663 and 2223 respectively. The States have been requested to expedite sanctioning the additional posts of under the scheme.

....3...

There are States which still have to establish sub-centres under minimum needs programme. The additional number of Sub-centres to be established is 6870.

Points for consideration:

1. The States may consider to extend the concept of integration of vertical programmes at the district and State level.

2. To start promotees training for qualified ANMs to become Health Supervisors under MPW Scheme.

3. All ANMs at present posted in Urban Hospitals should be transferred to rural areas, the posts in the hospitals should be filled up by trained nurses.

4. All vacant posts under the various programmes should be filled up from henceforth only by basically trained staff. For this purpose Basic training programme for Health Workers (M) should be started in all States either by converting any of the existing Training Centres into Basic Training Centre or by opening a new centre.

5. Two ANMs at present posted at each PHC Headquarters should be transferred to sub-centres and PHC posts should be filled up by trained nurses.

6. The MPW Scheme should be implemented in the whole country by 1982-83.

ANNEXURE I

List of Districts where the training Programme has been completed and the Scheme is being implemented.

.....

Sr.No.	Name of the State/UT	Sr. No.	Distts.where trg.programme has been implemented.	Sr. No.	Districts where training programme is likely to be completed by the end of 1977-78.
1.	2.	3.	4.	5.	6.
1.	Andhra Pradesh	1.	East Godawari		
		2.	Nellore		
		3.	Nalgonda		
		4.	Chittoor		
2.	Assam			1.	Kamrup
				2.	Patna
3.	Bihar			3.	Muzaffarpur
				4.	Bhagalpur
				5.	Hazaribagh
4.	Gujarat	5.	Rajkot		
		6.	Ahmedabad		
		7.	Baroda		
		8.	Jamnagar		
		9.	Surat		
		10.	Kheda		
		11.	Dangs		
		12.	Gandhinagar		
5.	Haryana	13.	Mohindergarh	6.	Rohtak
		14.	Ambala	7.	Hissar
				8.	Sirsa
				9.	Gurgaon
				10.	Sonepat
6.	Himachal Pradesh			11.	Simla
				12.	Kangra
				13.	Mandi
				14.	Kulu
				15.	Chamba
				16.	Sirmur
				17.	Bilaspur
				18.	Una
				19.	Hamirpur
				20.	Solan
				21.	Lahaul & Spiti
				22.	Kinnaur
7.	Karnataka			23.	Bangalore
				24.	Mandaya
				25.	Dharwar
				26.	Mysore
				27.	South Kanara

1.	2.	3.	4.	5.	6.
8.	Madhya Pradesh			28.	Indore
				29.	Bilaspur
				30.	Jabalpur
				31.	Bhopal
				32.	Gwalior.
9.	Maharashtra	15.	Kholapur		
		16.	Ratnegiri		
		17.	Wardha		
		18.	Amravati		
		19.	Akila		
10.	J & K.			33.	Srinagar
				34.	Jammu
11.	Kerala			35.	Trivandrum
				36.	Calicut
12.	Punjab	20.	Rupnagar		
		21.	Kapurthala		
13.	Manipur			37.	Imphal
14.	Mizoram			38.	Aizwal
15.	Orissa			39.	Cuttack
				40.	Sambalpur
				41.	Ganjam
				42.	Berhampur
16.	Rajasthan			43.	Jaipur
				44.	Tonk
				45.	Ajmer.
17.	Tripur			46.	Agartala
18.	Uttar Pradesh	22.	Lucknow		
		23.	Allahabad		
		24.	Meerut		
		25.	Agra		
		26.	Varanasi		
		27.	Jhansi		
		28.	Gonda		
19.	Tamil Nadu			47.	Salem
				48.	S. Arcot
				49.	Madurai
				50.	Kanyakumari
				51.	Chingleput
20.	West Bengal			52.	Nadia
				53.	Hooghly
				54.	Howrah
				55.	Bribhum
				56.	Murshidabad.

1.	2.	3.	4.	5.	6.
21.	Delhi			57.	Delhi
22.	Goa, Daman & Diu			58.	Panaji
23.	A & N Islands			59.	Port Blair
24.	Arunachal Pradesh			60.	Passighat
25.	Nagaland			61	Pondicherry
26.	Pondicherry			62.	Kohima
27.	Chandigarh			63.	Chandigarh
28.	Lakshadweep			64.	Lakshdweep

No.M.13011/2/76-Trg.,
Government of India,
Ministry of Health and Family Welfare,
(Deptt. of F.W.)

...

New Delhi, dated the 13th June, 1977.

To

1. All Health Secretaries of States/UTs.
2. All Directors of Health Services/States and U.Ts.
3. All State Family Welfare Officers.
4. All Regional Directors (FWMCH).
5. All Central Training Institutions.
6. All Health and Family Planning Trg. Centres.
7. National Institute of Health and F.P. New Delhi.

Subject:- List of Districts selected in the 2nd phase under Multipurpose Workers Scheme.

...

Sir,

In continuation of this Department's letter of even number dated the 10th/12th January, 1977, whereby a modified uptodate list of districts selected for implementation of multipurpose workers scheme during first phase was communicated, now I am to enclose herewith a list of districts selected in the first phase and proposed by the States to be taken up in the 2nd phase. It may be mentioned here that multipurpose workers scheme would be implemented fully in these districts only if it has been implemented fully in all the districts selected in the Ist Phase (although the training may be continued in the 2nd group of districts) if it has been completed on the first group. The States which have not proposed are requested to send the names of districts in which they want to implement MPWs in the second phase.

Yours faithfully,

Sd/- P.K.Karthiyani
(Smt.P.K. Karthiyani)
for Addl. Secy. and Commr. (F.W.)

Enclosures: As above.

Annexure III

List of districts selected in the First Phase and proposed by the States to be taken up in the second phase.

....

Name of the State/U.T.	Sr.No.	Name of the districts, selected in Ist Phase.	Sr.No.	Name of the districts proposed by the States to be taken up in 2nd Phase.
1.	2.	3.	4.	5.
Andhra Pr.	1.	E.Godawari	1.	Hyde-rabad.
	2.	Nellore.	2.	Vishkapatnam.
	3.	Nalgonda	3.	Kurnool.
	4.	Chitoor.	4.	Guntur.
Assam.	5.	Gauhati.		
Bihar.	6.	Patna		
	7.	Muzzaffarpur.		
	8.	Bhagalpur.		
	9.	Hazaribagh.		
Gujarat.	10.	Rajkot.	5.	Junagarh.
	11.	Ahmedabad.	6.	Surendra Nagar.
	12.	Baroda.	7.	Dargs.
	13.	Jamnagar.	8.	Mahesena.
	14.	Surat.	9.	Sabarkanta.
	15.	Kheda.	10.	Bhavnagar.
			11.	Bharuch.
			12.	Bulsar.
			13.	Gandhinagar.
			14.	Kutch.
			15.	Banskhanta.
			16.	Amroli.
			17.	Panch Mahal.
Haryana.	16.	Mohindergarh.		
	17	Ambala.		
	18.	Rohtak.		
	19.	Hissar.		
	20.	Sirsa.		
	21.	Gurgaon.		
	22.	Sonepat.		
Himachal Pr.	23.	Simla		
	24.	Kangra.		
Jammu& Kashmir.	25.	Srinagar.		
	26.	Jammu.		
Kerala.	27.	Trivandrum.		
	28.	Calicut.		
Karnataka.	29.	Bangalore.		
	30.	Mandhya.		
	31.	Hubli(Dharwar).		
	32.	Mysore.		
	33.	Mangalore.		

Madhya Pradesh.	34.	Indore.	18.	Dhar.
	35.	Bilaspur.	19.	Danoh
	36.	Jabalpur.		
	37.	Bhopal.		
	38.	Gwalior.		
Maharashtra.	39.	Kolhapur.	20.	Poona.
	40.	Ratnagiri.	21.	Nasik.
	41.	Wardha.	22.	Nagpur.
	42.	Amrawati.	23.	Aurangabad.
	43.	Akola.	24.	Thana.
			25.	Ahmednagar.
Manipur.	44.	Imphal.		
Mizoram.	45.	Aizwal.		
Orissa.	46.	Cuttack.		
	47.	Sambhalpur.		
	48.	Ganjim.		
	49.	Ballasore.		
Punjab.	50.	Rupnagar.	26.	Jullunder.
	51.	Kapurthala.		
Rajasthan.	52.	Jaipur.		
	53.	Tonk.		
	54.	Ajmer		
Tripura.	55.	Agartala.		
Uttar Pradesh.	56.	Lucknow.	27.	Fatehpur.
	57.	Allahabad.	28.	Etah.
	58.	Meerut.	29.	Jaunpur.
	59.	Agra.	30.	Bahraich.
	60.	Varanasi.	31.	Ghaziabad.
	61.	Jhansi.	32.	Bulandshahr.
	62.	Gonda.	33.	Lalitpur.
			34.	Jalaun.
			35.	Pratapgarh.
Tamil Nadu	63.	Salem.		
	64.	S. Arcot.		
	65.	Madurai.		
	66.	Kanya-Kumari.		
	67.	Chingleput.		
West Bengal.	68.	Nadia.		
	69.	Hooghly.		
	70.	Howrah.		
	71.	Birbhum.		
	72.	Murshidabad.		

...3/-..

1.	2.	3.	4.	5.
Delhi.	73.	Delhi.		
Goa, Daman & Diu.	74.	Panaji.		
A&N Islands.	75.	Port-Blair.		
Arunachal Pradesh.	76.	Passighat.		
Pondicherry.	77.	Pondicherry.		
Nagaland.	78.	Kohima.		
Chandigarh.	79.	Chandigarh.		
Lakshdweep.	80.	Lakshdweep (5 Islands).		

Agenda Item No.II.

FAMILY WELFARE PROGRAMME

NEW APPROACH

CONFERENCE OF HEALTH SECRETARIES

OF

STATES AND UNION TERRITORES

28th July 1977

CONTENTS:

XI

FAMILY WELFARE PROGRAMME

Introduction

Family Welfare Programme will continue to occupy a central place in the overall efforts of the Government to improve the lot of our country men. The revised Policy on Family Welfare Programme lays stress on this aspect and says "It must embrace all aspects of Family Welfare, particularly those which are designed to protect and promote the health of mothers and child. It must become a part of the total concept of positive health." The emphasis is on welfare through education and enlightenment of public opinion. The availability of services both for contraception and for maternity and child health will have to be ensured to the people. There is absolutely no place for any kind or compulsion or coercion in the promotion of contraceptive practices and all methods including 'संयम' and 'इच्छित निरोध' should be promoted.

The revised Policy of the Government provides for raising the minimum age of marriage from 18 to 21 for boys and from 15 to 18 for girls. The compensation for voluntary sterilisation and IUD insertion will be payable at the revised rates comm-unicated recently. Population education in schools and among the general public will receive special attention. The participation of voluntary organisations and organised sector institutions has to be made more active and for this purpose new ways shall have to be identified.

In order to ensure that the implementation of the Family Welfare Programme including stabilisation of population size is given its rightful place in the scheme of things, it has been provided in the revised Policy also that the 1971 Population figures will continue to be treated as the basis till the year 2001, for purposes of allocation of resources between the Centre and the States wherever population is a factor. Moreover 8% of the Central assistance for State plans will be linked to their performance in the field of Family Welfare Programme. This is with a view to ensure continued and purposeful efforts towards achieving the overall national objective of reducing the birth rate to a level of 30 per thousand by 1979 and 25 per thousand by 1984. It is with this objective that the suggested levels of performance have been indicated under different methods of contraception and there should be full realisation that the important thing is not to count the number of heads but to achieve the desired reduction in the birth rate.

Agenda Item No.II(i) Suggested levels of Performance and its Implications

The Objective laid down in the Fifth Five-Year Plan is to bring down the birth rate to 30 per 1000 of population by 1978-79. Keeping this in view, targets of 18.5 million Sterilisations, 5.7 million IUD Insertions and 10 million CC Users were initially fixed for the plan period. During the first three years of the Fifth Five-Year Plan, the actual performance was 12.1 million sterilisations, 1.6 million IUD Insertions and 3.5 million C.C. Users. It is estimated that as of March, 1977, 27.2 million couples, comprising of 21.9 million under sterilisations, 1.8 million under IUD and 3.5 million under CC were currently protected under the Programme. These constituted 25.6% of the thotal eligible couples in the country. Considering the use-effectiveness of the various methods, it is further estimated that 25.4 million or 23.9 million of the total were effectively protected.

2. As a result of the Programme performance since its inception, it is estimated, about 29 million births have been averted upto March, 1977, of which about 12.5 million were averted during the first three years of the Fifth Plan. Consequently the birth rate must have come down to 34.3 per 1000 of population in 1976-77. This compares well with the estimate of 35.2 given by the Sample Registration System for the year 1974-75. In order to achieve the desired objective of bringing down the birth rate to 30 per 1000 population by 1978-79, further progress has to be made to step up the coverage of the Programme. Statement I indicates the demographic implications of certain suggested levels of performance for the years 1977-78 and 1978-79. It shows that even to arrive at a birth rate of 30.5, about 10 million sterilisations and 2 million IUD insertion will have to be made over these two years and the number of CC users will have to be stepped up to about 6 million by 1978-79. That would raise the number of couples currently protected to near about 38 million or 34 per cent of the total.

3. The Government of India announced towards the end of March 1977 that the Family Planning Programme should be conducted henceforth as a Family Welfare Programme on a wholly Voluntary basis without any recourse to compulsion or coercion. The Conference of State Health Ministers held in April, 1977 has accordingly approved the suggested Performance levele of 4 million voluntary sterilisations, 1 million IUD insertions and 5 million CC Users (including oral pill users) for 1977-78.

A brief review of the performance of family welfare programme in India in 1977-78 (April & May, 77)

The table below summarises the progress under the family welfare programme in India during the first two months (April & May 77) of 1977-78 interms of the achievement of proportionate expectations and the trend in the current year's performance as compared to that in the corresponding period of last year.

Method	Suggested level of achievement for 1977-78	1976-77	Achievement in 1977-78* (April May,1977)	1976-77 (Corresponding period)	Percent decrease	Percent achvt. of proprtionate level (77 - 78)
Voluntary sterilisation	4,000,000	4,299,000	90,328	262,956	(-)65.6	13.5
IUD	1,000,000	1,136,700	27,912	60,466	(-)53.8	16.7
CC users @ (free distribution only)	3,400,000	3,190,300+	1,111,312	1,655,577	(-)32.9	33.7

@ for April,77 only.

* Figures provisional.

\+ includes oral also.

It may be seen from the above statement that the performance has gone down considerably in the current year in all the three methods as compared to that in the corresponding period of last year. This is true for all States/UTs except A&N Islands & D.N. Haveli in respect of Sterilisation, Punjab & D.N. Haveli in respect of IUD and Gujarat, Kerala and Pondicherry in case of CC users. In terms of achievement only 13.5% and 16.7% of the proportionate expectations have been achieved for voluntary sterilisation and IUD and 33.7% for CC users. It is thus seen that the programme performance needs to be stepped up considerably and, what is more closely and intensively monitored. The reporting of the monthly performance has considerably slackened since February'77 and needs to be expedited so as to conform to the target dates prescribed for the purpose by the Govt. of India viz. 15th of the succeeding month. As of 16th only one state and one U.T had reported the performance in June'77.