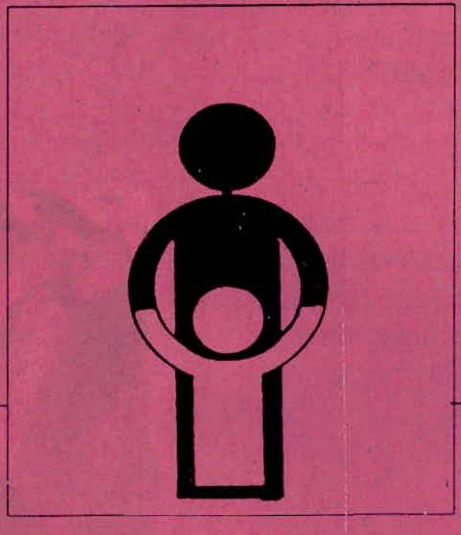
NATIONAL CHILD SURVIVAL
AND SAFE MOTHERHOOD PROGRAMME

PLAN AND IMPLEMENT MCH SERVICES



Ministry of Health and Family Welfare
Government of India
New Delhi
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GOALS AND COMPONENTS OF THE CHILD SURVIVAL AND SAFE MOTHERHOOD PROGRAMME

GOALS

- **Infant mortality rate** reduced from 81 to 75 by 1995 and 50 by 2000.
- **Child (1-4 years) mortality rate** reduced from 41.2 to < 10 by 2000.
- **Maternal mortality rate** reduced from 400 to 200/100,000 by 2000.
- **Polio eradication** by 2000.
- **Neonatal tetanus elimination** by 1995.
- **Measles** - prevention of 95% deaths and 90% cases by 1995.
- **Diarrhoea** - prevention of 70% deaths and 25% cases by 2000.
- **Acute respiratory infections** - prevention of 40% deaths by 2000.

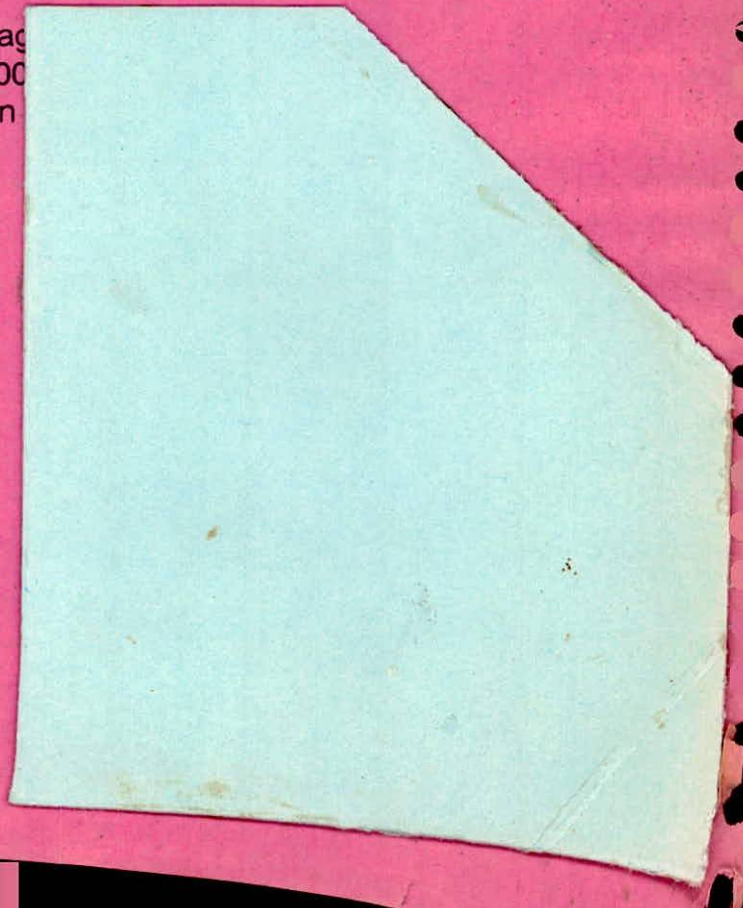
Components of this package would be:

Children

Newborn care at home - warmth and feeding.
Primary immunization by 12 months - 100% coverage
Vitamin A prophylaxis (9 months to 3 years) - 100% coverage
Pneumonia - Correct case management at home/health facilities.
Diarrhoea - Correct case management at home/health facility; ORS in every village.

Pregnant Women

Immunization against tetanus - 100% coverag
Anaemia prophylaxis and oral therapy - 100
Antenatal check-up - at least 3 check-ups in
Referral of those with complications
Care at birth - promotion of **clean** delivery
Birth timing and spacing



PLAN AND IMPLEMENT MCH SERVICES

ADAPTED FROM WHO MODULE

PLAN AND IMPLEMENT
MCH SERVICES

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List of abbreviations

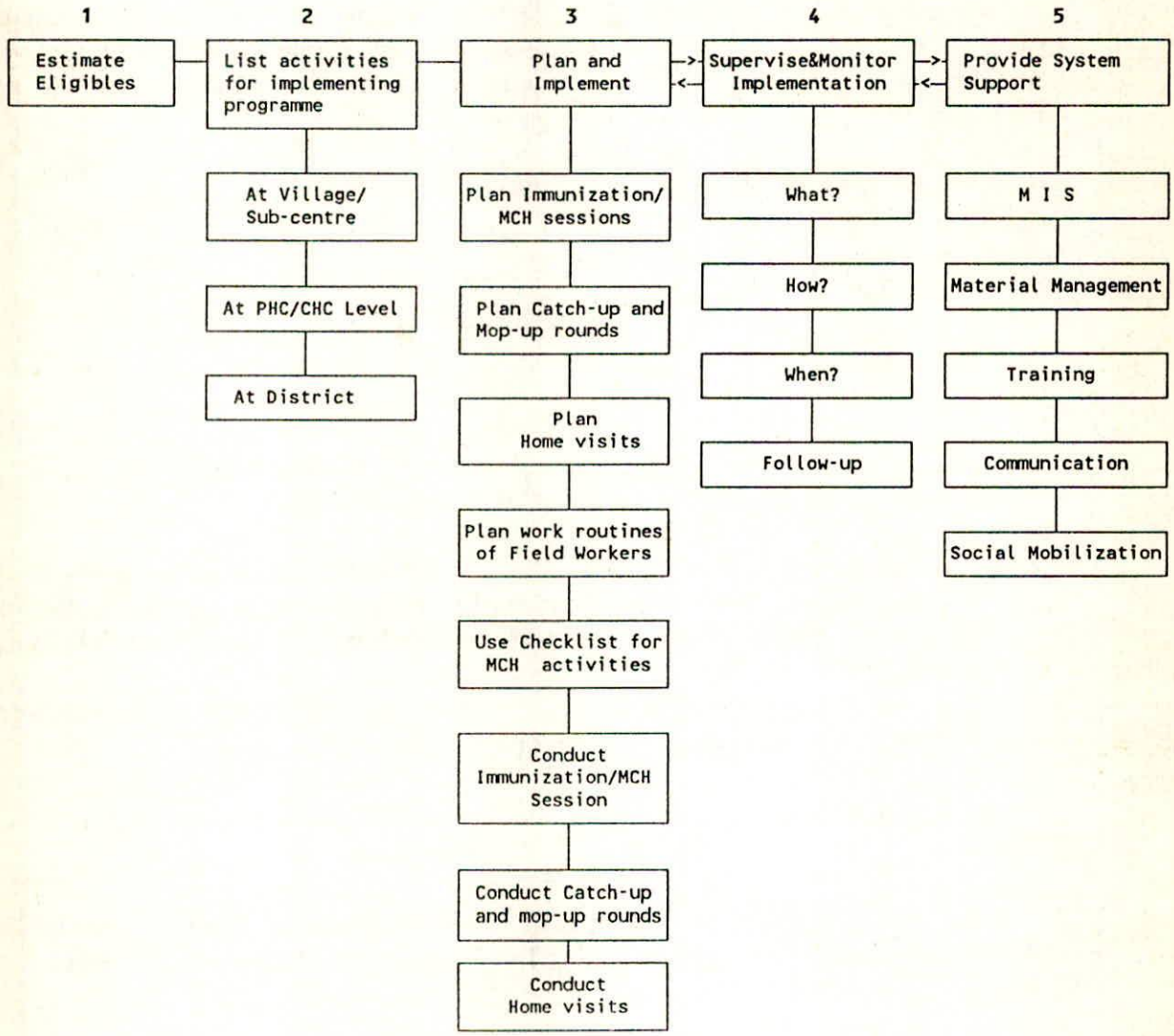
ANC	-	Ante-natal Care
AWW	-	Anganwadi Worker
AE	-	Adult Education
BCG	-	Bacillus Calmette Guerain
BEE	-	Block Extension Educator
BDO	-	Block Development Officer
CDPO	-	Child Development Project Officer
CHC	-	Community Health Centre
CMO	-	Chief Medical Officer
CHAI	-	Catholic Hospital Association of India
DRDA	-	District Rural Development Agency
DHO	-	District Health Officer
DWCRA	-	Development of Women and Children in Rural Areas
EDD	-	Expected Date of Delivery
FOGSI	-	Federation of Obstetrics and Gynaecology Societies in India
FWC	-	Family Welfare Centre
HW(F)	-	Health Worker (Female)
HQ	-	Headquarters
IAPSM	-	Indian Association for Preventive and Social Medicine
IFA	-	Iron and Folic Acid
IUD	-	Intra Uterine Device
ICDS	-	Integrated Child Development Services
IMA	-	Indian Medical Association
IAP	-	Indian Academy of Paediatrics
LBW	-	Low Birth Weight
LHV	-	Lady Health Visitor
MPW	-	Multi-purpose worker
MIS	-	Management Information System
MO	-	Medical officer
MCH	-	Maternal and Child Health
MS	-	Mukhya Sevika
NFE	-	Non Formal Education
NGO	-	Non Governmental Organization
NSS	-	National Service Scheme
NSSO	-	National Sample Survey Organization
NCC	-	National Cadet Corps
ORT	-	Oral Rehydration Therapy
ORS	-	Oral Rehydration Salts
OPV	-	Oral Polio Vaccine
PHC	-	Primary Health Centre
PNC	-	Post Natal Care
PPC	-	Post Partum Centre
PO	-	Programme Officer
SC	-	Sub-centre
TT	-	Tetanus Toxoid
TBA	-	Traditional Birth Attendant
TV	-	Television
UBS	-	Urban Basic Services
VHG	-	Village Health Guide

CONTENTS

PLAN AND IMPLEMENT

INTRODUCTION

This module will enhance your skills in planning and implementing delivery of child survival and safe motherhood services in the area of your responsibility. The five key components of this module are shown in the flow chart given below :



For a good plan, it is necessary for you to understand the details of various activities carried out by health workers in their sub-centre areas; hence you will, in this module, learn about activities at the sub-centre and then those at the PHC and finally at the district. You should read the Manual for Health Workers carefully so that you can support, supervise and monitor your health workers better.

Learning Objectives

You will acquire skills to plan, implement and monitor child survival and safe motherhood services in the area for which you are responsible.

As a manager of child survival and safe motherhood programme it is your responsibility to schedule immunisation/MCH sessions and to ensure the following:

- **All pregnant** women receive essential ante-natal care including TT immunization and Iron & Folic Acid tablets (IFA) and those with complications are promptly identified and referred to a facility with requisite manpower and capability to handle such complications.

- **All deliveries** are conducted observing the 5 CLEANS i.e.

    * clean surface
    * clean hands
    * clean razor blade
    * clean cord tie
    * clean cord stump - no applicant

- **All women in the reproductive age** group have access to information and services for contraception to ensure birth timing, spacing, and limiting.

- **All newborns** are weighed at the time of birth and are initiated with breast-feeding early, given home-level care (warmth and feeding) if birth weight is between 2000 and 2500 gms and are referred to a paediatrician if birth-weight is less than 2000 gms.

- **All infants** receive immunization against the six vaccine preventable diseases covered under UIP before completing one year of age.

- **All children** less than five years have correct case management and access to ORT/ORS packets when they suffer from diarrhoea.

- **All children** in the age group 9 months to 3 years receive five doses of Vitamin A at six monthly interval and those suffering from Vitamin A deficiency two extra mega doses.

- **All children** less than 5 years suffering from pneumonia have correct case management and have access to cotrimoxazole and referral when seriously ill.

This module describes tasks and organization of work routines which should be performed to achieve universal coverage under child survival and safe motherhood programme. You may have other responsibilities in addition to this programme, therefore the tasks and work methodology described here should be co-ordinated and performed in conjunction with other tasks.

PLANNING FOR CHILD SURVIVAL AND SAFE MOTHERHOOD PROGRAMME

Success of the programme will depend on the thoroughness of plans made by you. Various activities must be done correctly and in time.

To prepare a plan of action you should have the following information at sub-centre, PHC/CHC and district levels.

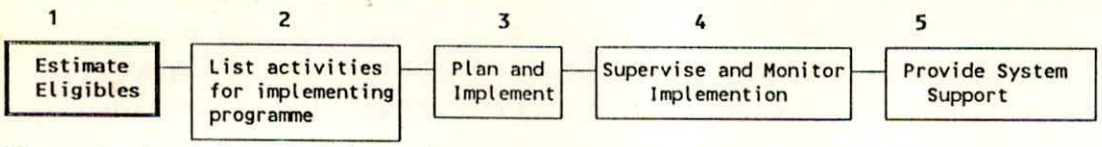
- The number (determined by enumeration) of pregnant women, infants, children between 9 months and 3 years of age and children less than 5 years of age.
- Manpower in the health system and in other sectoral programmes.
- Health facilities - their functional status as referral institutions for children and pregnant women.
- Availability of supplies and support systems.
- Geographical terrain, accessibility of different areas and communication facilities.
- Resources and assistance that can be tapped from other sources.

Tasks related to Management Information System (MIS), materials management and training have been discussed in brief only, as they have been described in greater detail in other modules.

Please take a few minutes to look at the flow chart so that you understand the relationship between various activities.

Several tasks can be done simultaneously and they need not follow the order given in the flow chart. For example major tasks 3, 4 and 5 can be done simultaneously.

1.0 ESTIMATION OF ELIGIBLES



Your aim is to ensure universal coverage of various components of Child Survival and Safe Motherhood programme. In order to do this you must have an estimate of number of pregnant women, infants, children less than 3 years and children less than 5 years. You should be able to estimate these eligibles in each one of the following areas:

* sub-centre area
* PHC area
* CHC (block level) area and
* District

The number can be enumerated from total population for the area based on these norms:

NO.	BENEFICIARY	PROPORTION OF TOTAL POPULATION	SERVICES PROVIDED
1.	Pregnant Women	3.2 %	Essential ANC, referral for complications, 100% coverage with TT & IFA tablets, Anaemia therapy
2.	Live-births and post-natal cases	3 %	Safe delivery with 5 cleans, referral, identify & care LBW render post-natal care
3.	Infants alive at 1 year	92% of livebirths	100% coverage against six vaccine preventable diseases
4.	Children 9 months to 3 years	8%	Booster-DPT/OPV to child 1-2 years 5 doses of Vitamin A to all 2 doses of Vit A for deficiency
5.	Children below five years	13%	Correct case management for diarrhoea and pneumonia. Access to ORT/ORS;ORS depot in every village

EXAMPLE

Using the norms given above, estimation of beneficiaries in a sub-centre area of 5,000 population.

Pregnant women - It is expected that 160 pregnant women will be in a sub-centre area in one year

$$\frac{(5000 \times 3.2)}{100} = 160$$

Livebirths - There will be 150 live births in one year.

Infants alive at one year - About 138 infants will be alive at age one.

Children 9 months - 3 years - About 400 children in this age group will be enumerated.

Children less than 5 years - There will be 650 children in this age group.

1.1 EXERCISE A

Estimate the number of beneficiaries in a PHC area of 30,000 population and a CHC catering to 100,000 population. Use the space provided below for calculations:

BENEFICIARY	PHC - 30,000 POPULATION	CHC - 100,000 POPULATION
Pregnant Women		
Livebirths		
Infants alive at 1 Year		
Children 9 months - 3 years		
Children less than 5 years		

Work space for EXERCISE A

1.2 READY RECKONER FOR ESTIMATING ELIGIBLES IN A YEAR

BENEFICIARY	SUB-CENTRE 5,000 Population	PHC 30,000 population	CHC 100000 population	DISTRICT 2000000 population
Pregnant Women	160	960	3,200	64,000
Livebirths	150	900	3,000	60,000
Infants alive at 1 Year	135	810	2,700	54,000
Children 9 months - 3 Years	400	2,400	8,000	160,000
Children less than 5 years	650	3,900	13,000	260,000

1.3 COMPARE ESTIMATED ELIGIBLES WITH ENUMERATED ELIGIBLES

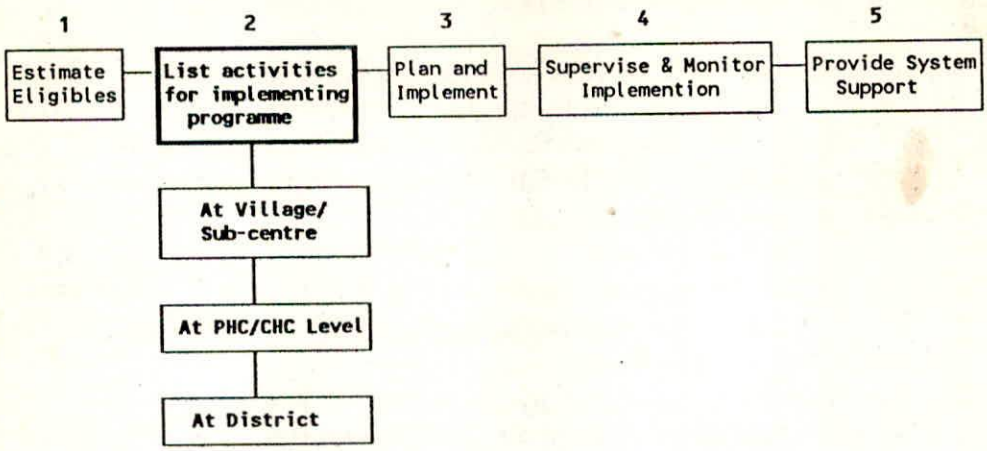
You should compare the **estimated eligibles** with the number of **eligibles actually enumerated by health worker** (with the help of VHG, TBA and AWW) to ensure completeness of registration.

At any given time all (i.e. 100% of the estimated number) infants and pregnant women[1] should be registered. There can be a variation of 10% from your estimates due to differences in age and sex structure of any population. However, if the number enumerated by a worker differs from the number estimated by you by more than 10% you should get the lists checked and updated by the health supervisor immediately.

You should encourage your health workers to use the mother-infant immunization card to enumerate the eligible pregnant women and children in her area. Use of mother-infant immunization cards for enumeration is a very effective tool for social mobilization. Your health workers while carrying out this process will be able to inform the beneficiaries and their family members about various services that are essential and are available as a part of the child survival and safe motherhood programme.

[1] At any given point of time during enumeration, you will be able to enumerate at least 50% of all pregnant women who are likely to deliver in one year. This is because pregnancy is a 9-months event and most women in India will be willing to acknowledge their pregnancy around the third month. Under the programme, you should ensure that pregnancy is enumerated and registered as early as possible, i.e. between 12 and 16 weeks.

2.0 LIST OF ACTIVITIES FOR IMPLEMENTING PROGRAMME



A detailed plan of action including **who** will do **what, when, where** and **how** is the logical first step to ensure proper implementation of your programme.

You should determine who is responsible for various components of the programme. Hence you will have to define tasks and responsibilities. You will make a list of activities and allocate responsibilities to your staff. Following is the list of activities that will have to be undertaken at different levels :

2.1 AT VILLAGE/SUB-CENTRE LEVEL

- Enumerate eligibles
  - children in the age groups
    - 0-1 year
    - 1-3 years
    - 3-5 years
  - pregnant women
  - women in the reproductive age group (15-45 years)
- Identify and meet influencers
- Meet villagers and establish rapport
- Attend mothers' meetings
- Identify communication sites for wall-paintings and hoardings
- Identify drop-outs and non-participants in various maternal and child health activities

- Conduct immunization/MCH sessions [2]

  * Immunize all eligible children and pregnant women
  * Administer Vit A first dose along with measles dose
  * Administer Vit A second dose along with DPT/OPV booster dose
  * Administer Vit A third to fifth doses to children between $1^1/_2$ to 3 years at six-monthly intervals
  * Administer two doses of Vit A at monthly interval to those with signs of Vit A deficiency (diagnosed during home visits or MCH sessions)
  * Give IFA tablets to all pregnant women for prophylaxis (@ 1 tablet every day for 100 days)
  * Diagnose anaemia in pregnant women clinically
  * Give IFA tablets to all anaemic pregnant women (@ 2 tablets every day for 100 days)
  * Make available ORS packets to the village-based depot holder and dispense directly in case child with diarrhoea presents
  * Assess child with acute respiratory infections (in case it presents during the session) and treat with cotrimoxazole tablets
  * Give OPV to all children below 3 years regardless of their immunization status twice in a year (at a gap of one month) in case the village falls under a polio eradication area.

- Conduct home visits

  * Identify priority houses and visit them
  * Motivate beneficiaries for availing services during Immunization/MCH sessions and sub-centre clinics
  * Meet village level workers - Traditional Birth Attendant (TBA), Village Health Guide (VHG), Anganwadi Worker (AWW), Village-level Informants

- Conduct community-based surveillance activities for cases and deaths due to vaccine-preventable diseases, pneumonia, diarrhoea, and neo-natal and maternal deaths (described in detail in the module 'Conduct Disease Surveillance').

- Organize activities for control of outbreaks/epidemics

- Identify depot holders for ORS, contraceptives and provide supplies.

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[2]One such session should be carried out in every village at least once a month. In larger villages, i.e. with population more than 2000, more than one session will be necessary. In smaller villages, i.e. with population less than 1000, the Immunization/MCH session may be combined with similar sessions organized in a neighbouring village on the same day.

- Register births, deaths and vital events

- Line list cases of poliomyelitis as well as neo-natal and maternal deaths. Initiate filling up of respective investigation forms.

- Provide supportive supervision and on-the-job training to village level health and support functionaries. Train TBAs at sub-centre/home deliveries for observing the 5 Cleans during delivery. In addition, TBAs will attend all mothers' meetings.

- Organize sub-centre clinics (once a week for MCH activities and at least once a month, immunization activities will also be carried out). In addition to various activities outlined in immunization/MCH sessions, the following will be done:

  * Provide ante-natal care

    . check up - blood pressure and weight
    . faetal growth and well-being through fundal height and faetal heart sounds
    . diagnose anaemia clinically and give therapy after deworming
    . identify complications and refer to the identified first level referral centre

  * Provide contraceptive services such as insertion of intra-uterine device (Copper-T), provision of oral pills, and conventional contraceptives

  * Weigh low birth weight infants referred by village-level workers and advise warmth and feeding if weight between 2000 and 2500 gms and refer to a hospital with paediatrician if weight below 2000 gms

  * Assess dehydration in a child with diarrhoea and ensure correct case management and referral

  * Assess a child with acute respiratory infection and ensure correct case management and referral

- Maintain records, including daily dairy, and make monthly reports for submission to the PHC. Update mother and child care register every month.

2.2 AT PHC/CHC LEVEL

2.2.1 Prepare a plan of action for every PHC. For coverage of eligible infants as well as children upto 5 years and pregnant women, schedule Immunization/MCH sessions in every village at least once a month. Every village should be visited by your health worker for home visits as per criteria laid out under Section 3.3 (priority houses)

2.2.2 Prepare a schedule for sub-centre clinics, immunization/MCH sessions in villages and home visits in consultation with Medical Officers of your PHC and dispensaries as well as the health workers who are to run these sessions/clinics. You should also ensure that Immunization/MCH sessions in the villages and sub-centre clinics are organized in sub-centre areas which are at present without health workers. This will have to be done by redeploying certain health workers/supervisors for running these sessions/clinics and also for ensuring timely supply of vaccines and other supplies.

2.2.3 Mobilize resources and cooperation of other government departments, voluntary organizations, community leaders and others. This subject is covered in detail later (sections 5.4 and 5.5).

2.2.4 Brief your staff and explain the programme content, responsibilities and depute functionaries for a training programme (Section 5.3). Keep an updated list of trained functionaries in your area. Conduct continuing education during monthly meetings. Prepare a list of topics to be covered every month for training/orientation of your workers in consultation with the health supervisors and other medical officers. The topics will have to be need-based and appropriate to your local conditions.

2.2.5 Schedule catch-up rounds for immunization and other MCH activities in villages and sub-centre areas poorly covered for these services towards the end of the year. Schedule mop-up rounds for polio eradication activities as a part of your Immunization/MCH sessions and sub-centre sessions in districts identified for polio eradication.

2.2.6 Calculate, procure and distribute in time, required quantities of vaccines and other supplies, i.e. the drug kits for sub-centre (containing ORS packets, Vit A concentrated solution, cotrimoxazole tablets, IFA tablets) as well as IUDs, oral pills, and conventional contraceptives. Plan for replenishing specific items in the drug kit from sub-centres where some of these items may not be used to those which consume them earlier.

2.2.7 Arrange for required quantities of kerosene, ice packs, contingencies for mobility of staff, payment of reporting fee to TBAs, etc. You should also include in your plan by name, workers/supervisors who will be responsible for transporting vaccines, Vit A concentrated solution and IFA tablets to the

villages where immunization/MCH sessions will be conducted.

2.2.8 Ensure the use of mother-infant immunization card for enumeration and thus information, education and communication to mobilise the eligible beneficiaries to avail of various services under the programme. In addition, you will arrange for wall-paintings/hoardings and hand bills on the sessions and services organized in different villages. Emphasis on communication activities will have to be on action at individual level for self-help and acceptance of services and thus demand generation.

2.2.9 Monitoring and supervision of work done by your health workers and supervisors should be essentially for problem-solving and organizing the planned services without any disruption. You will monitor whether the planned Immunization/MCH sessions, sub-centre clinics and the home visits are being carried out regularly. If any of these sessions are missed, as a manager, you will try and determine the reasons and also make alternate plans to take care of the problems which led to missing certain sessions. You may use the supervisory check-list to assist in your work and to solve performance problems. This is also discussed later (Section 4.0).

2.2.10 Line list all cases of poliomyelitis as well as neo-natal and maternal detahs occurring in your area. Investigate all neo-natal deaths and poliomyelitis cases using standard proformae (Forms 12 and 13) Ensure that your health workers are carrying out community-based surveillance (through a system of village-level informants) for cases and deaths due to vaccine-preventable diseases, diarrhoea, and pneumonia as well as neo-natal and maternal deaths.

2.2.11 Prepare and analyse monthly monitoring report. Carry out various surveillance activities, including preparation of disease charts and maps. Support coverage evaluation surveys done in your area and use the information obtained to identify gaps in your services and take corrective action.

2.2.12 Make a list of hospitals closest to your PHC area (even if they are in a neighbouring district) for referring newborns with birth weight below 2000 grams and pregnancies with specific complications. This list should be then available and known to every health worker and other village level health and other sectoral workers.

2.2.13 Obtain from your district health officers, list of nearby health institutions which have vaccines and other MCH supplies storage facilities. This will be helpful in obtaining vaccines and other supplies such as Vit A concentrated solution, ORS packets, IFA tablets, cotrimoxazole tablets in case of an urgent need.

2.3 AT DISTRICT LEVEL

2.3.1 Prepare a plan of action for the district. This will be done by compiling the plans of action of all PHCs and urban areas in your district. While preparing the district plan of action, you will review the plans of action of all the PHCs in your area along with the medical officers in charge of these PHCs. Specific attention should be paid to ensuring scheduling of Immunization/MCH sessions in every village (once a month), sub-centre clinics in every sub-centre (once a week), and home visits to all priority houses in the village. The plan will also include action required for polio eradication (mop-up rounds), elimination of neo-natal tetanus, sustaining high levels of immunization coverage (catch-up rounds), training medical officers and health workers of the district, maintenance of cold chain and other equipment (e.g. anaesthesia, laboratory and operation theatre equipment in first level referral centres and sub-centre and PHC delivery kits). A sample format is given at the end of this module.

2.3.2 Mobilize resources and cooperation of other government departments, voluntary organizations and organized sectors (see Section 5.5).

2.3.3 Arrange briefing session with concerned officers of PHC, hospitals, medical colleges and other agencies including voluntary organizations.

2.3.4 Define tasks and responsibilities at district level. Identify a nodal person at the district level for coordinating various activities under the national child survival and safe motherhood programme. Coordinate the work of various agencies involved in similar tasks as functionaries of the health system.

2.3.5 Calculate the vaccine and other supplies (such as drug kits for sub-centres, ORS packets, IUDs, oral pills, etc.) requirement on the basis of number of beneficiaries and number of sessions. These have been discussed in detail in the module "Manage cold chain and other supplies".

2.3.6 Arrange for collection of vaccines, maintain cold chain and other supplies from WIC location. Distribute vaccines and supplies as per norms and requirements outlined in the module on "Manage cold chain system and other supplies".

2.3.7 You should also have a plan giving details of alternate vaccine storage locations, WICs, etc. in case of prolonged electricity failure, vaccine storage etc. This list should be shared with your colleagues in PHCs and CHCs of your district.

2.3.8 Check if all supplies and equipment required are available. You will ensure that your district has a good maintenance plan for equipment, spare part management system, and an effective logistics system for movement and managment of supplies. The objective of such a plan would be to ensure that services are delivered without disruption and that high quality and standards are maintained.

If there is a WIC in your district, it should be functional at all times. At any point of time, not more than 2% of ILRs/deep freezers could remain out of order. All break-downs will have to be attended immediately and minor repairs carried out within 7 days and major repairs within 21 days. As a district manager, it is your responsibility to ensure that these objectives are met. For this, you will have to ensure that you have access to adequate quantities of spare parts and float assemblies for carrying out repairs.

2.3.9 Make a list of all hospitals within the district and also in the neighbouring districts (which are close to the PHCs/CHCs of your district) which can act as referral centres to provide:

* emergency care and treatment to complications during pregnancy and delivery and
* newborns with complications, including low birth weight (<2000 grams).

Communicate to all functionaries in the district where these referral institutions are located.

2.3.10 Identify 10 medical officers and 20 other senior health functionaries within the district to constitute the district core training team. Arrange for their training in the district or any other location identified by the state MCH Officer.

2.3.11 Constitute five training teams out of the district core training team and organize training of all health workers and supervisors in the district at five different locations.

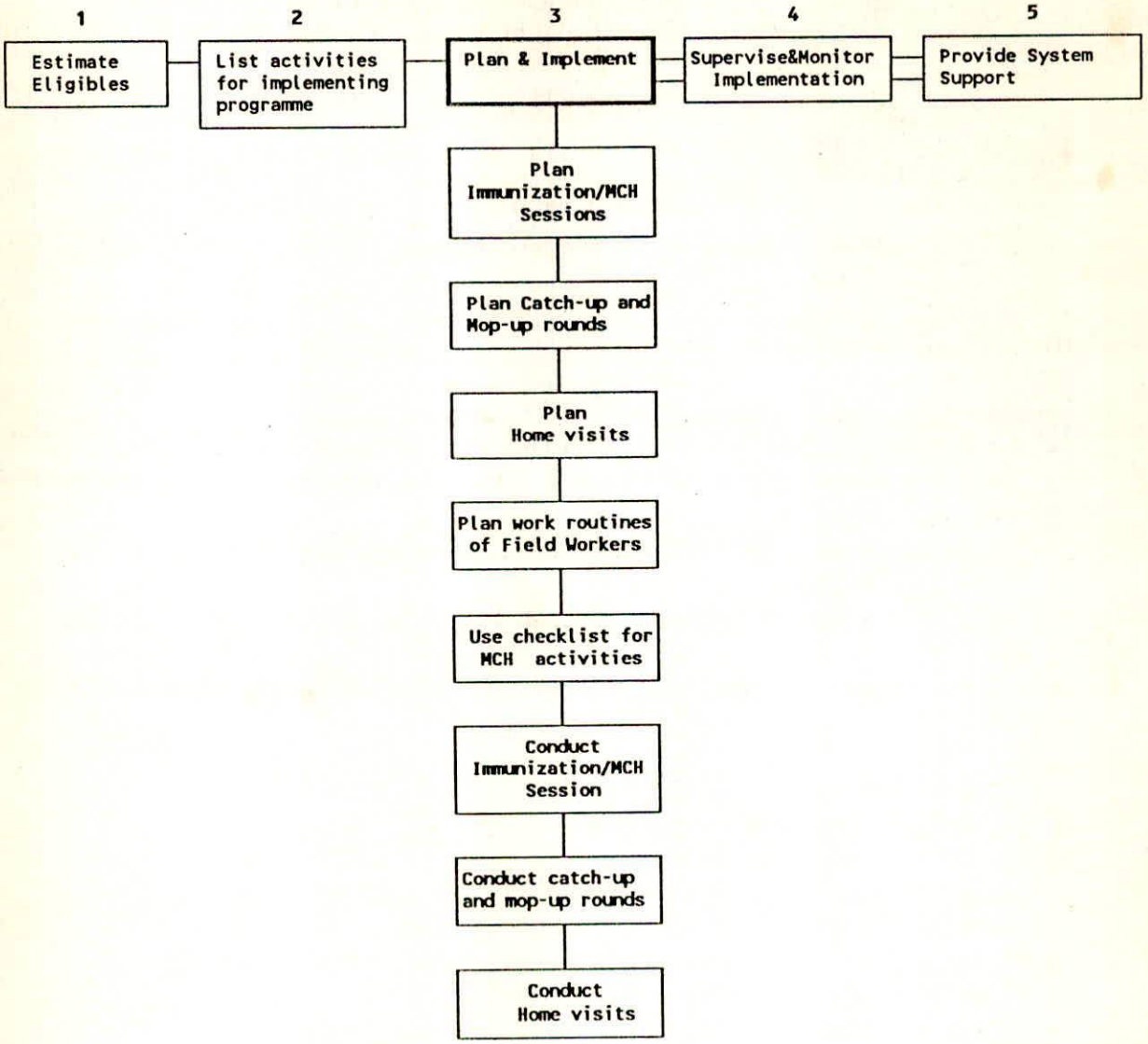
2.3.12 Arrange for investigation of cases of poliomyelitis, neonatal deaths and maternal deaths. Identify sentinel centres for surveillance, analyse and interpret surveillance data from routine monthly reports and sentinel surveillance reports.

2.3.13 Monitor and supervise activities at the PHC, sub-centre and village levels. Emphasis will have to be on ensuring carrying out of the schedules and identify problems which result in either missing sessions or outbreaks of diseases. You should as the district manager promote analysis of the problems and identification of solutions by your PHC medical officer. In case these solutions are not likely to yield results, you should point them out and suggest changes/remedies.

You will also receive, review, and analyse reports on services carried out in your area and surveillance for diseases and deaths. Based on your analysis and interpretations, you will give feedback to your health functionaries in the district. Sample check-lists for supervision have been provided in Section 4 of this module. You may use them for a comprehensive review/ supervision. Supervision should include on-the-job training of your health functionaries.

2.3.14 Conduct or facilitate coverage evaluation surveys as discussed in the module "Evaluate service coverage".

3.0 PLAN AND IMPLEMENT



Under the child survival and safe motherhood programme,you will ensure the following for your beneficiaries:

Pregnant women

I. Essential care for all

- o register by 12-16 weeks
- o check-up at least 3 times (BP, weight and fundal height)
- o immunize with 2 doses of TT

- o give prophylactic IFA tablets (@ 1 tablet a day for 100 days)
- o diagnose anaemia clinically and treat with IFA (@ 2 tablets a day for 100 days)
- o deworm with mebendazole (during 2nd/3rd trimester), if there is a history of passing worms
- o advise rest
- o care at birth ensuring 5 cleans
- o post-natal care, including advice and services for limiting and spacing births

II. Early detection of complications

- o clinical examination to detect anaemia
- o Bleeding indicating APH (before labour) or PPH (after delivery)
- o weight gain of more than 5 kg in a month or systolic BP more than 140 mm Hg
- o fever - 39°C and above after delivery (during post-partum) or after abortion
- o prolonged labour (for more than 24 hours) indicating obstruction

III. Emergency care for those who need it (in an institution - first level referral centre)

- o perform vacuum extraction
- o administer anaesthesia
- o give blood transfusion
- o perform caesarian section
- o perform manual removal of placenta
- o carry out suction curettage for incomplete abortion
- o insert intrauterine devices and
- o perform sterilization operations

All women (in the reproductive age group)

- o timing of births (between 20 and 30 years of age)
- o spacing of births (at least three years between successive pregnancies)
- o limiting of births (not more than two children)

Infants

Newborn care - Birth weight of all newborns within two days.

- o Exclusive breast-milk to be initiated within 2 hours of delivery and continued at least till the age of 4 months

- o Advise warmth and feeding at home if birth weight between 2000 and 2500 gms.
- o Referral to paediatrician if birth weight less than 2000 gms.

Immunization

BCG	-	1 dose at birth
DPT	-	3 doses beginning 6 weeks at monthly interval
Polio	-	3 doses beginning 6 weeks at monthly interval
Measles	-	1 dose at 9 months of age
Vitamin A		1 dose (100,000 I.U.) with measles dose

Children (1-3 years)

Vitamin A	-	2nd dose at 16 months with DPT/OPV booster 3rd to 5th doses at 6 monthly interval

Children(0-5 years)

IFA (small) tablets if anaemic
Correct Case Management including Home Available Fluids to those with diarrhoea and no dehydration and ORT/ORS for those to those with dehydration
Assess ARI and treat Pneumonia with Cotrimoxazole tablets

The programme is an integral part of primary health care and services are provided through existing health infrastructure. The programme will have to be continued on a long term basis and coverage levels sustained for many years. Please note that you will have to in your plan include redeployment of certain health workers/supervisors to areas with vacant posts to ensure that all eligible benificiaries in your area have access to the above-mentioned services.

3.1 PLAN IMMUNIZATION/MCH SESSIONS

You will provide immunization/MCH services both through fixed centres and through outreach sessions. Immunization sessions and MCH sessions can be held separately at the fixed centres according to the convenience of the community and the health functionaries. However, in outreach sessions it is desirable to organize a combined immunization and MCH session. In difficult areas it may be necessary to organize special campaigns to cover children and pregnant women.

Institutions which have vaccine storage facilities (ILRs/Deep Freezers) are termed as **fixed centres** for immunization.

All vaccines included in the programme, Vitamin A concentrated solution, IFA tablets, ORS packets, Cotrimoxazole tablets, Oral pills and conventional contraceptives should be available at every immunization/MCH session.

All immunization/MCH sessions organized in sub-centre area (including sub-centre HQ village) are termed as **outreach sessions** since sub-centres do not have any vaccine storage facilities.

Fix date and time of immunization/MCH sessions. Consult various members of the community before fixing the date and time. Remember if the date or time is not convenient, few will attend. Make sure that your workers conduct the sessions on the **designated day**. This **should be prominently displayed at the fixed centres.** In case of outreach operations, advance information must be given to the community and relevant workers.

Ask responsible persons in the community to identify contact person(s) for you. The contact person(s) should know when your worker will come; she (he) can inform mothers and other beneficiaries to avail of various services and find other people to help you. The contact person(s) should help your worker to collect eligibles in time at the immunization site.

Depending on the convenience and facilities available, it may be necessary to adopt a combination of strategies. Whatever strategies you may adopt, you should cover all eligible beneficiaries in your area. Please remember0xyou will have to sustain services and high levels of coverage.

Read the checklist of items to be carried for outreach sessions and ensure that your health workers have all these items. You will also take steps to deliver vaccines on the days of the sessions.

You should ensure that the planned Immunization/MCH sessions are conducted in every village.

3.2 PLAN CATCH-UP/MOP-UP ROUNDS

From time to time you will have to organise special campaigns in areas which cannot be covered either by fixed centres or by outreach operations. Teams of health workers move from village to village carrying adequate quantities of vaccines and other supplies. It may be necessary to mobilize manpower for a short period from other areas such as the district headquarters.

In certain villages/areas within your district, coverage levels for Immunization and MCH activities may be very low. Every effort should be made to ensure that no planned sessions are missed, and thereby coverage levels are sustained. However, due to a variety of reasons such as inaccessibility during rains/floods, etc., it may be necessary for you to schedule special sessions in certain villages or pockets to allow the coverage levels in these areas to catch up with those of other villages/areas of your district. You will plan such sessions only towards the end of your reporting year, i.e. based on the coverage levels obtained in the first 8 months of the year, the catch-up rounds will be planned for 3 successive months - 9th to 12th months of the year.

Polio eradication strategies

As a part of the fixed day Immunization/MCH sessions, you will organize communication/mobilization drives to give an additional OPV dose to all children below 3 years regardless of their previous immunization strategy. This will be done if your district has been identified as one of the districts to be taken up for polio eradication activities. Two successive rounds of such immunization at one-month interval will have to be organized. Additional doses of OPV will have to be made available. No individual records on doses given need to be maintained. Only tally marking and the reporting of total number of children so immunized will be done.

In case of an outbreak of poliomyelitis (in areas of coverage above 80%, even a single case of poliomyelitis will be treated as an outbreak), you will organize containment activities around the area where the polio case is detected for 2000-3000 children (to all children below 3 years) in urban areas and within a radius of 5 kms in low-density rural areas. The interval between the two rounds will be one month. The first round of OPV dose administration will have to be conducted within one week of onset of paralysis.

Mop-up rounds for polio eradication will be implemented in areas where coverage is relatively high and yet cases of acute poliomyelitis occur. These are to be implemented to replace the wild virus with the vaccine virus. They should be done before the epidemic season, which is generally between May and August. Therefore, the two mop-up rounds should be organized ideally during March and April when transmission is lowest. For each round, one dose of OPV is given to all the children less than 3 years (about 10,000 children in a PHC/block area) regardless of their immunization status.

3.3 PLAN HOME VISITS

Home visits of health workers, both female and male should be scheduled on fixed days of the month as noted in the section on planning of work routines for field workers. You will ensure that the health worker (female) is supported by health worker (male), TBA, VHG and AWW. You will also ensure that the HW(F) knows the "priority houses" to be visited. During supervisory visits you will assess the worker's knowledge and skill in providing relevant services to eligibles. If she is not able to perform a particular task efficiently, show her how to do it. Appreciate the worker for jobs done well.

It is necessary that the health worker during her field visits is able to use the time for effective delivery of services and to contact those who need services but do not avail of these during sessions. This is done by making a list of those houses which require priority attention. During home visits, your worker should not be visiting all houses in an area but economise her time by visiting a few for maximum effect.

PRIORITY HOUSES are those with any one of the following. Where there is

1. a pregnant woman (who is not enumerated or registered as yet)
2. a registered pregnancy with any of the complications **or** not attending MCH clinic for the second or third ante-natal visit in time.
3. a post-natal case not seen following delivery
4. a post-natal case with a low birth-weight baby
5. a new oral pill/IUD acceptor
6. a child with pneumonia
7. a child with diarrhoea
8. a child with vitamin A deficiency not turning up for the second therapeutic dosage
9. a mother of infant not turning up for various doses of immunization in time
10. a case referred to PHC/CHC/hospital by you during an earlier visit/clinic/session
11. a person acutely and serious ill
12. a couple who is a prospective client for any birth spacing, timing or birth limiting measure
13. a child who has adverse reaction to any immunization during a previous visit/session
14. a neonatal death
15. an infant, child or maternal deaths
16. a recent case of acute poliomyelitis

Before proceeding for home visits, the health worker should ensure that she has all the necessary items as per check-list included under Section 3.5.

EXERCISE B

Do steps 1 through 5. Check your answers with a course facilitator when you have completed step 5.

1. Determine the annual eligible population (number of children to receive immunizations for the year) for each village on the map shown on page 22. For this exercise, assume that the number of children to receive immunizations is 3% (0.03) of the total population. Use columns 1 and 2 of the worksheet provided on page 23 to do your work.

2. Determine the number of immunization/MCH sessions (minimum and maximum) to schedule for each of the villages on the map. Use columns 3 through 6 of the same worksheet you used for step 1.

   * Divide the annual target population of each village (from step 1) by 12 in order to determine the monthly target population (number of children to receive immunization doses per month) (column 3).

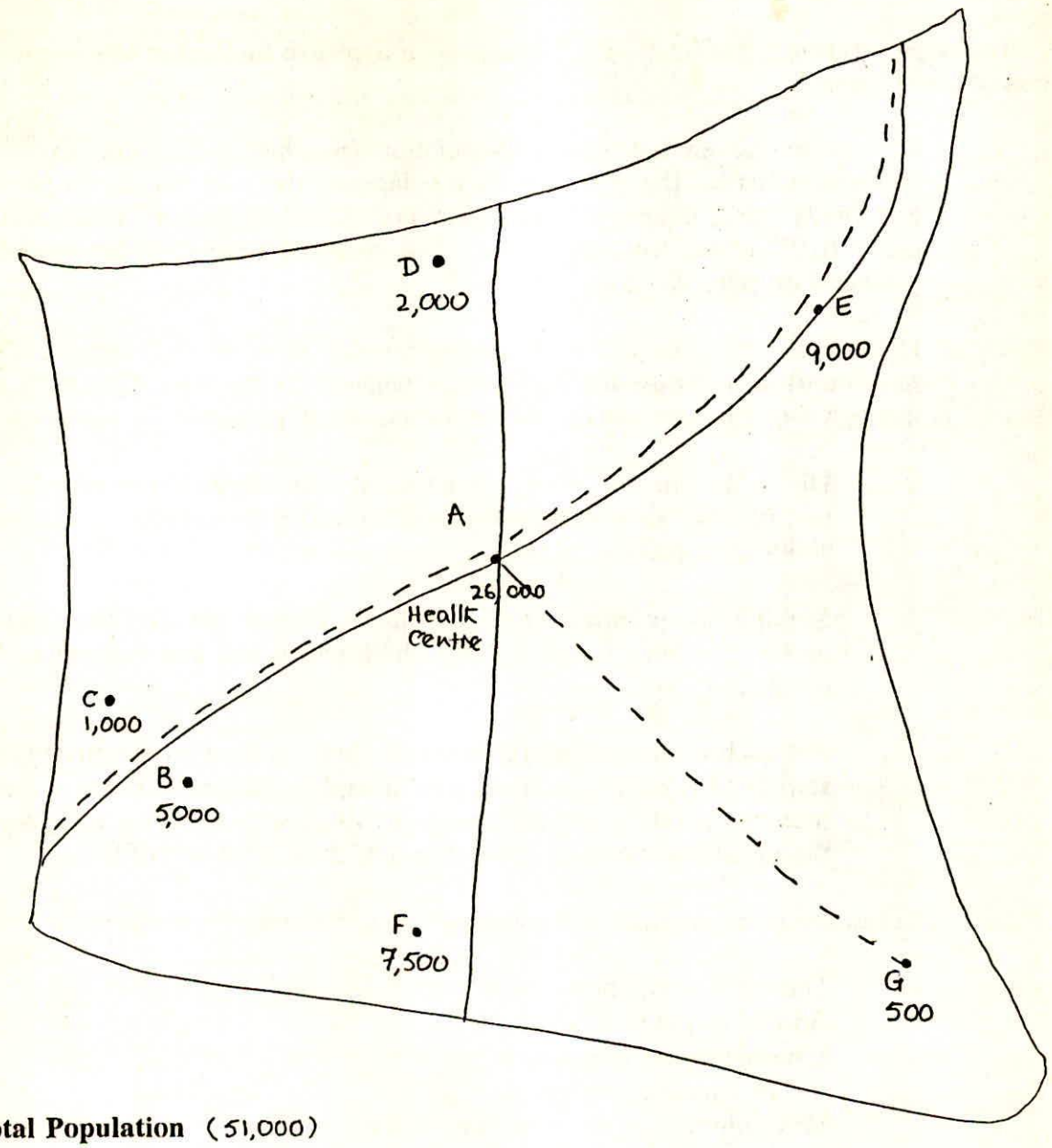
   * Multiply the monthly target population of each village (from step 2a) by the number of contacts per child, which you can assume to be 4 (column 4).

   * For each village, divide the total number of contacts per month (from step 2b) by 10/30 (the minimum or and maximum number of infants recommended for an immunization/MCH session). This will give you the maximum number of sessions per month (column 5).

   Following is an example of how steps 1 and 2 should be performed:

-	The total population of a village is	-	3,000
-	Annual target population	-	3,000 x 0.03 = 90
-	Monthly target population	-	90 / 12 = 7.5
-	No. of contacts per month	-	7.5 x 4 = 30
-	Maximum no. of sessions per month	-	30 / 10 = 3
-	Minimum no. of sessions	-	30 / 30 = 1
-	No. of immunization sessions[3] to schedule (minimum)	-	3 every month and 1 every month

[3] For a single immunization session, the minimum child immunization contacts should be 10 (to be cost-effective) and maximum could be 30 (to avoid complications due to worker fatigue).



Total Population (51,000)

Village A	:	26,000	Scale _____	10 Kilometers
Village B	:	5,000		
Village C	:	1,000	_____	All-weather Roads
Village D	:	2,000		
Village E	:	9,000	----------	Bus Routes
Village F	:	7,500		
Village G	:	500		

WORKSHEET FOR EXERCISE B, STEPS 1, 2 AND 3 (p.21)

Village	Population	Annual Infant Beneficiaries	Monthly Infant Beneficiaries / 12	Monthly Infant Contacts x 4	No.of Sessions to be scheduled Maximum / 10	Minimum / 30
Example : x	3,000	90	7.5	30	3 Every week	1 Once a month
A						
B						
C						
D						
E						
F						
G						

MCH SESSIONS SCHEDULE

[Including Vitamin A, ORS, Cotrimoxazole and IFA Tablets]

_____Health Centre

D A Y	M O R N I N G	A F T E R N O O N	E V E N I N G
SUNDAY			
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			

MCH SESSIONS SCHEDULE (FOR MAXIMUM SESSIONS)

Outreach activities for_____Health Centre

Village or Immunization Site	Day	Time	Person Responsible

3. Use your answers from steps 1 and 2 above to schedule immunization/MCH session for every village on the map. Be sure you schedule the appropriate number of sessions for each village. Assume that you have enough staff members to conduct as many immunization/MCH sessions as you need to. Also assume that you have talked to mothers in each village in order to determine which day and time would be most convenient for them to attend immunization/MCH sessions and that you have learnt the following:

Village A	-	Mothers prefer different days, but most can come in the morning.
Village B	-	The market is held on wednesday and saturday mornings. Mothers are too busy to come in the morning, but they can come in the afternoon.
Villages C, D and G	-	Mothers have time to come to the immunization during the market hours of saturday morning.
Village E and F	-	Markets are held on wednesday and saturdays, but mothers are too busy throughout the day to attend immunization/MCH sessions on those days.

As you determine the specific day and time for the immunization/MCH sessions for each village, fill in the spaces on the blank immunization/MCH session schedule forms provided on page 23. For this exercise **do not** write in the column labelled "person responsible", even though you will fill in this column when making immunization/MCH session schedules for your health centre.

4. List at least ten possible obstacles which could prevent Immunization/MCH sessions from being conducted as scheduled. Use the workspace provided on page 25 to do your work.

5. Describe the precautions you can take in order to prevent the problems which might arise from three of these obstacles. Use the workspace provided on page 25.

Workspace for answers to steps 4 and 5

4. Obstacles which prevent conduct of sessions

(i) _____ (vi) _____

(ii) _____ (vii) _____

(iii) _____ (viii) _____

(iv) _____ (ix) _____

(v) _____ (x) _____

5. Precautions you will take to overcome 3 of the above obstacles

(i) _____

_____

_____

(ii) _____

_____

_____

(iii) _____

_____

_____

3.4 PLAN WORK ROUTINES OF FIELD WORKERS

Broad principles for planning work routines are:

- Health worker (female) is the best worker available at village level. However to meet various objectives of child survival and safe motherhood programme you should ensure that she is able to take maximum help from four other workers available at village and SC levels - health worker (male), TBA, VHG and AWW. Many tasks can be shared amongst these functionaries at village level. Mothers' meetings at the village level provide very useful opportunities to share knowledge and responsibilities. The health worker (female) should ensure that these meetings are attended by all mothers of the village as well as the TBAs, VHG and AWW.

- Work routines of health workers - female and field supervisors should be scheduled and rationalized so that maximum number of eligibles receive services.

- During field visits, the workers should visit homes as per priority houses list on page 20.

Basic assumptions/premises for work routine scheduling:

- Field workers have approximately 24 working days in a month. The time taken for provision of immunization/MCH services would not need more than 16 days a month. This leaves 8 days for the field worker to attend meetings, maintain records, carry out activities related to family planning, etc.

- It is assumed that 4 hours of work can be carried out on a field visit day with the remaining time spent on travel. This time is sufficient for conducting home visits using the concept of priority houses visit.

- Health assistants (male & female) should spend a minimum of 8 working days per month in field supervision of which half should be working with health worker at clinic/session and half during home visits. Thus each health worker will receive support and on the job training from a supervisor twice in six weeks - once at a clinic and once during 'home visit'.

- Every PHC, CHC and district level medical officer should spend a minimum of 4 days a month in field work for the child survival and safe motherhood activities. The remaining time is adequate for administrative and curative work load. Thus, these visits can be enforced by the supervising officers at every level.

STEP 1 PREPARE THE WORKPLAN OF HW(F)

At the time of planning work routines of your health workers, you should have the following information:

* number of villages in the sub-centre area and their population
* distance between the PHC and HQ village and other villages
* means of communication - whether bus is available, Vaccine and other supplies can be sent on the same day from the nearest vaccine/supplies depot.
* specify vaccine delivery i.e. who will carry. Look for other resources who will assist in vaccine delivery e.g., milk carrying vehicle, bus, train, etc.

SAMPLE MONTHLY WORK PLAN

Week	Monday	Tuesday **	Wednesday	Thursday	Friday*	Saturday
First	Home Visit Village 1	FP services	SC (MCH) clinic	*Immun. Session Village 3	Home visit Village 5	Open
Second	Home Visit Village 2	FP	SC(MCH) Immun. clinic	*Immun. Session Village 4	Immun. session in ham-let(s) left out	Open
Third	Home visit Village 3	FP	SC(MCH) Clinic	*Immun. Session Village 1	Home visit to hamlets	Open
Fourth	Home visit Village 4	FP	SC(MCH) Clinic	*Immun. Session Village 2	Immun. Session Village 5	Open
Fifth	For missed work on any day of above day due to leave or holiday and meetings					

* Fixed immunization day as per state guidelines - not to be changed, wide publicity to be given.

** Can be changed to another day e.g. if a fixed family planning camp is held at your PHC on every Friday then change Tuesday with Friday and vice versa.

Open means - State/District to indicate activities like mothers meetings / sectoral meetings, etc.

Use one day of the week to organise home visits, immunization sessions etc. for additional villages / hamlets with population above 500 by rotation

You should plan a fixed monthly routine for the health worker in consultation with them and their supervisors. Such a routine will ensure effective programme implementation and will make it easier for you to achieve targets. You should give sufficient time to make such a routine. A sample monthly Health Worker's (Female) work plan is given on page 27 for your guidance. You can make necessary changes and alterations keeping in view your area specific needs.

According to the schedule on page 27, a minimum of 5 Immunization/MCH sessions, 5 home visits and 4 sub-centre MCH clinics (of which one will be an Immunization/MCH clinic) can be organised every month. In addition, the health worker can visit, by rotation, hamlets/areas left out every week. The days and number of immunization/MCH sessions, however, will be scheduled by you based on needs and as per Section 3.1. For example, if the HW (F) has 4 villages, then only 4 sessions will require to be fixed in a month. The working days beyond Day 28, may be used for any of the missed activities.

Preoccupation with specific peak time workload during certain months should not interfere with planned delivery of services under child survival and safe motherhood programme. It will not interefere with achievement of targets of other programmes. On the contrary, mothers' confidence in health workers builds up through provision of good MCH care under child survival and safe motherhood programme. This will facilitate achievement of targets of other programmes as well.

STEP 2 CONSOLIDATE SUB-CENTRE WORKPLANS TO MAKE PHC PLAN

Once you have planned a monthly work routine for every sub-centre in your PHC or CHC area, you will have to consolidate all of them especially for immunization/MCH session days. This will ensure that all sub-centres on a particular route organize immunization/MCH session on the same day of the week or month so that you can easily transport vaccines and other supplies to all sub-centres by a single person/vehicle.

3.5 USE CHECK-LIST FOR MCH ACTIVITIES

Immunization/MCH session

- adequate number of sterilized syringes (usually 20) and needles
- adequate vaccine vials in vaccine carrier (2 vials of DPT, and 1 each of other vaccines with diluent for a village of 1000 population)
- container for used syringes and needles
- ampoule file, cotton, forceps
- sauce pan with lid or sterilizer, stove, match box
- village MCH register, immunization cards (counterfoils and new cards)
- IFA and mebendazole tablets
- vitamin A concentrate solution with measuring spoon
- contraceptives (condoms, oral pills, IUD)
- ORS packets
- cotrimoxazole tablets, a spoon, thermometer and a watch with second's hand
- ergometrine injection
- soap, towel, pen, paper
- disposable delivery kits (for distribution)
- weighing scale (infant)

MCH Clinic at subcentre

All items listed above plus -

- stethoscope
- blood pressure instrument, measuring tape
- weighing scale (adult)

Home visits

- village MCH register and list of priority houses
- mother-infant immunization cards
- IFA and mebendazole tablets
- ORS packets
- cotrimoxazole tablets
- vitamin A concentrate with measuring spoon
- BP instrument, stethoscope, measuring tape
- colour coded weighing scale (infant)
- soap, towel, pen, paper
- daily diary
- disposable delivery kit (for distribution)

3.7 CONDUCT CATCH-UP AND MOP-UP ROUNDS

You have on page 18 learn about planning for catch-up and mop-up rounds. You will organize these activities specifically in areas identified as requiring either catch-up rounds for accelerating coverage or mop-up rounds for polio eradication activities in your district.

Catch-up rounds need to complement the routine immunization services provided through the primary health care system, as the fixed-day strategy becomes institutionalised ensuring regular contact of the health worker with every village every month, catch-up rounds will need to be implemented progressively in fewer areas and districts covered under the programme. Catch-up rounds are to be implemented where coverage levels are low, specially in areas that remain cut-off due to natural calamities. You should note that catch-up rounds should not be a strategy for covering areas with vacant staff positions. Such areas should form part of regular fixed-day strategy with functionaries from other areas being redeployed on the designated day.

Mop-up rounds are implemented only in areas taken up for polio eradication strategies. They should not interrupt regular service delivery and therefore should be implemented as a part of the Immunization/MCH session. This means that health workers will complete the primary immunization of all those children under one year of age first, and then subsequently, children below 3 years will be given OPV regardless of their previous immunization status. The OPV given during mop-up rounds will not be entered in the Immunization Card, unless it is part of the primary immunization that is due for an infant on that day. The health worker will have to submit a statement on the total number of children below 3 years of age who have been given OPV and does not need to identify children by name or address.

Since mop-up rounds are implemented to replace the wild virus, it does not matter if a few children are left out, or a few children over 3 years of age are included. House-to-house listing of children below 3 for mop-up rounds is **not recommended**. Instead, it is advisable that all children below 3 years are brought to the immunization session through a village-level social mobilization and communication initiative.

3.8 CONDUCT HOME VISITS

Once a fixed monthly plan is prepared and the HW(F) is visiting homes as per schedule, you should ensure proper time management by the worker. The worker should be aware of what is to be done in how much time in each priority house visited. A sample is given below.

ANTE-NATAL CARE

There will be about 160 pregnant women in a sub-centre area during 12 months. At any point of time, there will be half of them who are registered and not delivered. It is possible to register 13-15 pregnant women every month. They will need a thorough ante-natal examination and advice. Those registered earlier will require check up which will take short time period unless they have complications.

In a **new ante-natal case**, the health worker will :

- o register and prepare a mother and infant immunization card
- o take history to rule out too old (>30 years) or too young (<20 years) primigravida and examine clinically to diagnose anaemia.
- o do an abdominal examination to detect lie, rule out associated general diseases, record blood pressure, weight, give IFA tablets, take weight and motivate for first dose of TT (can be done at sub-centre clinic)
- o give ante-natal advice on (i) diet (ii) rest and (iii) danger signs (complications)
- o if there is history of worms, give mebendazole tablets (only in second/third trimester)
- o motivate pregnant women to attend ante-natal clinic at least three times

During the 2nd visit, the health worker will:

- specifically look for anaemia, give IFA tablets and give mebendazole tablets if there is history of worm infestations (only in second/third trimester)
- record BP
- motivate for 2nd dose of TT
- record weight and determine if there is adequate weight gain

  Weight gain of more than 5 kg in any month is an early warning sign for toxaemia - can be done at SC clinic

- reinforce diet, rest and inform about warning signs such as bleeding, loss of foetal movements, headache, dizziness, blurred vision for which the pregnant woman should seek immediate help from health worker/medical officer.

During the 3rd visit, the health worker will carry out all activities:

- included for 2nd visit (except deworming and TT dose, unless not given earlier)

- enquire about place of delivery and motivate for institutional delivery, remind 5 CLEANS

- give a disposable delivery kit (where available)

- advise regarding preparation for labour including 5 cleans during delivery, early initiation of breast feeding, i.e. within 2 hours of birth of the baby.

Several ante-natal activities can be carried out by TBA or AWW and hence HW(F) can easily complete examination of a new ante-natal case in 30-45 minutes and subsequent visits in 10-15 minutes.

NATAL CARE

All deliveries should be conducted, observing 5 CLEANS:

- clean surface, clean hands, clean razor blade, clean cord tie, and clean cord stump (no applicant)

POST-NATAL CARE

There will be about 13-15 new post-natal cases every month in a sub-centre area:

- look for complications i.e. foul smelling discharge, bleeding as well as fever and refer to primary health centre for antibiotic therapy/examination
- advice on cord care and exclusive breast feeding
- motivate for spacing/limiting subsequent births.

If the baby is of low birth weight, i.e. <2500 g (LBW)

It has been observed that one out of three babies has low birth weight, about four babies in a sub-centre area may be identified as LBW every month. Your health worker should:

- advise warmth, frequent feeding and prevention of infections by handling the baby minimally and washing hands before touching the baby.

- if the baby is unable to be fed, or has jaundice, or infection, then refer to hospital or community health centre.

If the weight of the baby is less than 2500 g and the child is unable to suck, your worker will have to transport the baby with the mother (to provide warmth through body contact) to a health facility for further assessment and care.

In a child with **acute respiratory infections**, your worker will:

- determine if the child is breathing fast (more than 60 times per minute in children below 2 months, more than 50 in a child of 2 to 12 months and more than 40 times in a child aged 1-5 years).
- give co-trimoxazole as per dose schedule (refer to 'Interventions Module')
- Inform mother to bring child for assessment after 2 days.
- Inform her of the danger signs requiring urgent attention.
- **Refer if there is chest indrawing or difficulty to wake up or child has fits or severe undernutrition.**

In a child with **diarrhoea**, your worker will have to ensure correct case management after assessing for dehydration. You will have to train her to:

- assess degree of dehydration by looking at general condition, eyes thirst and feeling for skin pinch
- demonstrate how to prepare ORS solution and how much to give
- advise increased fluid intake and continued feeding
- identify and stock possible depot holders in every village with ORS packets within the village to children with diarrhoea and dehydration

To a new **oral pill/IUD** acceptor, your worker will:

Reassure and look for side effects as described under drug kit pamphlet.

SAFE MOTHERHOOD
LIST OF ACTIVITIES TO BE DONE AT DIFFERENT LEVELS

Level	ANC	Delivery	Post-natal care
HOME (by other women and family)	- extra diet and rest - regular intake of IFA tabs. daily - self referral if bleeding/ high fever (more than 39°C) - prepare for home delivery or arrange transport if institutional delivery decided upon.	- Contact trained TBA at onset of labour - ensure 5 cleans o clean hands o clean surface o clean cord tie o clean razor blade o clean cord stump - Self-referral for PPH/ prolonged labour	- Start breastfeeding as early as possible. - Self-referral if foul smelling discharge - Warmth/feeding for LBW baby
VILLAGE (by TBA/AWW)	- register early - advice on above + TT immunization - coordinate with ANM for AN care - Referral in case of complications	- use aseptic technique i.e. 5 CLEANS o clean hands o clean surface o clean cord tie o clean razor blade o clean cord stump - appropriate referral if prolonged labour, PPH	- as above - advice on cord care - referral if fever or bleeding present
SUBCENTRE (ANM/LHV) Some of these activities ca0xbe carried out by ANM at village during MCH/Immunization sessions also.	- 3 antenatal check ups (last at 32-38 weeks) - take history - screen for anaemia, age, weight gain - Give TT, IFA tablets - Deworm if required (2/3rd trimester) - Referral in case of complications	- Same as above	- look for bleeding - look for fever - treat mild sepsis - advice spacing/timing - weigh baby at birth - advise warmth & feeding - provide oral pill, IUD, condoms
PRIMARY HEALTH CENTRE (Medical Officer)	- all above + - treat toxemia, UTI, fever (malaria) - refer to CHC/1st level if bleeding or systemic diseases present	- all above + - care of referred cases and referral after stabilization	- all above + - treat referred cases of sepsis, UTI - provide IUD/pills/ sterilization
CHC/POST PARTUM CENTRE DISTRICT HOSPITAL 1st level referral	- All above + - Treat severe anaemia by blood transfusion - Treat eclampsia, associated diseases - Manage APH/PPH	- all above + - Delivery in eclampsia severe anaemia, systemic disorders - Ceasarian section and blood transfusion if indicated	- All above
	PREFERENTIAL ATTENTION AND MANAGEMENT OF ALL REFERRED CASES		

REFER APPROPRIATELY

It is extremely important that complications during pregnancy or delivery are recognized early. You should ensure that cases are referred to the appropriate health facility. For example, referring a case of post-partum bleeding to a PHC which does not have any facility for blood transfusion will be counter-productive.

The duration between onset of a complication and death is VERY SHORT as given below:

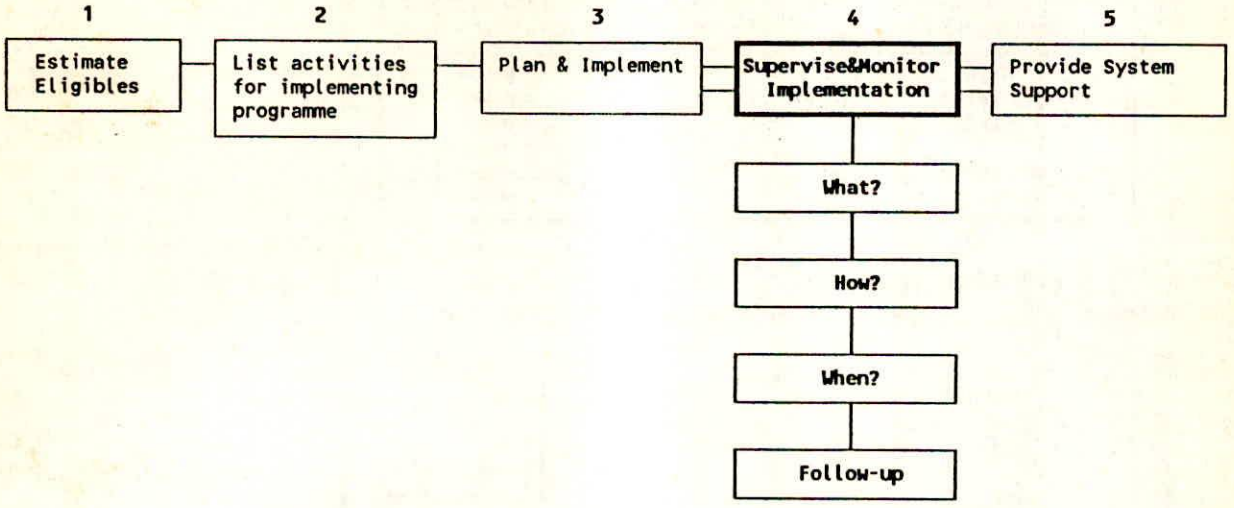
COMPLICATIONS	AVERAGE INTERVAL FROM ONSET OF COMPLICATION TO DEATH
Bleeding before delivery (APH)	12 hours
Bleeding after delivery (PPH)	2 hours
Ruptured uterus	1 day
Eclampsia	2 days
Obstructed labour	3 days
Infection (sepsis)	6 days

Thus it is vital that all your staff and village level functionaries are aware of when to refer and where to refer as quickly as possible.

When to refer	Where to refer
A. PREGNANCY	
History of: - difficult labour/caesarean - elderly primigravida - bleeding/spotting	For detailed examination and investigation at PHC/CHC
During pregnancy - more than 5 kg weight gain in a month	- investigation at PHC/CHC
- blood pressure >140/90 mm	- treatment at PHC
- severe pallor	- blood transfusion at CHC/dist
- spells of headache	- investigation at PHC/CHC
- high fever (>38 C)	- investigation at PHC/CHC
- bleeding	- treatment at 1st referral centre (CHC/district)
- abnormal lie	
B. DURING DELIVERY AND POST NATAL	
- Excessive bleeding - No progress in labour for 24 hours) -->	- blood transfusion & surgery (CHC/district)
- Severe headache/convulsions	- first level referral(CHC/Dist
- High fever	- injectable antibiotics and IV fluids at PHC
C. NEWBORN - Low birth weight (<2000 gm) - Jaundice - Congenital anomalies	To a health facility with paediatrician

REFERRAL SHOULD BE IN TIME
(e.g. immediately for bleeding after delivery)
REFERRAL SHOULD BE TO APPROPRIATE FACILITY
(e.g. obstructed labour to CHC/Dist. Hospital with surgical facilities)
REFERRED CASE SHOULD GET URGENT AND ADEQUATE CARE AT PHC, CHC OR DISTRICT

4.0 SUPERVISE IMPLEMENTATION



The success of child survival and safe motherhood programme depends on whether your field functionaries are performing tasks assigned to them properly. If certain tasks are not done or done incorrectly you will not be able to achieve programme objectives.

Supervision includes giving support, overseeing, directing and above all assisting your staff in carrying out their responsibilities. The purpose of supervision is to reinforce when your staff perform well and to identify areas requiring assistance and support and not for finding faults only. A good system of supervision includes the following two essential elements:

- o periodic visit by supervisors; and
- o periodic reports by staff to the supervisors

It is necessary for you to observe the work of your staff frequently in the field and study the reports submitted by them carefully. To be a good supervisor, you should be able to carry out yourself, all the tasks your supervisees, i.e. the health workers, supervisors, the cold chain mechanic, pharmacist, etc., are normally expected to do.

4.1 WHAT?

You will select those items for supervision. For example, they may be:

* most critical for correct service delivery e.g. "fixed day" for immunization and MCH services held as scheduled or not.

* elements which are difficult e.g. recognizing chest in-drawing in a case of pneumonia; and

* programme components in which the expectations of the community are not met or there are complaints from the community.

In general, what you supervise can be grouped under the following areas:

* activities of health worker i.e. assessment of the condition of the beneficiaries and provision of services e.g. clinical assessment for anaemia and therapeutic dose of IFA tablets in a pregnant woman with anaemia.

* knowledge of mothers e.g. mother's understanding of actions to be undertaken by her at home level for coughs and colds.

* logistics e.g. availability, storage and optimal utilization of drugs, vaccine, equipment and essential supplies.

* outcome of services i.e. monitoring results of activities e.g. recovery or death or referral of a case with pneumonia at sub-centre, occurrence of an outbreak of poliomyelitis in immunised children, etc.

* record keeping - scrutiny of records and registers, daily diary, monthly reports.

* community participation - utilization of services, assistance rendered by members of community during sessions, interactions with village leaders etc.

Supervision **does not mean** identifying problems for corrective action only but also assisting functionaries and helping them in case of difficulties. Opportunity should be given to functionaries to clear their doubts whenever they arise. You should, by your supervision, ensure that your community is provided the best MCH services under the prevailing circumstances. Peoples' experience of sessions and home visits will have a major effect on their motivation. Hence you should ensure that every health functionary under you is reliable, punctual, polite and friendly.

4.2 HOW?

Supervisory checklists are included at the end of this section. You should use them for supervising functionaries at various levels. Activities for supervisor have been limited to those considered essential for the success of the programme. Depending on your local, area specific situations you can modify and add to these checklists. However, it is always beneficial to use a checklist for supervision so that you do not forget. Also a completed checklist will serve as a good record of the outcome of supervision.

Review records, observe health workers as they do their work and talk to health workers and mothers. Determine if activities listed in the checklist are being done correctly or incorrectly or not being done at all. Determine what is being done well. As you supervise, record on your checklist your assessment and any important observations.

Use this opportunity to compliment health workers for doing a good job. Ask them about the problems they face. They may have certain ideas for improving their own work and the ways you can help them. Answer questions they may ask and give information (on-the-job training) that will help solve problems. During supervision, one of the key interventions will be demonstration of activities your functionaries are unable to perform correctly. Make special efforts to show by your action, what you expect from your health workers and supervisors.

How to supervise - some of the frequently used methods for supervision are:

METHOD	REMARKS
1. Observe the health worker actually doing work	It is vital that workers know that you are not observing them to criticise but to help them improve quality of services.
2. Talk to health worker	You can identify problems and solutions. It gives you an opportunity to compliment workers when they perform well.
3. Review record	You should ensure that records are properly maintained and are up-to-date.
4. Meet members of the community and discuss	You can determine mothers' knowledge and their understanding of actions to be taken at home. You can also get an idea of their complaints or suggestions about services.
5. Review Monthly Monitoring reports	To assess trends, reported coverage etc. and to identify problems and solve them.

4.3 WHEN?

Supervisory visits should not be too frequent since this will not allow sufficient time to pass to implement recommendations of the previous visit. On the other hand, visits should not be too infrequent as they are essential to sustain staff motivation. Supervision should not be for pointing out mistakes, but for **problem-solving.** Depending on category of personnel, performance at each unit and stage of programme you should ensure that:

a) every health assistant (male and female) should spend a minimum of 8 working days per month in field supervision of which half should be working with health workers at clinic or sessions and half on a home visit. Thus each health worker will receive support and on-the-job training from a supervisor twice in six weeks - once at the clinic and once during home visit day.

b) every PHC and CHC MO and district level officer should spend a minimum of 4 days a month in the field working for Child Survival and Safe Motherhood programme. Thus it is expected that each PHC/CHC medical officer can provide supervision and on-the-job training to the health assistant and multipurpose worker of a sub-centre once every quarter at the clinic or immunization/MCH sessions and once every quarter on a home visit.

Performance at each unit

You should identify poor performing units and provide supportive supervision more often to determine and solve problems which lead to poor delivery of services and coverage. Thus a PHC/CHC medical officer should visit a sub-centre which is below average in performance at least twice as often as a better performing unit. Similarly the district level officers should visit PHCs and CHCs performing below average more frequently.

Stage of programme implementation

During the first few months of implementation of the programme, supervision at all levels should be more frequent. This will ensure smooth operationalization of the programme in every village, sub-centre, PHC and urban area.

4.4 FOLLOW UP

Once a problem is identified, you should determine its cause.

The cause could be:

a) Lack of necessary skills in a worker, e.g. Cotrimoxazole is not given for pneumonia because the worker cannot count respiratory rate. Arrange an informal on-the-job training for staff and ask the supervisor to follow up.

b) The worker lacks motivation. In other words he/she knows how to perform the task but does not do it. You should reward good performance through positive comments/public recognition.

c) There are obstacles in the way of doing a task e.g. lack of time (due to improper time management, lack of equipment or supplies, lack of authority etc.) This would require appropriate management action on your part to eliminate obstacles.

Supervisory checklists :

In the next few pages, sample supervisory checklists are given for use by various health functionaries to supervise and support functionaries at the next level. These check-lists include certain items on each category of the tasks carried out by various health functionaries. You may, depending on how well your district is performing, modify items in the check-list. It is, however, important to remember that monitoring and supervising to ensure that the **fixed-day sessions** for various child survival and safe motherhood activities **are held as per schedule.**

The check lists included are for use by :

(a) health worker - female during visit to villages

(b) health assistant during visit to a sub-centre/village

(c) Medical Officer during visit to a sub-centre and its areas

(d) Medical Officer at village during session/home visit

(e) District Level Officer during visit to PHC and its areas

A. FOR USE BY HEALTH WORKER (FEMALE) DURING VISIT TO VILLAGES (HOME VISITS)

Village :
Sub-centre :
PHC :

Name(s) of trained TBA/VHG/AWW who was/were provided supportive supervision

Workers assessment

- o 5 cleans during delivery, observed; knows when and where to refer a complicated delivery YES/NO
- o Can weigh newborn and identify low birth weight babies? YES/NO
- o Can identify priority houses correctly? YES/NO
- o Record of priority houses kept well YES/NO
- o Can recognize neonatal tetanus/poliomyelitis YES/NO

Adequacy of stock position :

- ORS packets YES/NO
- IFA tablets YES/NO
- Vitamin A solution YES/NO
- Condoms (where applicable) YES/NO
- Disposable delivery kits YES/NO

- o Are they distributed correctly YES/NO
- o Are mothers aware of location of depot YES/NO

Problems identified/solved :

Details of any on-the-job training provided:

Date: **Name and signature of the Health worker**

B. FOR USE BY HEALTH ASSISTANT TO SUPERVISE HEALTH WORKERS

Village: _____

HW (F):_____

During home visit

- o No. of visits scheduled last month_____, actually conducted_____
- o Is a list of priority houses kept? - YES/NO.
- o Does the worker know how to use BP instrument, foetoscope and delivery kit? - YES/NO
- o Does she do ante-natal check-up properly? - YES/NO
- o Can she correctly identify and refer complicated cases to the appropriate institution? - YES/NO
- o Is she assisted by TBA/AWW - YES/NO
- o Time management by worker satisfactory - YES/NO
- o Problems narrated by women - YES/NO

Details of any on-the-job training provided

During session

- o Whether a session was planned last month? - YES/NO
- o Was it conducted?
- o During the current immunisation session : session held/not held; if not held, Why?
  - worker not available_____
  - vaccine not available_____
  - needles/syringes not available_____
  - transport not available_____
  - People/eligibles did not come_____
  - any other, please specify_____
- o Attendance of beneficiaries less than expected - YES/NO
- o Is she polite and considerate? - YES/NO
- o Assistance from TBA/VHG/HW(M)/AWW - YES/NO
- o Problem identified/solved :

Date : **Name & Signature of Health Assistant**

CHECK LIST FOR SUPERVISION DURING SESSION/HOME VISIT

Items to Monitor	Immunization	Diarroh. Disease	Pneumonia	Vitamin A	IFA Tablets	SM & ANC/Delivery	P N C
1. Correct Assessment of Eligibles	For Immunization Y/N	For degree of dehydration	for fast breathing/chest indrawing	For Vit. A prophylaxis for every child 9 months-3 years For Deficiency signs	For Prophylaxis For Anaemia	For EDD For risk factors including anaemia	Mother - for fever/foul smelling discharge - bleeding birth spacing Neonate; for birth weight
2. Correct Provision of Services	- Cold chain maintained - YES/NO - Sterilization of syringes and needles - YES/NO - One needle/syringe for one inj. -Y/N - Correct technique of vaccination - Y/N	- Demonstration & provision of ORS - Appropriate use of antibiotics - Appropriate referral	- Appropriate use of Cotrimoxazole - Appropriate referral	- Correct Dosage (prophylactic/ therapeutic)	- Correct Dosage (prophylactic/ therapeutic)	Inj. T.T. Deworming in case of history of worms	- Treatment/ referral of complication - Care of Low birth weight baby - birth spacing
3. Instructions to Mothers	- About mild side effects - Y/N - When to come back - Y/N	- about fluids, feeding, ORS - when to go to a health facility	- About home management of coughs & cold - When to come back for going to health facility	- Need to come back for next dose - Increased intake in diet	- Regular use and come back next month for continuation of prophylaxis	- For Diet - Rest - Warning Signs	- Diet - Care of newborn if LBW - Advise for birth spacing
4. Records	- Proper filling of Card - Village Register updated	- Recording on Register/daily diary	- Recording on Register/ daily diary	- Recording on the Card - Village Register Updated	- Recording on Card - Village Register updated	- Recording on Mother & Child Card	- Recording on Card/Register
5. Logistics	- Kerosene, sterilizer adequate vaccine & syringes available - cards	- Adequate ORS packets available	Adequate cotrimoxazole available	Adequate Vit. A syp. available	Adequate IFA tablets available	- Disposable delivery kit	Contraceptives - condoms - oral pills - IUDs
6. Outcome of earlier services	Any case in a vaccinated child	Recovery, referral or death	Recovery, referral or death	Recovery from night blindness	Recovery or referral		
7. Mothers' Response	Satisfied with Services (Y/N)	Satisfied with services (Y/N)	Satisfied with services (Y/N)	Satisfied with services (Y/N)	Satisfied with services (Y/N)	Satisfied with services (Y/N)	Satisfied with services (Y/N)
8. Problems identified during supervision							
9. On-the-Job Training	Y/N	Y/N	Y/N	Y/N			
10. Any other							

C. FOR USE BY MEDICAL OFFICER DURING VISIT TO SUB-CENTRE

Name of the PHC :
Name of the sub-centre :
Population covered :
No. of villages :

FROM MONTHLY REPORTS

[Please complete this section before proceeding for field visit]

S.No.	D E S C R I P T I O N	No. as reported	Expected	Comments/Satisfactory [Y/N]
1.	Number of infants completely immunized from the beginning of year			
2.	No of PW given TT vaccine - 2nd dose/booster			
3.	New ANC cases registered in the last 1 month			
4.	Pregnant women with complications referred			
5.	IFA tablets given - prophylactic/therapeutic			
6.	Number motivated for spacing			
7.	Number motivated for sterilization			
8.	Deliveries conducted			
9.	Acute Diarrhoea cases reported			
10.	Pneumonia cases reported			
11.	Vitamin A doses given			
12.	LBW babies identified			
13.	No. of immunization/MCH sessions conducted			

Problem identified/solved by Medical Officer:_____

Problems identified/solved by LHV (as per supervisory visit record)_____

[During field visit please concentrate on performance problems that can lead to above identified problems]

D. FOR USE BY MEDICAL OFFICER DURING VISIT TO VILLAGES/SESSIONS

Date of visit :
Name of village :

During an immunization/MCH Session

o No. of sessions scheduled last month _____
No. of sessions actually held _____

If immunization session not held, Why?

- worker not available _____
- vaccine not available _____
- needles/syringes not available _____
- mobility not available _____
- People/eligibles did not come _____
- any other, please specify _____

o Attendance of beneficiaries less than expected - YES/NO
o Disorderly movement of people, long waiting - YES/NO
o Impolite or rude behaviour of worker - YES/NO
o Assistance from TBA/VHG/HW(M)/AWW - YES/NO
o Supervision by LHV satisfactory - YES/NO
o Problems narrated by worker

_____

During a Home Visit

o Priority houses correctly identified - YES/NO
o Help from VHG/TBA/HW(M)/AWW - YES/NO
o Supervision by LHV adequate - YES/NO
o Impolite or rude behaviour of worker - YES/NO
o Time management by worker satisfactory - YES/NO
o Problems narrated by worker

_____

Action suggested by you for the Health Team

1. Medical officer (for supplies, intersectoral activity)

2. Block extension educator (BEE)
(for communication needs)/others

3. Health supervisor - female (LHV)
(for technical skills)/others

4. Health supervisor - male (HS)
for assistance in work/others

5. Health Worker - male (MPW)
for assistance in work/others.

Follow up action on your recommendations during last visit

Not done at all/inadequately done/adequately done

Problem identified/solved

Date: **Name & Signature of the Medical Officer**

THIS IS AN IMPORTANT DOCUMENT

PLEASE KEEP ALL FILLED SUPERVISORY FORMS IN CHRONO-LOGICAL ORDER IN A FIELD SUPERVISION FILE.

GET THIS FORM INITIALLED BY DISTRICT OFFICER DURING PHC VISIT.

E. FOR USE BY DISTRICT LEVEL OFFICER DURING VISIT TO PHC AND FIELD AREAS

Name of PHC/CHC :
No. of sub-centres :
Total population :

FROM MONTHLY REPORTS

Problems identified

o No. of sessions scheduled _____. No. of sessions actually held _____
If immunization session not held, why?

worker not available	_____
vaccine not available	_____
needles/syringes not available	_____
transport not available	_____
people/eligibles did not come	_____
any other, please specify	_____

o Disease surveillance

No. of cases reported with low vaccine coverage	- YES/NO
Cases in immunization persons	- YES/NO
Large number of cases while coverage is high	- YES/NO

o Performance coverage less than expected for:

Immunization (antigenwise)	- YES/NO (specify)
Iron & Folic Acid	- YES/NO
Vitamin A prophylaxis	- YES/NO
Diarrhoea treatment	- YES/NO
Pneumonia treatment	- YES/NO
High dropout rate	- YES/NO
IUD acceptors	- YES/NO
Oral pills	- YES/NO
Sterilization	- YES/NO
ANC coverage	- YES/NO

o Supply and equipment

Wastage rate for vaccine - too high	- YES/NO
High cold chain sickness rate	- YES/NO
Response time for cold chain equipment satisfactory	- YES/NO
Others (adverse reaction etc.)	

[During PHC/CHC visit concentrate on the performance problem causing the above identified problem]

Supervision during PHC/CHC Visit

Name of Medical Officer in-charge or doctor available:
Vehicle - available/not available, on road/off road
Staff position and training

Staff		No vacant	No in position	No not trained
Health Assistants	Male Female			
Health Workers	Male Female			

Plan of action available/not available

Supervisory visits

No. of sub-centres visited in last one month (specify)

by Health assistant_____ adequate/inadequate
by Medical officer _____ adequate/inadequate

Has the PHC been visited by

Medical officer of CHC in the last one month YES/NO
District/state level officer in the last six months YES/NO.

Intersectoral activity (if yes, specify)

ICDS/Social welfare YES/NO
Education - primary school YES/NO
NGOs YES/NO
Panchayat YES/NO
Does intersectoral activity need improvement YES/NO

Immunization sessions

No. scheduled last month_____ No. actually conducted _____

Main reasons for cancellation of schedule_____

Vaccine distribution to session site

a) PHC staff delivers - same day or one day prior
b) Sub-centre staff collects - same day or one day prior

Unused vials received back - same day/after one day
Observations on a vaccination session at facility_____
Problems identified in scheduling or conducting session
by district officer_____

Supplies

Vaccines

Nil stock or more than 1 month requirement -	YES/NO
Temperature book maintained -	YES/NO
Frequent rise of temperature above 8 degree celcius -	YES/NO
Defrosted timely -	YES/NO
Vaccines stacked haphazardly or beyond date of expiry	YES/NO

Drug Kits

Inadequate stock at any sub-centre for Vit A, IFA, ORS, Cotrimoxazole	YES/NO
Drug kits distributed to each sub-centre in time -	YES/NO

Care of referrals from field (types of cases seen in last one month)

Knowledge of medical officers adequate	YES/NO
Treatment of referred cases adequate	YES/NO
Supplies and equipment for care of referrals	YES/NO
Essential obstetric emergency services adequate	YES/NO

Communication and Social Mobilization

Does block extension educator perform his extension duties for child survival and safe motherhood well	YES/NO
IEC materials available	YES/NO
Problems identified in IEC activity	

Follow-up action

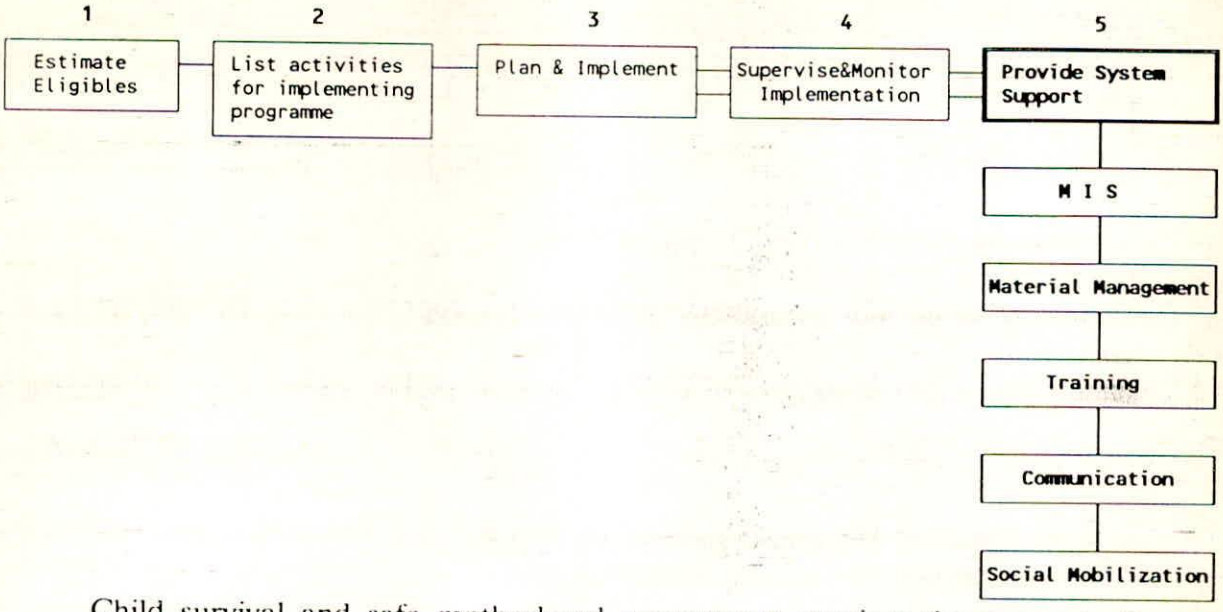
Action on suggestions/recommendations made during your last visit adequate	YES/NO
Suggestions/recommendations made during this visit.	

Any other observation/remark

Name & Signature
Designation

Date :

5.0 PROVIDE SYSTEMS SUPPORT



Child survival and safe motherhood programme requires the support of several systems. These include:

* An information system through reports on activities and causes of diseases and deaths you aimed to prevent (Management Information System)

* Effective maintenance of equipment, including those related to cold chain, deliveries at the sub-centre and hospitals, and anaesthesia and laboratory support services. These equipment should be functioning effectively and need regular maintenance and repairs.

* Training of manpower, i.e. training of health workers as well as those related to providing systems support for child survival and safe motherhood programme.

* All health and non-health functionaries involved in the programme will act as communicators to create a demand for service and also to ensure utilization of services. There needs to be a system of disseminating accurate, consistent and reinforcing information related to the programme elements.

* Mobilization of the beneficiaries through a system of informants and through prominent individuals within the village is also an integral part, which you should be aware of as a programme manager.

5.1 MANAGEMENT INFORMATION SYSTEM (MIS)

Child survival and safe motherhood programme has several interventions as discussed earlier. Many components of programme implementation like training, supplies, equipment, communication etc. have to be coordinated at various levels of management i.e. PHC/CHC, sub-district and district. Therefore, it is necessary to establish a system which provides at every level the correct information in time which will allow analysis of data. MIS for child survival and safe motherhood programme includes the following components:

i) Monthly Monitoring Reports - These are compiled from sub-centres to central level. They include information on :

* surveillance
* performance
* supplies
* status of essential equipment and
* untoward reactions.

The standard format of such a report is given in Annexure-III. Please go through it carefully and discuss with your course facilitator for any clarifications.

ii) Evaluation of service coverage - It is an extended form of CES many of you may have undertaken under UIP. It is discussed in detail in the module "Evaluate Service Coverage".

iii) Epidemic investigation - Standard formats for investigating cases of poliomyelitis, neonatal tetanus and gastroentenities should be used by you. These have been discussed in the module "Conduct disease surveillance".

Two records at village and sub-centre level are very important to ensure quality of data generated at grassroot level. These are (i) mother and child protection card and (ii) village register. You should ensure correctness of information in these vital records. The formats of these records are given as Annexures I and II in this module.

5.2 MATERIALS MANAGEMENT

It is absolutely essential that the supply of vaccines, drugs, cold chain equipment and other supplies are provided in time in adequate quantities at each level of operation. It is your responsibility to correctly calculate, procure, distribute and maintain these supplies for your area. This component of systems support has been discussed in detail in the module "Manage cold chain and other supplies". You should determine needs and requirements in relation to following items:

a) Vaccines : These depend on the number of pregnant women and children as well as number of sessions to be conducted. Also you may need extra doses of OPV to undertake ring immunization and pulse immunization in your area.

b) Cold chain equipment : It is estimated that the cold storage capacity at district level should be for roughly 30,000 to 40,000 vials. A PHC would need 400 to 500 vials for a month. Cold boxes, vaccine carriers and day carriers would be needed to carry vaccines to PHC and to sub centres/villages. Norms for supply of equipment is given in the module "Manage Cold Chain and other supplies".

c) Drugs and other supplies : You will need sufficient stocks of vitamin A solution, cotrimoxazole, ORS packets, IFA tablets inj./tab ergometrine, contraceptives and IUDs. You can use a ready reckoner for these and other supplies as given in the module "Manage Cold Chain and other supplies".

5.3 TRAINING

It is obvious that unless the quality of services is very good, the objectives of child survival and safe motherhood programme will not be achieved. To maintain a high quality of service training for each category of health personnel involved in the programme delivery is essential. You will organize and coordinate training activities at your level of programme implementation as follows:

A. Training of Medical Officers

- o senior state and district health functionaries, district public health nurse and faculty members of medical colleges and HFWTCs will be trained at national or regional level for 7 days.

- o all other Medical Officers within the district will be trained for 6 days at divisional/district level in batches of 30. The course will cover 5 modules on :

  - Plan and Implement MCH services
  - Evaluate service coverage
  - Conduct disease surveillance
  - Manage cold chain and other supplies, and
  - Programme Interventions

- o In addition the first batch of 30 which will include faculty members of ANM/LHV training schools and BEE will be trained in using the "Health Workers Manual" for training health workers.

B. Training of health supervisors and health workers

All health workers and their supervisors will undergo a 5 days skill oriented training within your district at an ANM/LHV or a similar training school. Each batch would be of 30 persons.

C. Orientation of Village level non-health functionaries

Anganwadi workers, VHGs or other development functionaries in your district will be oriented in home based and village based actions for two days at sub-centre level.

D. Specialists skills training

In every district, first level referral institutions will be identified. Two specialists from each of the disciplines - paediatrics, obstetrics and gynaecology, anaesthesia, blood transfusion and laboratory services (thus a total of 10 specialists per institution) will be given specialists skills training to handle complications.

READY RECKONER FOR ESTIMATING TRAINING REQUIREMENT AT DIFFERENT LEVELS

Category of Personnel	Per SC - 5000 Popn.	Per PHC - 30,000	Per CHC/PHC - 100,000	Per Dist. 2000,000
Medical Officers	NIL	1-2	10	210
Special Skill Training	NIL	NIL	10 PER UNIT	40
Health Worker	1	6	20	400
Village Level Functionary	2-3	20	75	1500

Based on your estimation of training needs you can use the following workspace for planning training.

WORKSPACE FOR PLANNING TRAINING

Category of Personnel Training	Current No. At PHC	Current No. At Dist.	No. needing Training	No. can be trained per course	No. of courses required	Suggested Dates	Material Required
Medical Officers				30			
Special Skill Training	NIL						
Health Workers				30			
Village Level Worker		NIL					

5.4 COMMUNICATION[4]

Effective communication will publicise child survival and safe motherhood programme and its components and support health functionaries to promote a change in behaviour based on new health knowledge.

To ensure community participation, it is essential that people should be informed about the diseases and deaths occuring in young children and pregnant women which can be controlled by encouraging families to take health action at home and utilize health services when required.

Principles of communication strategy

The following principles of communication in UIP will be adapted in child survival and safe motherhood programme:

* The central theme is **protection.** Therefore, you should always stress on the protection offered by each of the interventions under Child Survival and Safe Motherhood programme e.g. Vitamin A doses protect the child from blindness, ORS protects from death due to dehydration etc.

* Unified **strategy** - The concept of "shishu rakshak" (child protection) mela should be dilated to incorporate all other activities to protect the health of mothers and children.

* Linking services with communication - At district level and below, you should always try to shift the communication focus away from demand creation towards **action.** Therefore, it is essential that all services are available to the eligibles. You should ensure that fixed day schedules as discussed in work routines earlier are being followed.

* Communication must facilitate an "**enabling process**" in the community. It must encourage "**self-help attitude**" in solving health problems as much as they can.

* Communication must also highlight the "timely action", i.e. the right action at the right time. Self-referral for expert care at the appropriate time must be made very clear to the masses.

---

[4] **The best communication is an effective and continuous service delivery which satisfies majority of the community.**

* **Consistency** of messages : An unclear message or too many messages may confuse the mother. Therefore, you should ensure that village level functionaries are able to impart accurate and consistent messages. You should ensure that services of BEE at PHC/CHC level are adequately utilized to upgrade the communication skills of health workers.

5.4.1 Objectives of communication

* Create continued awareness regarding immunization and the importance of full immunization before the age of one year.

* Inform people about fixed day services including the time and place.

* Encourage mothers to give plenty of home available fluids (HAF) and continue feeding during episode of diarrhoea in children.

* Increase knowledge and change practice of mothers regarding correct mixing and administration of ORS and ensure ORS packets availability at village level through ORS depots.

* Reinforce mothers beliefs about dangers of pneumonia and encourage timely action at home and ensure the practice of referring early to health worker.

* Disseminate knowledge of mothers regarding availability of first dose of vitamin A with measles immunization and four subsequent doses of vitamin A at six monthly intervals.

* Communicate the importance of TT immunization for pregnant women and the dangers of lack of it to the newborn and mother.

* Promote the **five cleans** during delivery vigorously [clean surface, clean hands, clean razor blade, clean cord tie and clean cord stump (no applicant)].

* Communicate that the pregnancy which is a happy event in a woman's life should not run into risk and hence the need for ante-natal care and referral, when necessary.

* Inform mothers about the importance of taking tablets of iron and folic acid for 100 days, and the dangers of not taking it.

* Educate, inform and motivate mothers, fathers and mothers-in-law about importance of birth spacing for the sake of health of the mother and child. Inform about availability of contraceptive services (village depot) and the services for limiting births after 2 children.

* Provide family life education to adolescent girls and boys for preparing them for married life.

* Educate the mothers about the importance of early (within 2 hours of birth) and exclusive breast-feeding of babies.

* Teach mothers on the art of home-level care of low birth weight babies, especially keeping baby warm, frequent feeding, etc.

5.4.2 Prepare a District Plan for Communication

Inter-personal communication will be the key strategy for success of the project. You will make all efforts to involve media for demand generation and utilization of services. However, emphasis will be on total care. The following principles will be adhered :

* communication **for action**;
* communication **linked to service delivery**;
* the overall theme of "**protection**";
* the same **theme tune and logo** in all communication material.

You will include the following themes in communication. You may do this by preparing appropriate handbill messages and wall-paintings which should be displayed prominently for all to see and avail of services.

* Care of pregnant women:	ensure early registration, check ups, tetanus toxoid, iron and folic acid, early detection of complications and referral.
* Clean delivery:	ensure clean hands, clean surface, clean razor, clean cord tie, and clean cord stump (no applicant).
* Immunization	ensure that the infant receives full immunisation (3 doses of DPT, 3 doses of OPV, one dose of BCG and measles)
* Vitamin A	every child at 9 months of age should receive one dose of Vitamin A ; and then, every six months four times more till the age of three years - total five doses
* Diarrhoea	give more fluids; continue feeding. If no improvement, give ORS. Get ORS from a village functionary or from other sources. If no improvement, seek medical help.

*	Pneumonia	can be dangerous; if difficulty in breathing, or fast breathing, see HW-F and Medical Officer
*	Birth timing, spacing and limiting	no pregnancy before 20 years of age and after 35 years; minimum 3 years interval between births and not more than two children.

Every district will have various resources and varying needs for communication efforts. The district team lead by CMO or DHO should prepare a plan for communications in consultation with the district information officer and/or district health education officer and media officials.

You will also take into account the following district or area specific factors before deciding the correct "Media Mix" for your area:

* Reach of media (TV, radio, newspapers, cinema) in the district. Assess what percentage of population is regularly exposed to these media.

* Literacy rates in rural areas of the district especially whileplanning print messages.

* Traditional or folk media are very useful in increasing the "reach" of your communication in areas where TV, radio, print or cinema do not have adequate coverage.

* The availability of sites suitable for wall paintings and hoardings.

* Exhibitions, fairs, religious broadcasts etc. need to be assessed for their potential to propogate messages.

You will make use of mothers' meetings and village contact teams to organize the communication events. Efforts will be made to popularise the mother-infant immunization card and the fixed-day strategy.

The messages will be few, frequent, recurrent and right ones. You should also **prioritize messages** according to the specific needs of your area. For example, if coverage with TT is low and there are many cases of neonatal tetanus then you should give high priority to the messages of **5 cleans** during delivery and TT immunization during ante-natal period.

You will print handbills and circulate them widely. The handbills will essentially promote the fixed day strategy and services and ensure that everyone in your district knows where these services are organised and when. You should identify the person(s) controlling or inflencing the media and orient them on child survival and safe motherhood programme. You can take them to demonstrate programme activities in an area where such activities are being done particularly well. Plan news items, features etc. in consultation with media personnel. Motivate them at regular intervals.

The communication package can also be channelized through non-health government sector as well as non-governmental organizations (NGOs) at district level and below.

5.4.3 Communication strategy at PHC level

All available channels of communication (radio, TV, field publicity, print, folk arts etc.) are being used to promote essential messages on child survival and safe motherhood programme. However, coverage through media (print, TV, radio, cinema) is limited. Therefore you should focus and concentrate on INTER-PERSONAL communication using all credible communicators in the community. Every person is converted into an effective communicator. They will talk about the availability and regularity of services in their villages and in the sub-centres. Block Extension Educator (BEE) would be the main person responsible at PHC level to help you plan the strategy.

Family should be taken as the unit for communication package. Your communication efforts should encourage families **to take health action** at home (e.g. during pregnancy, delivery, an episode of pneumonia or diarrhoea) and **utilize health services** when required. The evidence of an effective communication is the real attitudinal changes that take place in the families.

Enumeration as a mobilization strategy

The annual enumeration activity and its quarterly updating is an important mobilization strategy. It links perfectly the service with communication. Therefore, you should ensure that during the "enumeration week" all village level workers along with health workers make a team. While one or two of them are helping health worker in identification and registration of eligibles, the rest should:

- promote home based care for diarrhoea, pneumonia and newborn care;
- promote early and appropriate referral of cases who need emergency care or additional care;
- promote 5 CLEANS during delivery, immunization of all infants and pregnant women; and
- protection of all children with Vitamin A concentrate solutions; and
- essential ante-natal care to all pregnant women.

Other contact points for communications

Immunization sessions, MCH clinics, home visits and mothers' meeting in an Anganwadi centre should be utilized for promoting specific messages for child survival and safe motherhood programme. Village market and festivals can also be

used effectively for demand generation and utilization of services.

Field publicity at village level

This can be achieved by wall writings and distribution of hand bills. Village influencers e.g. panchayat members, religious leaders etc. should be specifically contacted and motivated to support the programme.

5.4.4 Indicators on effectiveness of communication

The best indicator of success of your programme communication are the behavioural changes and compliance by the family of various activities in your messages. Following are some of the indicators:

i) % of eligibles issued Mother-Infant Immunization card = $\frac{\text{No. of cards issued}}{\text{Total no. of eligibles}}$

% of cards retained (Card holding rate) = $\frac{\text{No. of cards retained/brought to session}}{\text{Total no. of cards issued}}$

Dropout rates = $\frac{\text{Highest Covered Antigen Dose (HCAD)} - \text{Lowest Covered Antigen Dose (LCAD)}}{\text{HCAD}} \times 100$

ii) % of fully immunized under 5 children

iii) % of pregnant women registered and number of appropriate referrals.

iv) % of children with diarrhoea

- Given ORS
- Given HAF
- Given continued feeding

iv) % of children with pneumonia brought to health centre.
% of children with pneumonia treated by Cotrimoxazole

5.5 SOCIAL MOBILIZATION

The surest way of achieving the objectives of child survival and safe motherhood programme is through fully protected hamlets, villages, panchayats, blocks, districts and states. This is possible only with complete involvement of the government development functionaries from health and non-health sectors as well as the non-government organizations (NGOs). Following is a list of possible partners who can help in child survival and safe motherhood programme. You can check how many of such allies are functioning in your area. Ensure each one of them familiar with various components of child survival and safe motherhood progrmame. The district magistrate should be motivated by you to preside over these meetings and enlist co-operation of various agencies.

5.5.1 List of sectors and NGOs

Inter-sectoral activity

- o Social Welfare (PO/CDPO/MS/AWW)
- o Rural Development (BDO & his staff/DWCRA/DRDA functionaries)
- o Urban Development (UBS/Municipal bodies
- o Education (Primary School Teachers/AE Project/NFE/Others specify)
- o Information & public relations (District public relation officer)
- o Public Health Engineering Department (Water Supply & Sanitation Progamme)
- o Women's groups
- o Any Others

Non-Governmental Organizations (NGOs)

- o Panchayats (Pramukh/Mukhiyas)
- o Youth associations (NSS/NCC/Nehru Yuva Kendra)
- o Professional associations (IMA/IAP/FOGSI/Trained Nurses Association/Others)
- o Service clubs (Rotary/Lions/Others)
- o Employees associations
- o Women's organizations
- o Field health and development activitists - local groups
- o Organized health missions e.g. CHAI, Ramakrishna Mission etc.

Once you have identified all possible partners and allies you should try to focus on the possible actions each of these can undertake for the programme. The check list of possible activities which can be undertaken is given in the next page.

5.5.2 List of possible intersectoral activities

Sustain Immunization	- Enumeration - Publicise fixed day and fixed place - Remind dropout - Promote complete immunization
Eradicate Polio	- Identify and report cases - Promote immunization - Publicise fixed day and fixed place - Assist in outbreak response
Eliminate Neonatal Tetanus	- Identify and report neonatal deaths - Promote safe delivery practices with 5 CLEANS - Inform people about trained help
Measles Reduction	- Promote 100% coverage, to all infants in time
Manage Diarrhoea	- Promote HAF and continued feeding - Stock and distribute ORS packets round the clock (depot-holder) - Demonstrate preparation of ORS - Advise referral if signs of dehydration are present - Promote safe drinking water - Promote personal hygiene and hand washing
Manage Pneumonia	- Home care of coughs and cold - Help mothers recognize pneumonia early enough - Know the nearest source of cotrimoxazole and refer accordingly
Prevent Vitamin A deficiency	- Promote 5 doses of vitamin A at 6 monthly interval to every child between 9 months and 3 years. - Refer children with symptoms of vitamin A deficiency to subcentre or PHC - Promote Vitamin A rich locally available foods.

Prevent Anaemia	-	Distribute tablets of iron and folic acid to all pregnant women for 100 days.
	-	Refer pregnant women who are pale to sub-centre or PHC
	-	Promote iron-rich foods.
Promote Safe Motherhood	-	Mobilize people for various activities for safe motherhood
	-	Inform about nearest source of contraceptives - the depot-holders in the villages
	-	Information on child spacing to all women and limiting family size to 2-child norm
	-	Promote immunization and ANC registration
	-	Refer pregnancies with complications to the nearest referral centre
	-	Facilitate timely transport to those with complications
	-	Advice on diet, rest and warning signs
	-	Promote stock and distribute disposable delivery kits
	-	Produce disposable delivery kits in groups
	-	Promote **5 cleans** to be observed during home deliveries
	-	Promote institutional deliveries
	-	Appropriate education for adolescent girls

Non-Governmental Organizations (NGOs)

You should enlist the active support of NGOs who meet one or more of the following criteria:

- Can they take the responsibility of sustained programme implementation in a given geographic area.
- Will they visit the community, identify the eligibles and follow up and motivate drop outs.
- Are they able to win over and work through opinion leaders.
- Can they help arrange immunization sessions, emergency transport or waiting maternity homes near first referral hospital.

You should clearly spell out the tasks assigned to the NGOs while making a plan of action. All or some of the actions listed earlier under 5.5.2 can also be performed by NGOs. However, some of the major roles of NGOs can be to:

- o promote messages of child survival and safe motherhood programme.
- o inform on births and deaths (especially neonatal and maternal deaths)
- o identify complicated pregnancies/labour and provide for emergency transport
- o activities related to immunization
- o distributing ORS, IFA, contraceptives

5.5.3 Plan of action for intersectoral activity at district Level

To effectively coordinate intersectoral activities following tasks should be undertaken:

- o Constitute district child survival and safe motherhood co-ordination committee with district magistrate as the Chairman and all partners/sectors nominating representative of theirs as a member of the Committee.

- o Invite representatives of all partners (esp. the major partners i.e. ICDS, UBS, Education and water and sanitation) during the workshop for district action plan.

- o Form an intersectoral district task force for random field visits and feedback to district committee.

- o Include child survival and safe motherhood review in developmental programme review meeting.

- o Monitor intersectoral activity. Conduct joint field visits with district level officers of ICDS, UBS, education etc.

5.5.4 Plan of action at block level/PHC

- o Constitute a block level committee
- o Work with other partners during preparation of block level plan of action. Ask them to specifically agree to assist in any or all activities listed earlier.
- o Include child survival and safe motherhood review in block level meetings.
- o Plan joint field visits with CDPO and block development officers.
- o Encourage health workers and their supervisors to coordinate with other village level functionaries and volunteers.
- o Strengthen and develop Mahila Swastha Sanghatan (MSS) or women's groups

5.5.5 Items for review in the intersectoral committee

- % of fully immunized infants
- % of fully immunized mothers
- % of villages/bastis in project area having ORS round the clock (depot holder)
- % of villages having cotrimoxazole round the clock
- % of cases in which birth weight recording by village level worker or health worker is being done.
- % of deliveries conducted by untrained birth attendants
- % of delivery cases referred
- % of cases where support was received from referral institution
- % of villages in project area where health education sessions held involving sectors/partners
- % of fixed day immunization sessions held as per schedule.

The above indicators may be used to rate the progress of the programme and specifically identify who would assist with various aspects to ensure better service delivery, utilization and outcome.

DISTRICT PLAN OF ACTION

Name of the District:

PART I

BACKGROUND INFORMATION

Demographic Profile

- o Population (1991 Census) - Rural
  - Urban
- o Growth Rate (annual)
- o Projected Population: 1992 -
  1993 -
  1994 -
  1995 -
- o Age and sex structure

Age Group	Male	Female	Total
0 - 1 Years			
1 - 4 "			
5 - 14 "			
15 - 44 "			
45 - 60 "			
=> 60 "			

Socio-economic Profile

- o Percentage of population below poverty line
- o Literacy rate - overall_____ female_____

Health Profile

- o 10 Leading causes of mortality in less than 5 years (use hospital data)
- o 10 Leading causes of morbidity in less than 5 years (use OPD data)
- o 5 Leading causes of maternal mortality (use hospital data)

Coverage Rates 1991-92

Parameters	Reported % coverage	C E S
DPT3 OPV3 BCG Measles TT (2 doses) Vitamin A Prophylaxis Ante-natal care Delivery attended by trained personnel ORS use rate (if available) couple protection rate		

District Resource Inventory

o Health facilities

Rural - Sub-centre
- PHC
- CHC
- Others

Urban - FWC
- PPC
- Hospitals
- Others

o List of Hospitals within the district or closest to the district to serve as referral institution :

a) Newborn care (<2000 g birth weight)

b) Diarrhoea with severe dehydration

c) Pneumonia

d) Severely anaemic pregnant women

e) Pregnant women with bleeding/obstructed labour

f) Pregnant women with toxemia

g) Pregnant women/post-natal women with fever

o Manpower

- Medical Officer
- District Public Health Nurse
- Block Extension Educator
- Health Supervisor (male)
- Health Supervisor (female)
- Health Worker (male)
- Health Worker (female)

o Departments identified for social mobilization/collaboration

o Non-governmental organizations identified for intersectoral activity

PART II

A. District's year-wise goals and objectives for Child Survival and Safe Motherhood Programme

Y E A R	Current Level	Coverage Goals	Disease & death reduction objectives

B. Programme interventions

o Sustain immunization

o Neo-natal tetanus elimination

o Polio eradication

- o Vitamin A prophylaxis
- o Pneumonia therapy
- o Control of diarrhoeal diseases
- o Essential care of all pregnant women including clean delivery (5 cleans)
- o Early identification of complications and referral
- o Emergency care to those with complications
- o Birth timing, spacing and limiting.

C. Operational strategy

Summary of plan of action of each rural/urban unit

Name of Unit	Popu-lation	Enumerated eligibles	No. of villages with hamlets	Immun. Session scheduled per month		Home visits scheduled per month	Remarks
				Outreach	Fixed		
RURAL							
URBAN							
TOTAL							

List planned campaigns/intensive drives (if any)

SYSTEMS SUPPORT

MIS AND FEEDBACK (mention here the dates of review meetings at PHC and district levels)

MATERIAL MANAGEMENT

Estimated Requirement	Quantity	Details of obtaining	Details of distribution
o Cold Chain Equipment - ILR - Freezer - Vaccine Carriers o Vaccines - DPT - OPV - BCG - Measles - TT o Drugs/SC Kits o Other supplies			

TRAINING PLANS

WORKSHEET FOR PLANNING TRAINING

Category of Personnel Training	Current No. At PHC	At Dist.	No. Needing Training	No. That can be trained per course	No. of Courses required	Suggested Dates	Materials Required
Medical Officers				30			
Special Skill Training	NIL						
Health Workers				30			
Village Based Worker		NIL					

SUPERVISION

Details of fixed routine field supervision of

District Officers
Medical Officers - PHC/CHC wise
Health Supervisors
Checklist for supervision

COMMUNICATION STRATEGY

Media mix decided

i) Inter-personal methods
ii) Hand-bills / Wall-paintings / Hoardings
iii) Cinema slides
iv) Village talks, Mothers' meetings
v) Others

Priority messages

Activities

SOCIAL MOBILIZATION

Details of district child survival and safe motherhood committee

Details of intersectoral activity

Details of non-governmental organizations support

REMEMBER THIS ABOUT PLAN MCH SESSIONS

* Estimate the number of each category of eligibles according to the proportions of that category in general population. Compare with enumerated eligibles.

* List activities to be undertaken for implementing the programme from village level to the level of your responsibility.

* Fixed centres, outreach operations, campaigns/intensive drives and home visits are the main strategies of operation.

* Schedule fixed day immunization session at fixed as well as outreach centres in such a way that approximately 30 sessions are held in 30,000 population per month. Generally, you will schedule 4 to 6 sessions in a subcentre area.

* Plan fixed monthly work routine of health workers having 4-6 immunization sessions and 6 home visit days per month.

* During home visits priority houses should be visited by health worker (female) and she should be supported adequately during her work by village level workers (VHG, TBA and AWW).

* Supervise implementation of the programme at recommended frequency using the supervisory checklist. Identify and solve the performance problems during your supervisory visits.

* Mother and child register and mother and infant immunization cards are main records to generate data at village level. Ensure that these are properly maintained and review monthly monitoring report for local action.

* Make a communication plan in consultation with BEE. Use every contact including enumeration for interpersonal communication. Ensure accuracy and consistency of messages.

* Mobilize support of other government departments especially ICDS, UBS and DWCRA. Make joint field visits, constitute coordination committees and review intersectoral activity. Mobilize NGOs service clubs, youth associations for specific activities support.

जच्चा-बच्चा रक्षा कार्ड

II-III दूसरे से तीसरे साल तक (12-36 महीने)

तिथि डी.पी.टी.-बू	तिथि पोलियो-बू	तिथि विटामिन ए-2
तिथि विटामिन ए-3	तिथि विटामिन ए-4	तिथि विटामिन ए-5

क्रम संख्या

जच्चा का नाम

पति का नाम

शिशु होने की सम्भावित तिथि

घर नं० गाँव/वार्ड

पी.एच.सी./नगर

उप-केन्द्र/क्लिनिक

शिशु का नाम

लड़का/लड़की जन्म तिथि

● कार्ड का यह भाग स्वास्थ्य कार्यकर्ता के पास रहेगा।

स्वास्थ्य कार्यकर्ता के हस्ताक्षर

कार्ड यहाँ से अलग करें

II-III दूसरे से तीसरे साल तक (12-36 महीने)

तिथि डी.पी.टी.-बू	तिथि पोलियो-बू	तिथि विटामिन ए-2
तिथि विटामिन ए-3	तिथि विटामिन ए-4	तिथि विटामिन ए-5

उचित टीकाकरण सूची

गर्भवती महिलाओं को :-	
गर्भावस्था में जितनी जल्दी हो सके	टेटनस-1 का टीका
टेटनस-1 के 1 माह बाद	टेटनस-2 या बूस्टर का टीका
बच्चे के लिए :-	
1½ माह पर	बी.सी.जी. व डी.पी.टी.-1 के टीके और पोलियो-1 की खुराक
2½ माह पर	डी.पी.टी.-2 का टीका और पोलियो-2 की खुराक
3½ माह पर	डी.पी.टी.-3 का टीका और पोलियो-3 की खुराक
9 माह पर	खसरे का टीका
16 से 24 माह के बीच में	डी.पी.टी. और पोलियो की बूस्टर टीका/खुराक

■ **यदि किसी टीके/खुराक के लिए आपको देरी हो जाए, तो भी आप इसे जरूर लगवाइये। इस विषय में आप अपने स्वास्थ्य कार्यकर्ता से सलाह लें।**

■ इस कार्ड को अपने पास सँभाल कर रखें।

■ आप जब भी स्वास्थ्य केंद्र आयें, इस कार्ड को अपने साथ जरूर लायें।

■ टीकाकरण के बाद इस कार्ड में टीके/खुराक लेने की तारीख जरूर दर्ज करवायें।

• यदि बच्चे का जन्म अस्पताल/क्लिनिक में हुआ है, तो उसे जन्म के समय ही बी.सी.जी. का टीका लगायें।

● कार्ड का यह भाग जच्चा/बच्चे की माँ के पास रहेगा।

कार्ड यहाँ से अलग करें

जच्चा-बच्चा रक्षा कार्ड

क्रम संख्या

जच्चा का नाम

पति का नाम

शिशु होने की सम्भावित तिथि

घर नं० गाँव/वार्ड

पी.एच.सी./नगर

उप-केन्द्र/क्लिनिक

शिशु का नाम

लड़का/लड़की जन्म तिथि

राष्ट्रीय टीकाकरण मिशन
भारत सरकार

गर्भावस्था में जाँच और टीकाकरण का ब्यौरा

स्थिति तिथि जाँच-1	स्थिति तिथि जाँच-2	स्थिति तिथि जाँच-3
तिथि आयरन	तिथि आयरन	तिथि आयरन
तिथि टेटनस-1	तिथि टेटनस-2 (बूस्टर)	

- गर्भवती महिला को स्वास्थ्य कार्यकर्ता से मिलकर अपने स्वास्थ्य की नियमित जाँच कराते रहना चाहिए।
- याद रहे, गर्भावस्था में, टेटनस के दो टीके अथवा टेटनस का 1 बूस्टर टीका लगवाना और तीन महीनों में आयरन की 100 गोलियाँ लेना बहुत ज़रूरी है।
- याद रखिए कि टेटनस-2 (बूस्टर) का टीका शिशु होने की सम्भावित तिथि से कम से कम 1 माह पहले दिया जाना चाहिए।

राष्ट्रीय टीकाकरण मिशन
भारत सरकार

शिशु रक्षक टीकों का ब्यौरा

I पहले साल में (0-12 महीने)

तिथि बी.सी.जी.		
तिथि डी.पी.टी.-1	तिथि डी.पी.टी.-2	तिथि डी.पी.टी.-3
तिथि पोलियो-1	तिथि पोलियो-2	तिथि पोलियो-3
तिथि खसरा	और तिथि विटामिन ए-1	

- सभी टीके सही समय पर लगवाएँ और उन्हें यहाँ दर्ज करवाएँ।
- याद रखिए, डी.पी.टी. और पोलियो की हर टीका/खुराक के बीच में एक महीने का अंतर होना चाहिए।

स्वास्थ्य कार्यकर्ता के हस्ताक्षर

राष्ट्रीय टीकाकरण मिशन
भारत सरकार

काट यहाँ से अलग करें

गर्भावस्था में जाँच और टीकाकरण का ब्यौरा

तिथि जाँच-1	तिथि जाँच-2	तिथि जाँच-3
तिथि आयरन	तिथि आयरन	तिथि आयरन
तिथि टेटनस-1	तिथि टेटनस-2 (बूस्टर)	

शिशु रक्षक टीकों का ब्यौरा

I पहले साल में (0-12 महीने)

तिथि बी.सी.जी.		
तिथि डी.पी.टी.-1	तिथि डी.पी.टी.-2	तिथि डी.पी.टी.-3
तिथि पोलियो-1	तिथि पोलियो-2	तिथि पोलियो-3
तिथि खसरा	और तिथि विटामिन ए-1	

राष्ट्रीय टीकाकरण मिशन
भारत सरकार

INSTRUCTIONS FOR FILLING UP SUB-CENTRE MOTHER AND CHILD CARE RECORD

1. This register has been developed for you to record all MCH activities of the sub-centre area.

2. Separaters are provided to separate the records of each village.

3. On the separaters fill in the details of the village.

4. Binding of the register is such that it will help you to insert extra leaves whenever required.

5. On the top of every page enter the year. For example enter 1992-93 for cases to be registered during 1st April 1992 to 31st March 1993.

6. Col.2

   During the field visit you should identify all pregnant women and register them in this column after giving a Serial No.

7. The same Serial No. should also be entered in the MCH Card. Please remember to indicate the year of registration in the card for example a case listed at S.No.2 in 1992-93 should be written on the card as 2/92-93.

8. Col.5

   The number of pregnancies the woman had including the present one should be entered.

9. Col. 10, 14 & 18

   While examining the pregnant women look for certain danger signs which may require your personal continuous supervision and/or referral. These danger signs are:-

   * Anaemia
   * B.P. above 140 mm Hg.
   * Abnormal weight gain (>5 kg/month)
   * First pregnancy with age less than 20 and more than 30 years
   * More than 4 pregnancies
   * Bleeding during pregnancy (APH)
   * Ceasarian operation during previous pregnancy
   * Abnormal/lack of movements
   * Convulsion

   Please enter appropriate code from the above list.

10 Col. 19

Please choose the appropriate code from the following:

* At home
* At sub-centre
* Other institution including private hospitals

11. Col. 20

Please enter appropriate code from the following on the basis of delivery conducted by:

* Doctor
* ANM/LHV/Nurse
* Trained Dai
* Untrained Dai and/or others (relations etc)

12. Col. 12

Choose the appropriate code from the following and enter in this column.

* Mother and child healthy
* Mother died
* Child died
* Dead child born

13. Col. 23

Please enter:

* If the child was healthy upto 7 days;
* If the child was healthy upto 28 days;
* If the child dies within 7 days, and
* If it dies after 7 days but before 28 days

14. You are aware that the primary vaccination i.e. one dose of BCG, three doses of DPT and OPV each, one dose of measles and the first dose of Vitamin A should be given before the completion of the first year of the child. Hence at Col.36 fill in the code as:

* if primary immunization was completed before the first year of the child;

* if primary immunization was not completed before the first year of the child.

MOTHER AND CHILD CARE RECORD

MOTHER'S RECORD

Sl. No.	Name of pregnant woman	Age	Husband' name & Address	Order of pregnanc	Expected Date of delivery	ANC-1				ANC-2					ANC-3			Place of delivery	Delivery attended by	Delivery outcome **
						TT-1 date	IFA Qty	Wt. Kg.	Danger Code *	TT-2/B Date	IFA Qty.	Wt. Kg	Danger Code *	Date	IFA Qty.	Wt. Kg	Danger Code *			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

MOTHER AND CHILD CARE RECORD

CHILD'S RECORD

REGISTRATION YEAR 199____

Weight at birth	Child was healthy upto 7 or 28 days	Name of the child	Date of Birth	Sex	Date of BCG	Dates of OPV Doses			Dates of DPT Doses			Date of Measles dose	Date of Vit. A 1st dose	Immun. * Status 1st year	Date of OPV-B dose	Date of DPT-B dose	Dates of Vit. A doses			
						1st	2nd	3rd	1st	2nd	3rd						2nd dose	3rd dose	4th dose	5th dose
22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42

MONTHLY PHC REPORT

Reporting Date:_____

P.H.C._____ District_____

State_____ Month_____ Year_____

Yearly Target I) Infants_____ II) Pregnant Women_____

Number of Sessions a) Planned_____ b) Actually Held_____

A. SURVEILLANCE

Disease		Number Reported			
		For the Month		Cummulative Since April	
		Cases	Deaths	Cases	Deaths
Diphtheria Pertussis Neonatal Tetanus Tetanus (others) Poliomyelitis (Acute) Measles					
Under five years	Tuberculosis Pneumonia Acute Diarrhoea Dysentry				
Maternal Deaths (Repoorted) : Before Delivery During Delivery Within 6 weeks of delivery					

B. PERFORMANCE

			Dose	No.of Beneficiaries		Cummulative since April	
PREGNANT WOMEN	T T		1 2 B				
	IFA TABLETS	(Prophylactic) (Theraputic)		Initiated	Completed	Initiated	Completed
CHILDREN				Under 1Yr	Under 1Yr	Under 1 Yr	Under 1 Yr
	B C G		1				
	O P V		1 2 3				
	D P T		1 2 3				
	MEASLES Vitamin A OPV Booster DPT Booster		1 1 1 1				
	Vitamin A		1 2 3 4 5				

CHILDREN	DT (5 Years)	1 2 B				
	TT (10 Years)	1 B				
	TT (16 Years)	1 2				

ANTE-NATAL CARE

Cases		During the month	Cummulative since April
Registered Institutional Deliveries Complicated Cases referred			
Domicilliary deliveries conducted by	HW(F)/LHV Trained Dais Others		
Condition of newborn at birth	Weight below 2,000 gm. Weight 2,000-2,500 gm. Weight 2,500 and above Weight not taken Still born		
*Abortion			

C. SUPPLY POSITION

Vaccine/Drugs	Opening Balance	Received during the month	Consumed during the month	Balance at the end of month
DPT				
OPV				
BCG				
MEASLES				
TT				
DT				
Syringes 2 ml				
Syringes 1 ml				
Needles 20 G				
Needles 23 G				
Needles 26 G				
Immunization Cards				

D. STATUS OF EQUIPMENT (inlcuidng deep freezers, ILRs, voltage stabilizers, vaccine carriers, cold boxes, weighing machines, BP instruments, vehicles etc.)

Equipment/ Make	Machine Number	Whether working	If not, date of breakdown	Date of Intimation	Remarks*

* Please mention in this column: a) If machine is beyond repair
b) If the machine has been attended to by the mechanic within a week of breakdown.

E. UNTOWARD REACTIONS

1. Reported deaths associated with immunization 2. Number of absessess 3. Other complications	

Date: Signature of Medical Officer
To:
The District M.C.H. Officer

MONTHLY DISTRICT REPORT

Reporting Date:_____

No. of PHCs_____ District_____

State_____ Month_____ Year_____

Yearly Target I) Infants_____ II) Pregnant Women_____

Number of Sessions a) Planned_____ b) Actually Held_____

A. SURVEILLANCE

Disease		Number Reported			
		For the Month		Cummulative Since April	
		Cases	Deaths	Cases	Deaths
Diphtheria Pertussis Neonatal Tetanus Tetanus (others) Poliomyelitis (Acute) Measles					
Under five years	Tuberculosis Pneumonia Acute Diarrhoea Dysentry				
Maternal Deaths (Repoorted) : Before Delivery During Delivery Within 6 weeks of delivery				[redacted]	

B. PERFORMANCE

			Dose	No.of Beneficiaries		Cummulative since April	
PREGNANT WOMEN	TT		1 2 B				
	IFA TABLETS	(Prophylactic) (Theraputic)		Initiated	Completed	Initiated	Completed
CHILDREN				Under 1Yr	Under 1Yr	Under 1 Yr	Under 1 Yr
	B C G		1				
	O P V		1 2 3				
	D P T		1 2 3				
	MEASLES Vitamin A OPV Booster DPT Booster		1 1 1 1				
	Vitamin A		1 2 3 4 5	[redacted]		[redacted]	
	DT (5 Years)		1 2 B				

C H I L D R EN	TT (10 Years)	1 B				
	TT (16 Years)	1 2				

ANTE-NATAL CARE

Cases		During the month	Cummulative since April
Registered Institutional Deliveries Complicated Cases referred			
Domicilliary deliveries conducted by	HW(F)/LHV Trained Dais Others		
Condition of newborn at birth	Weight below 2,000 gm. Weight 2,000-2,500 gm. Weight 2,500 and above Weight not taken Still born		
Abortion			

C. SUPPLY POSITION

Vaccine/Drugs	Opening Balance	Received during the month	Consumed during the month	Balance at the end of month
DPT OPV BCG MEASLES TT DT Syringes 2 ml Syringes 1 ml Needles 20 G Needles 23 G Needles 26 G Immunization Cards				

D. STATUS OF COLD CHAIN EQUIPMENT

Equipment ILR/DEEP FREEZER	Total Supplied	Total not working	No. attended to within 1 week	No. not working for more than 1 month*	No.Beyond Repair
ILR 300 Litre Deep freezer 300 Litre ILR 140 litre Deep freezer 140 litre					

* Excluding those beyond repair.

Please attach details of beyond repair equipment as:

Location	Machine No.	Date of installation	Out of order since

E. UNTOWARD REACTIONS

1. Reported deaths associated with immunization 2. Number of absessess 3. Other complications	

Date: District MCH Officer

To:

1. Monitoring and Evaluation Unit
   Child Survival & Safe Motherhood Programme Division
   Ministry of Health & Family Welfare, Nirman Bhavan, New Delhi - 110 011.
2. State MCH Officer

ANNEXURE-IV

DELIVERY KIT FOR HEALTH WORKER

S.No.	Item description	Qty.
1.	Aneroid Sphygmomanometer	1 each
2.	Color coded Weighing Scale (Baby)	3 each
3.	Instrument Sterilizer SS 222 x 22 x 41 mm	1 each
4.	Spring Type Dressing Forceps - Stainless Steel (150 mm)	1 each
5.	Kidney Basin - Stainless Steel (825 ml/280 oz)	1 each
6.	Sponge bowl - Stainless Steel (600 ml)	2 each
7.	Uretheral Catheter (12 Fr) rubber	1 each
8.	Clear vinyl plastic sheeting (910 mm wide)	2 each
9.	Enema can with tubing	1 each
10.	Clinical oral thermometer (Dual Celsius/Fahrenheit Scale)	1each
11.	Clinical rectal thermometer (Dual Celsius/Fahrenheit SCale)	1 each
12.	Surgeon's hand brush with while nylon bristles	1 each
13.	Mucus Extractor	1 each
14.	Artery Forceps	2 each
15.	Cord-cutting scissor	1 each
16.	Cord ties/rubber band	1 packet
17.	Nail Clipper	1 packet
18.	Foetoscope (Stethoscope Foetal)	1 packet

NATIONAL IMMUNIZATION MISSION

Time table of scheduled immunization session

Village	Date of Session	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	Scheduled												
	Actual												
	Scheduled												
	Actual												
	Scheduled												
	Actual												
	Scheduled												
	Actual												
	Scheduled												
	Actual												
	Scheduled												
	Actual												

FOR DISPLAY AT SUB-CENTRE

ALWAYS USE ONE NEEDLE, ONE SYRINGE FOR ONE CHILD

Education is empowerement. Every girl and boy must be helped to complete at least primary education in school. This will facilitate attainment of good health. In this endeavour all of us can contribute and make a difference.

You can :

* ask every family you meet during your health work, whether their children are in primary school;

* persuade them to send all their children including girls, to attend and complete primary school, if they are not in school;

* identify the primary school teachers of the villages covered by you;

* facilitate communication between the family and the school teacher whenever possible;

* encourage all functionaries working with you to actively promote school attendance and completion of primary school; ask them regularly, what they have done;

* include a panel/discussion on primary education whenever you organize a health exhibition/camp.