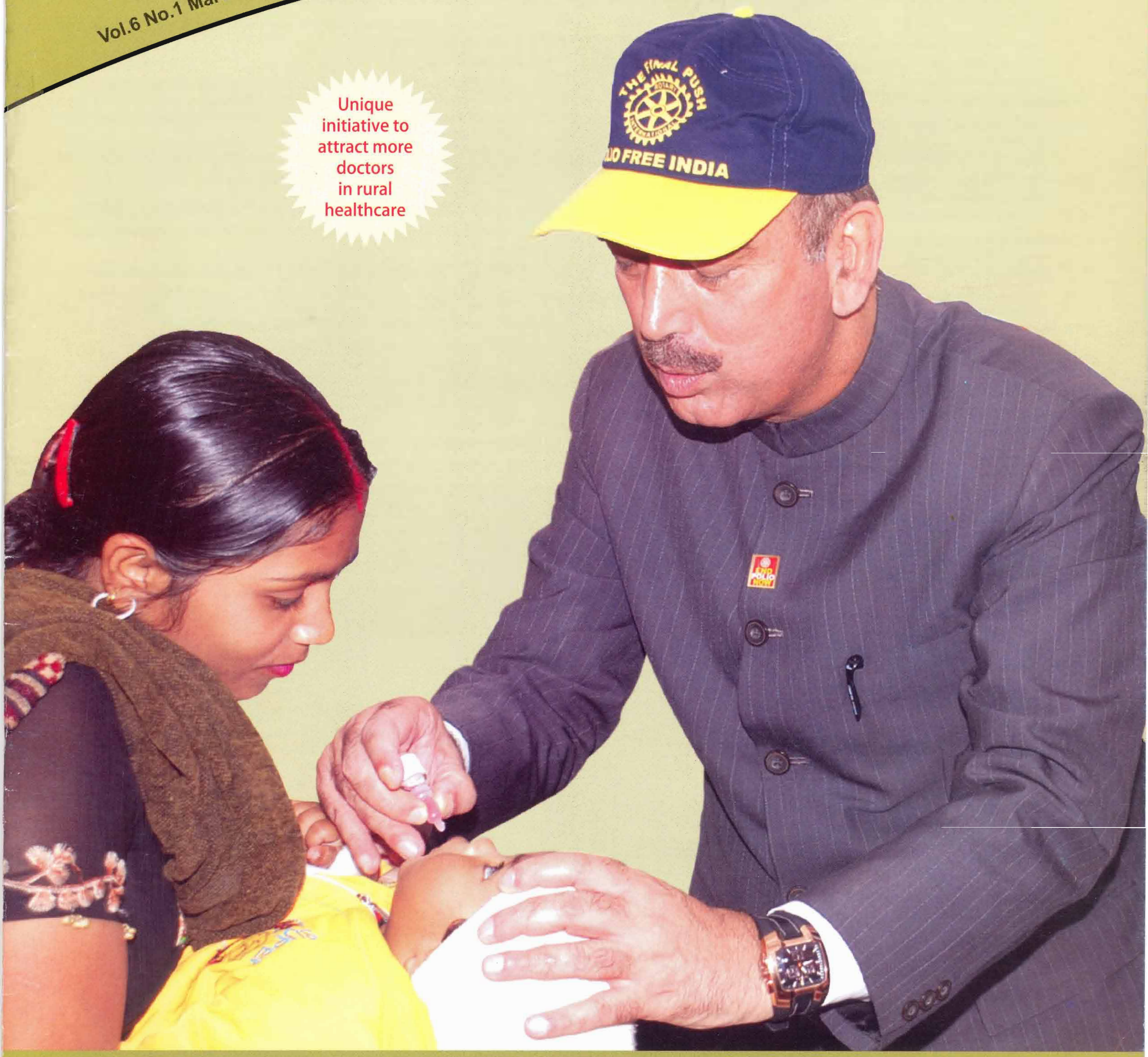
NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM NEWSLETTER

Vol.6 No.1 March - April 2010

Unique initiative to attract more doctors in rural healthcare



New system for child immunization, pregnancy tracking

Progress under NRHM

ASHAs

- 7,49,440 ASHA/Link workers selected.
- 7,05,095 ASHA given orientation training and 5.20 lakh ASHA have been positioned with kits.

Institutional Delivery

- Janani Suraksha Yojana (JSY) is operationalised in all the States 7.04 lakh women are benefited in the year 2005-06, 29.31 lakh in 2006-07, 71.19 lakh in 2007-08, 86.22 lakh in 2008-09 and 78.41 in the year 2009-10.

Monthly H&N Days in Anganwadi

- Over 58 lakh Monthly Health and Nutrition Days have been organized at the Anganwadi Centres in various states during till Dec 2008-09.

Neo Natal Care

- Integrated Management of Neonatal and Childhood illnesses (IMNCI) started in 310 districts.
- With the help of Neonatology Forum over 2,42,079 health care personnel training conducted in Newborn Care in the country.
- Module for Home based new born care developed and ASHAs to be trained in Home based new born care.

Immunization

- ASHA helping mobilization of beneficiaries
- JE vaccination completed in 86 districts in 12 states-610 lakh children immunized.
- House tracking of polio cases and intense monitoring
- Neonatal Tetanus declared eliminated from 15 states in the country
- Full immunization coverage evaluated at 54.1% at the national level (DLHS-3)

Village Health & Sanitation Committees

- 4,51,473 Village Health and Sanitation Committees have been constituted by the States. They are being involved in dealing with health planning at grass root level.

Rogi Kalyan Samitis

- Over 29,223 Rogi Kalyan Samitis set up in various health centres and hospitals.

Infrastructure

- 1.46 lakhs Sub centres in the country are provided with untied funds of Rs. 10,000 each. 4,42,817 Sub centres & VHSC have operational joint accounts of ANMs and Pradhans for utilization of annual untied funds. 40,426 Sub centres are functional with second ANM.
- Out of 4276 Community Health Centres, 3029 CHCs have been selected for upgradation to IPHS and facility survey has been completed in 2881 CHCs (includes other also).
- 29,223 Rogi Kalyan Samitis have been registered at different level of facilities.
- 9,144 Sub centres for new construction and 8997 for renovation taken up under NRHM.
- 1009 Primary Health Centres taken up for new construction and 2081 for renovation under NRHM.
- 435 Community Health Centres for construction and 1255 for renovation taken up under NRHM.

Manpower

- 11,084 Doctors and Specialist, 46,690 ANMs, 26,793 Staff Nurses, 14,490 Paramedics have been appointed on contract by States to fill in critical gaps.

Management Support

- 1,691 professionals (CA/MBA/MCA) have been appointed in the State, 639 District level Programme Management Units (PMU) and 3,760 blocks to support NRHM.

Mobile Medical Units

- 1031 Mobile Medical Units operational under NRHM in States.
- Emergency Transport System operational in 12 States with the assistance of 2919 Ambulances
- Another 1674 Ambulances provided to States for working at PHC, CHC, Sub District and District Hospital.

Health Action Plans

- State PIPs have been received from 31 states during 2006-07, 35 in the year 1007-08, 35 in the year 2008-09 and 35 State PIPs received in the year 2009-10. Project Implementation Plan (PIPs) of the States under NRHM are being apprised and approved for the year 2010-11.
- The first cut of Integrated District Health Action Plans (DHAP) has been finalized for 617 districts.

Mainstreaming of AYUSH

- Mainstreaming of AYUSH taken up in the States. AYUSH practitioners co-located in 10,872 facilities PHCs. AYUSH part of State Health Mission/Society as members.

Trainings

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

Mother NGOs

- 300 Mother NGOs appointed for 412 districts till date are fully involved in ASHA training and other activities.

Health Resource Centres

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

Monitoring and Evaluation

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

Financial Management

- Financial Management Group set up under NRHM in the Ministry.
- During the DY 2005-06, out of total allocation of Rs. 6731.16 crore for the Ministry, an amount of Rs. 5862.57 crore was released as part of NRHM.
- Against Rs. 9065 crore for NRHM activities during 2006-07, Rs. 7361.08 crore released.
- During the FY 2007-08, out of total allocation of Rs. 11,010 crore for the Ministry, an amount of Rs. 10,189.03 crore was released as part of NRHM.
- During the FY 2008-09, out of total allocation of Rs. 12,050 crore for the Ministry, an amount of Rs. 11,229.47 crore was released as part of NRHM.
- During the FY 2009-10, out of total allocation of Rs. 14,050 crore for the Ministry, an amount of Rs. 10,011,41 crore was released as part of NRHM.

Unique initiative to increase Medical Personnel in rural healthcare

Doctors serving Rural India to get benefit in PG entrance exam

Union Health and Family Welfare Minister Ghulam Nabi said in New Delhi on March 17 that the rural health cadre was being set up to address the health care needs in the rural areas.

Addressing the Lady Harding Medical College Convocation, he said an alternative medical education formula was imperative at this juncture.

For generating rural heath health manpower, distance learning, family medicine courses and a rural health cadre were required besides motivating young graduates to opt for rural service, he said. "We must aim at a system of education which should seek to promote rationality, independent thinking and innovative approach."

Impressing upon young graduating doctors and specialists to join hand with the government and come forward to serve in the rural areas, Mr. Azad said the medical education sector would have to undergo a series of reforms to meet the cutting edge level of primary health care requirement in rural India.

To encourage rural posting among doctors, additional weightage would be given in the Post Graduate entrance examination at the rate of 10 per cent for each year rural service subject to a maximum of 30 per cent in three years of rural service.

"Today the young graduates in this hall are at the threshold of a new dawn, a new beginning. Many of you would opt for specialization and post-graduation in subjects of your choice. We have the best brains in the IT sector who have impacted the world. Let us show our mettle in medical research too. This could be a bright career option as well. Indigenous technology, newer drugs, novel interventions are waiting to be discovered and we must explore this terrain," he said.


LHMC CONVOCATION

While more and more people are entering the medical profession, quite a large number, about 80 per cent of them, are treating only 20 per cent of the population - and the vast majority of our people are still deprived of proper medical attention, Mr Azad pointed out. "Our young graduates must volunteer themselves to serve in difficult and inaccessible areas. They must be willing to serve the unprivileged in society. We all owe our service to the rural India first, as rural India has been the backbone of our agriculture, environment, culture and ethos," he said.

National Population Register coming

All residents of the country will now have identity cards

The Union Cabinet on March 19, 2010 approved the creation of the National Population Register (NPR) that will complement the issue of identity cards to every resident of the country. This is a path-breaking initiative of the Government to document and digitalise the entire population gradually.

"The project would cover an estimated population of 1.2 billion and the total cost of the scheme is Rs 3,539.24 crores," the information and broadcasting minister, Ms Ambika Soni, said after a cabinet meeting chaired by the Prime Minister, Dr Manmohan Singh.

She said the creation of a digital database with identity details of all individuals along with their photographs and finger biometrics "will result in the creation of a biometrics based identity system in the country".

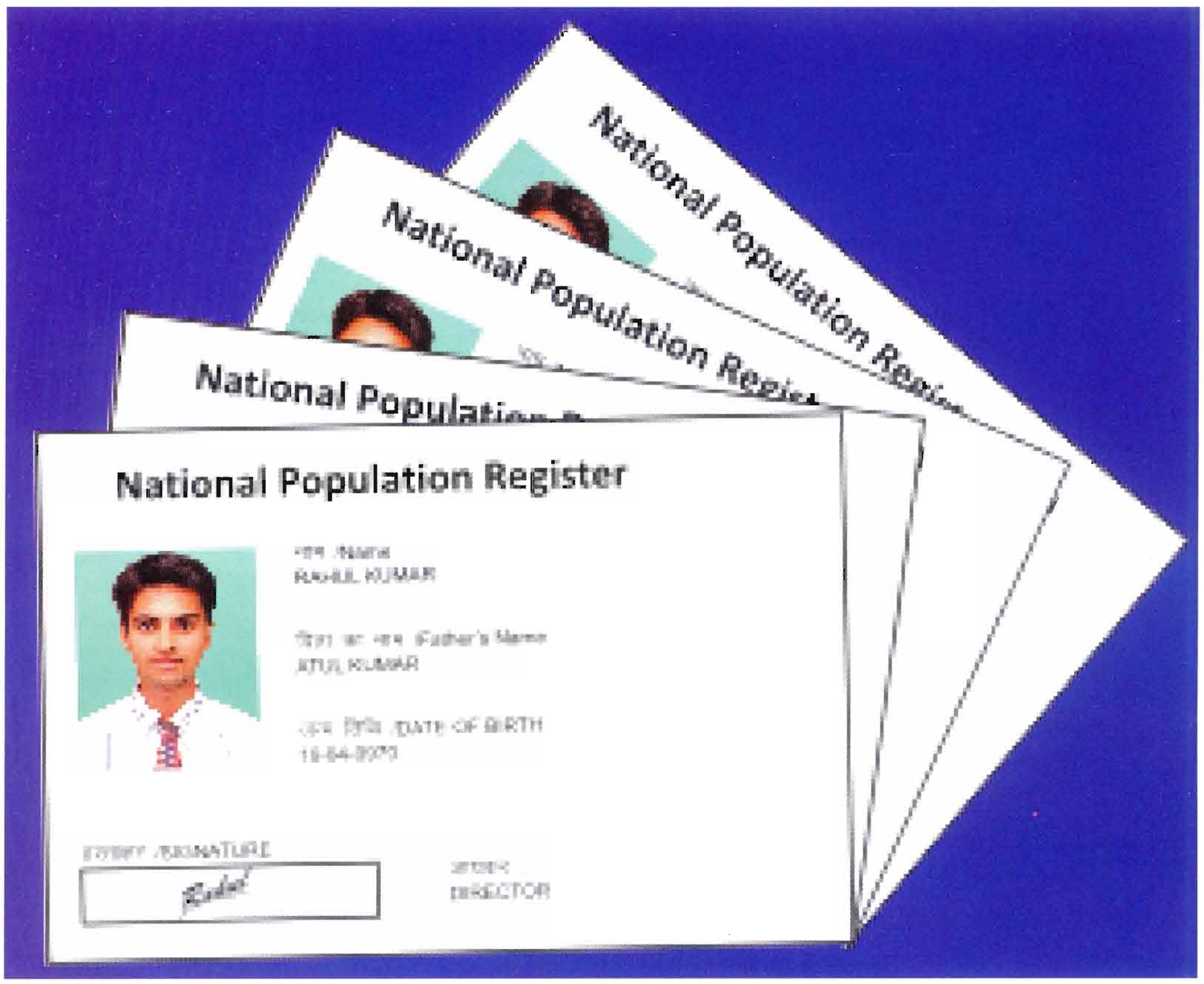
Such a database "will enhance the efficacy of providing services to the residents under government schemes and programmes, improve the security scenario and check identity frauds in the country".

Data for the National Population Register will be collected along with the house listing and housing Census starting in April and will be completed by September. The office of Registrar General and Census Commissioner will undertake the job on national scale.

The collection of particulars of each usual resident will be undertaken by house-to house enumeration. The enumerators canvassing House listing Schedule of Census 2011, will canvass the National Population Register schedule also. The filled in National Population Register schedule will be digitized in two languages – English and the official language of every State/UT. This will be followed by capture of photographs and 10 fingerprints of all those who are of age 15 years and above.

A printout of certain data fields and photographs will be displayed in villages in rural area/wards in urban areas for inviting objections from the public for corrections in spellings of names, date of birth, residency status etc. These objections will be disposed of through a series of appellate authorities at village, tehsil and district levels. The draft database will be placed before the Gram Sabha/Local bodies for authentication of usual residents. Once finalized, the NPR database will be sent to Unique Identification Authority of India (UIDAI) for biometric de-duplication and assigning of a unique identification number. This UID number will be added to the NPR database.

This will help trace individuals if they are part of an electronic record. This will avoid duplication in respect of a number of programmes. (See also pregnancy/ child immunization tracking system in the issue).



Operational Plan for Mother and Child Tracking System

It has been decided to have a name-based tracking system initiated by Government of India, for pregnant women and children. Pregnant women and children can be tracked for their ANCs and immunisation along with a feedback system for the ANM, ASHA etc to ensure that all pregnant women receive their Ante-Natal Care (ANCs) and Post-Natal Care Check-ups (PNCs); and children receive their full immunisation.

The information to be captured for pregnant women for their ANC and PNC checkups is specified in Table-I and for child immunisation in Table-II (Refer Page 6 &7). A soft copy of the formats in MS-Excel format is also available on the HMIS Portal at http://www.nrhm-mis.nic.in under the "Downloads" section. An online module for the name based tracking system is being developed and is to be integrated with the HMIS web portal. Till such time, the states may capture the relevant data as per the enclosed format which is already in an Excel template available on the HMIS web portal. Till the data is uploaded to the HMIS Portal, each District shall send the data in a soft copy to the State and the Ministry for record.

Reference Date and Coverage

The Reference Date for capturing information will be as follows:

a. All new Pregnancies detected/being registered from 1st December, 2009 at the first point of contact of the pregnant mother with the health facility/health provider

b. All Births occurring from 1st December, 2009 also need to be captured

This is to be followed by capturing and entering data for all pregnant women and births from 1st April 2009. This data is already available in the registers being maintained by the ANM/Health facilities at various levels. The necessary ID codes for capturing information has also been shared with the states.

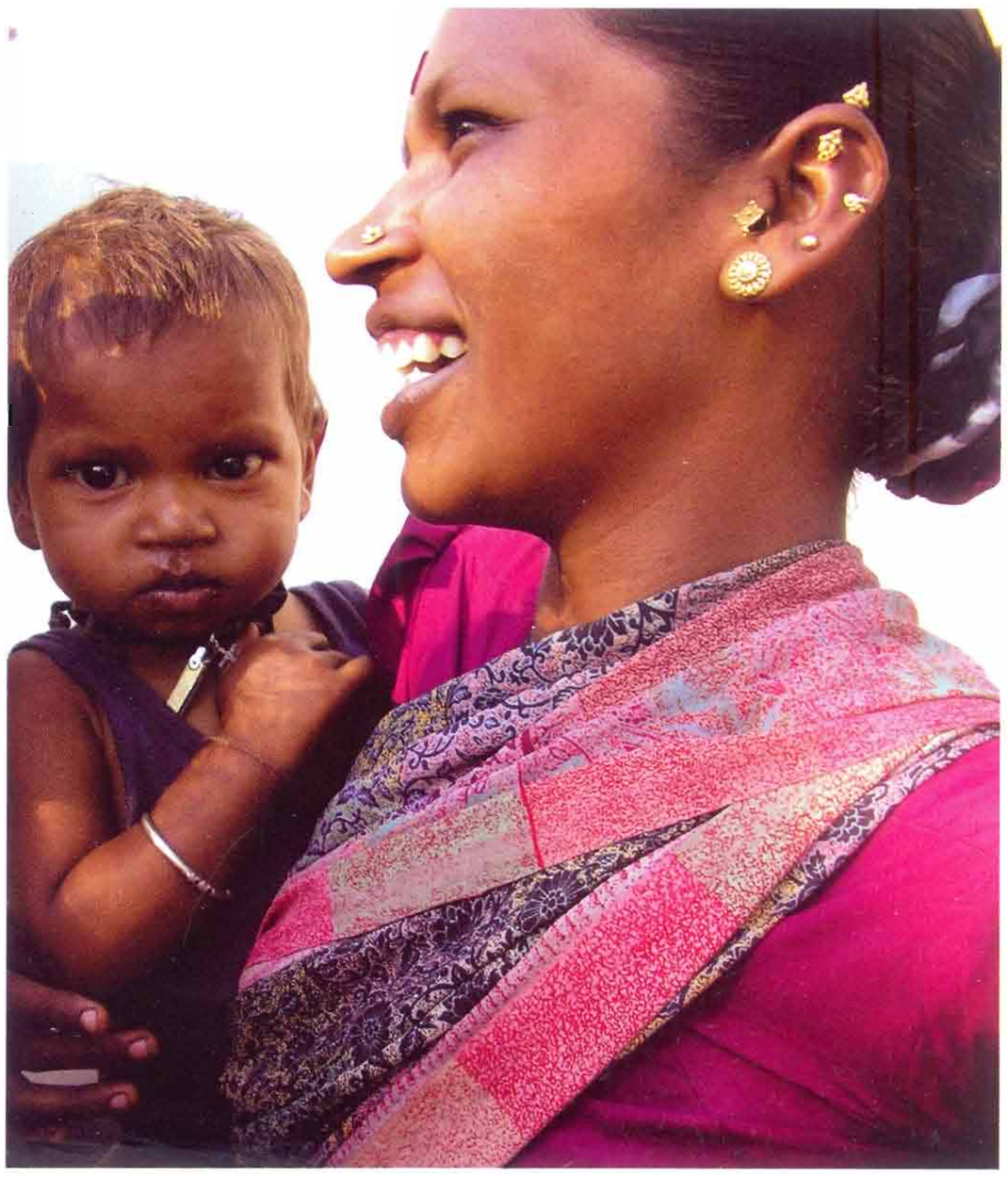
All pregnancies and births will be captured irrespective of where (place) the ANC checkups are being given or the place of delivery. Thus details of all deliveries taking place either at home, public or private institution is to be captured irrespective of the fact whether the mother is a JSY beneficiary or not.

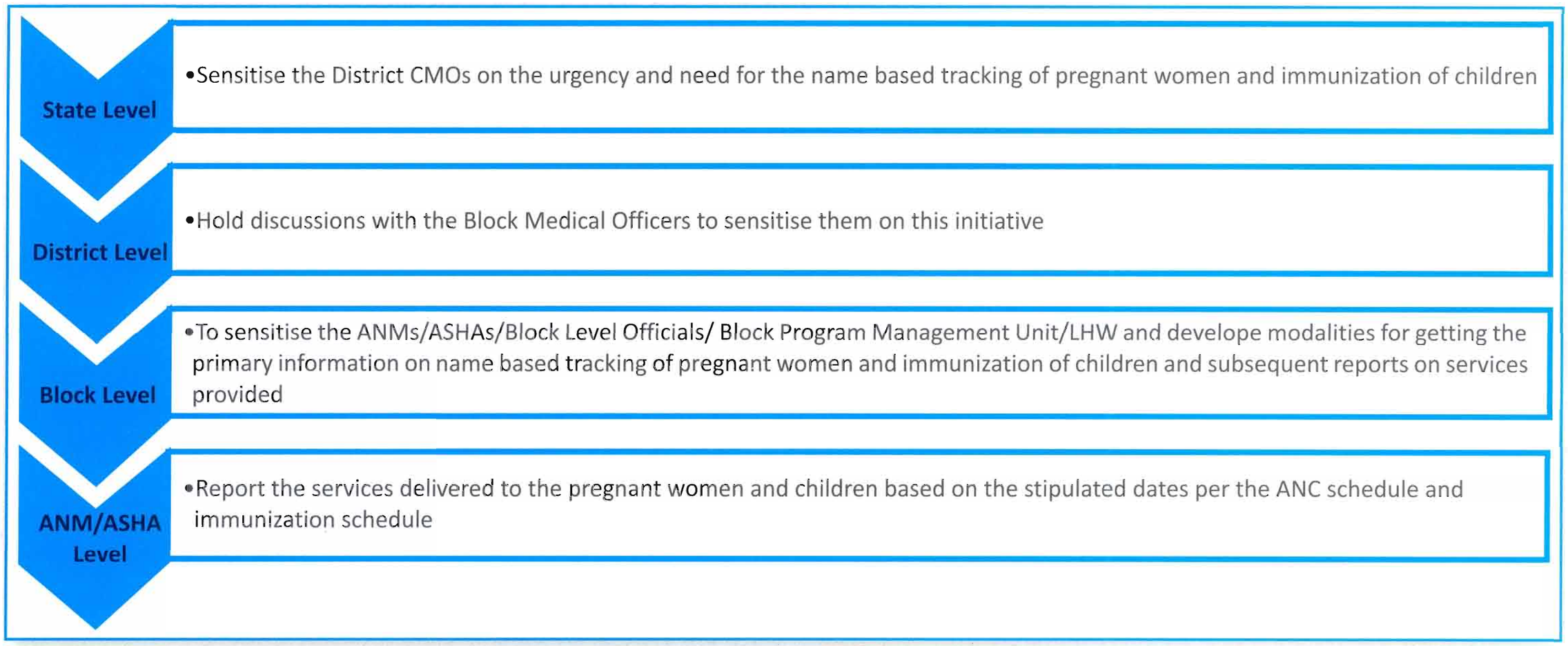
Suggested Action Plan

State level: The states would need to advise the District CMOs and sensitise them on the urgency and need for the name based tracking of pregnant women and immunization of children.

District level: The District CMOs would need to hold meetings of the Block Medical Officers immediately to sensitise them on this initiative.

Block level: The Block Medical Officers would need to hold meetings of the ANMs/ASHAs/Block Level Officials/ Block Program Management Unit/LHW to apprise them of the details and decide on the modalities for getting the primary information on name based tracking of pregnant women and immunization of children. ASHAs are to play a vital role in gathering information for the ANMs.





Identity Numbers: The Identity Numbers to be allocated to the pregnant women and children is to be as follows:

Digits (Nos)	Item	Description /Remarks
01-02 (2)	State Code	As per Census codes
03-04 (2)	District Code	As per Census codes
05-07 (3)	Block PHC/CHC Code	As per Census codes given to Block HQ
08-09 (2)	Health Sub-Centre Code	To be serially given by Block HQ.
10-10 (1)	Pregnant Woman – Code 1 Child – Code 2	
11-12 (2)	Year Code	Last 2 digits for the year is to be given, for example, for the year 2009, "09" will be entered and so on
13-16 (4)	To be given serially to each mother / child from 1st December, 2009 starting from 5000	From 1st April each year, the codes will be given afresh starting from 0001.
Total: 16 digits		

ANM/ASHA level: After the ANM has captured the base information for the name based tracking of pregnant women and immunization of children and passed on to the Block PHC, she would be reporting the services delivered to the pregnant women and children based on the stipulated dates as per the ANC schedule and immunization schedule each month. Each pregnant mother/child record will result in the generation of a Unique ID with which the pregnant mother/child can be tracked subsequently.

It is emphasized that on no account, i.e. for want of an ID number or otherwise, will service be denied to a pregnant woman for ANC/PNC checkups or a child for immunization. The ID number would be generated by the system and would be available at the time of next updation on the computer system.

Supervisory Checks: The field functionaries are to be constantly encouraged to capture information of all pregnant women and children so that they can monitor the progress of service delivery to the target beneficiaries. However, supervisory checks may also be carried out as per the following guideline to ensure correctness of primary data and services delivered.

S.No.	Level	% of cases formonthly checks
1.	State	1%
2.	District	2%
3.	Block	5%

Training Institutions for training on HMIS and Use of Data

The States may entrust a training institution in the State, say, the State Institute for Health & Family Welfare (SIHFW), RHFWTC, SHSRC or at the District level, to take up responsibilities for

imparting training on the following:

(i) Technical support for the name based tracking of pregnant women and child immunization at the District and Sub District level.

(ii) Data capturing on the HMIS Portal, preparation of Reports, analysing data (both HMIS and Survey data) and using it for local action and planning. This would include (populating the facility masters), mapping of health facilities and data capture at the Sub-District/Facility level on the HMIS Portal.

(iii) Data capturing for the National Health Programmes and FMRs from the District level

(iv) Steps to be taken for improving the quality of data at various levels.

The assistance required from the Ministry or NHSRC for capacity building at the State/District level may also kindly be indicated.

Potential Offshoots/Benefits

- Better control on estimates of infant and maternal mortality
- Off-take of JSY benefits
- Improved supply chain management of vaccines and drugs
- Focussed deployment of personnel based on the case load
- Improvement in Registration of births
- Used as basis for ICDS, Primary education, Adolescent health
- Better data analysis for preparation of Block/District health action plans and State PIPs with realistic/accurate denominators.

Processes involved

1. Inputs required

- MCH Card – Both JSY and Non-JSY
- Individual identification details – linked to household's
- Services rendered

2. Output reports

- Facility Service Statistics
- ANM's Monthly Action Plan – For ANC and Immunization

3. Processes involved

- Registration of MCH Card
  - New card on first interaction
  - De-duplication and linkages subsequently – IT based
- Updation of MCH Card
- Monthly updation at Block level – tied up with the Monthly Meeting
- Action plan of ANM for following month
- Individual details do not flow up in reports

4. Limitations

- Reach of ANM
- IT infrastructure and connectivity at Block level
- Data Officer/Assistant at Block level

5. Implementation challenges

- Training of ANM
- Training of Block Data Officers/Assistants
- Usage of CSC network wherever feasible – (costing to be decided)

6. Roll out plan

- Linking roll-out with sub district/facility level HMIS roll out
- Training at block level for Block level Data Officer/Assistant and ANMs
- System audit after 6 months of implementation
- After stabilisation – feasibility of using mobile technology

Pregnant Woman Tracking (Table I)

A Identification Details

ID No. ..... Name ..... Husband's Name .....

Phone No. (If not available, phone number of nearest neighbor) Home...../ Neighbour .....

Date of Birth (DD/MM/YY) or Age in Years (if DOB not available) .....

JSY Beneficiary (Y/N) Caste (SC/ST/Others) .....

B Location Details

State ..... District ..... Block ..... Gram Panchayat/Village .....

Address .....

C Health Provider Details

Name of Sub-Centre _____ Name of ANM _____ Phone Number of ANM _____

Name of associated ASHA _____ Phone Number of ASHA (if available) _____

Linked facility for delivery (DH/SDH/CHC/PHC/Private/ etc)

D ANC Details Date to be specified (dd/mm/yyyy)

LMP	Date	☐☐ ☐☐ ☐☐☐☐
1st ANC (including Registration)	Date	☐☐ ☐☐ ☐☐☐☐
2nd ANC	Date	☐☐ ☐☐ ☐☐☐☐
3rd ANC	Date	☐☐ ☐☐ ☐☐☐☐
4th ANC	Date	☐☐ ☐☐ ☐☐☐☐
Tt1 (immediately at detection of pregnancy)	Date	☐☐ ☐☐ ☐☐☐☐
TT2 (after 1 month of TT1 administration)	Date	☐☐ ☐☐ ☐☐☐☐
TT Booster	Date	☐☐ ☐☐ ☐☐☐☐

(Booster is required only for those women who have been previously immunised and hence require only single dose)

IFA tablets given	Date (on which 100 IFA Tabs completed) .....
Anaemia (Hb level)	Classify: (Moderate<11/Severe<7/None)
Complication	(Hypertensive/Convulsions/Diabetics/APH/Malaria/None)
RTI/STI	(Y/N)

E Pregnancy Outcome

Place of delivery (Home-Type/Institutional-Type) _____

(Home Type - SBA/Non SBA Institutional Type: HSC/PHC/CHC/SDH/DH/Private) Delivery Type (Normal/CS/Instrumental)

Complications (Y/N) Date of Delivery (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Date of Discharge from Institution (if applicable) (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ JSY Benefits paid (Y/N)

Abortion (MTP<12/MTP>12/Spontaneous/None) (If None, then other details to be filled)

F PNC Details

PNC Home Visit	(Within 48 hours/7 days)
PNC Complications	(PPH/Sepsis/Death/Others/None)
Post Partum Contraception Method	(Sterilisation/IUD/Injectibles/Others)
PNC Checkup	(Y/N)

G Infant Details

Outcome Numbers (0/1/2/3/4/5) 0=Still Birth

The following details to be captured for each child born – for child tracking

Name _____ Sex M/F _____ Weight at birth(kgs) ____ Initiated Breastfeeding within 1 hour (Y/N)

H Remarks

Reasons for closure of case

{Migration, Death etc}

Child Immunization Tracking (for each child) (Table II)

A Identification Details

ID No. ..... Name ..... Mother's/Father's Name & ID No. .....

Phone No. (If not available, phone number of nearest neighbor)

Home...../Immediate Relation...../ Neighbour .....

Date of Birth (DD/MM/YY) or Age in Month (if DOB not available) .....

Place of delivery (Home, Public/Private Institution)

Blood Group (if available) .....

Caste (SC/ST/Others)

B Location Details

State ..... District ..... City/Mohalla ..... Block ..... Gram Panchayat/Village .....

Address .....

C Health Provider Details

Name of Sub-Centre ..... Name of ANM ..... Phone Number of ANM .....

Name of associated ASHA ..... Phone Number of ASHA (if available) .....

D Immunization Detail — Date to be specified (dd/mm/yyyy)

At Birth — Date

BCG
OPV 0
Hepatitis-B1

At 6 weeks after birth

DPT1
OPV1
Hepatitis-B2

At 10 weeks after birth

DPT2
OPV2
Hepatitis-B3

At 14 weeks after birth

DPT3
OPV2
Hepatitis-B4

9 -12 months after birth — Date

Measles
Vitamin A Dose-1

16-24 months after birth

MR Vaccine
DPT Booster
OPV Booster
Vitamin A Dose-2
Vitamin A Dose-3
JE vaccine

2 years & above

Vitamin A Dose-4 to 9
DT5
TT10
TT16

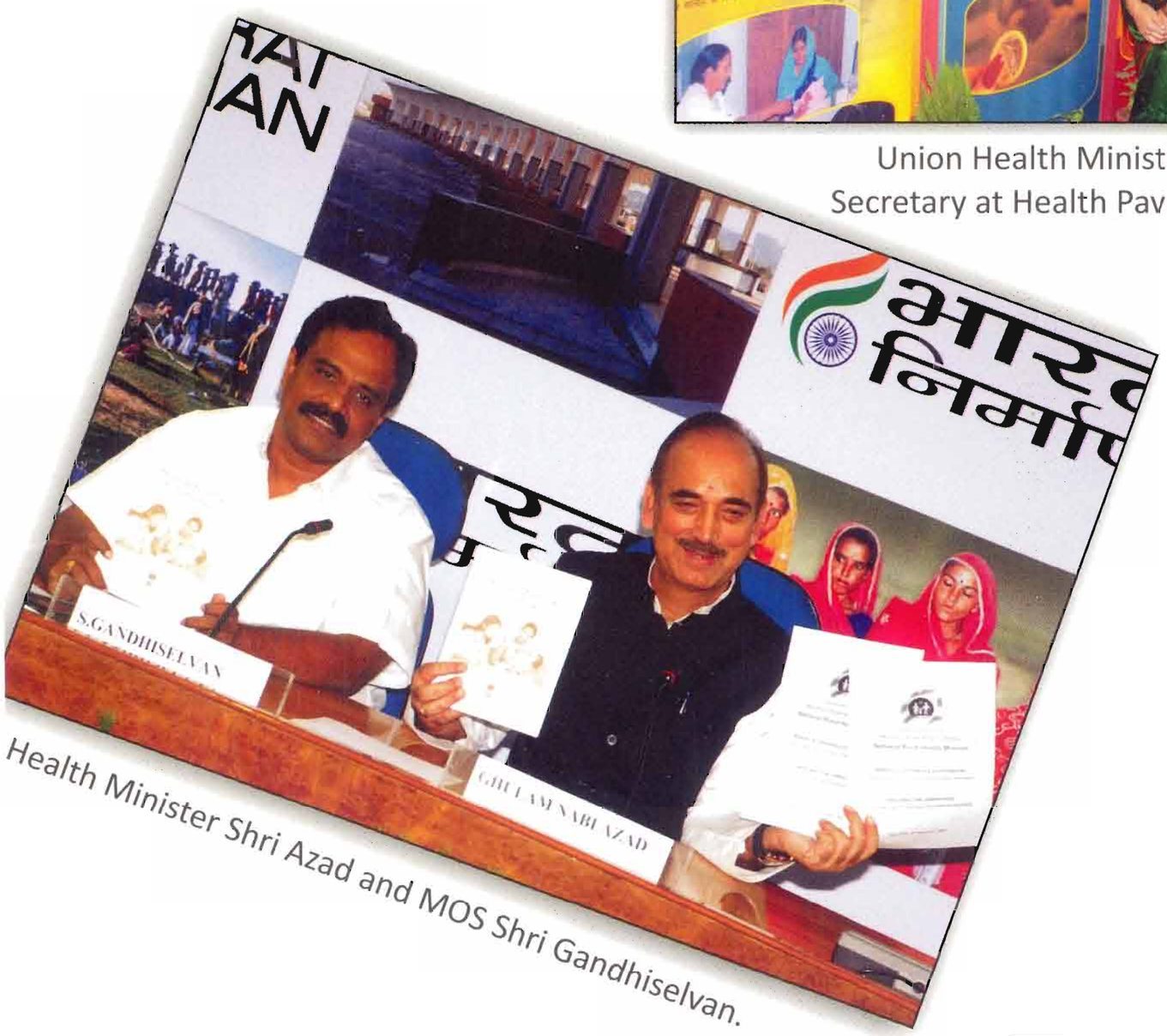
E Remarks

Reasons for closure of case
{Migration, Death etc}

Union Health Minister greeting the Swedish Health Minister in New Delhi.

Union Health Secretary Miss Sujata Rao

Union Health Minister with Union Health Secretary at Health Pavilion, IITF, New Delhi.

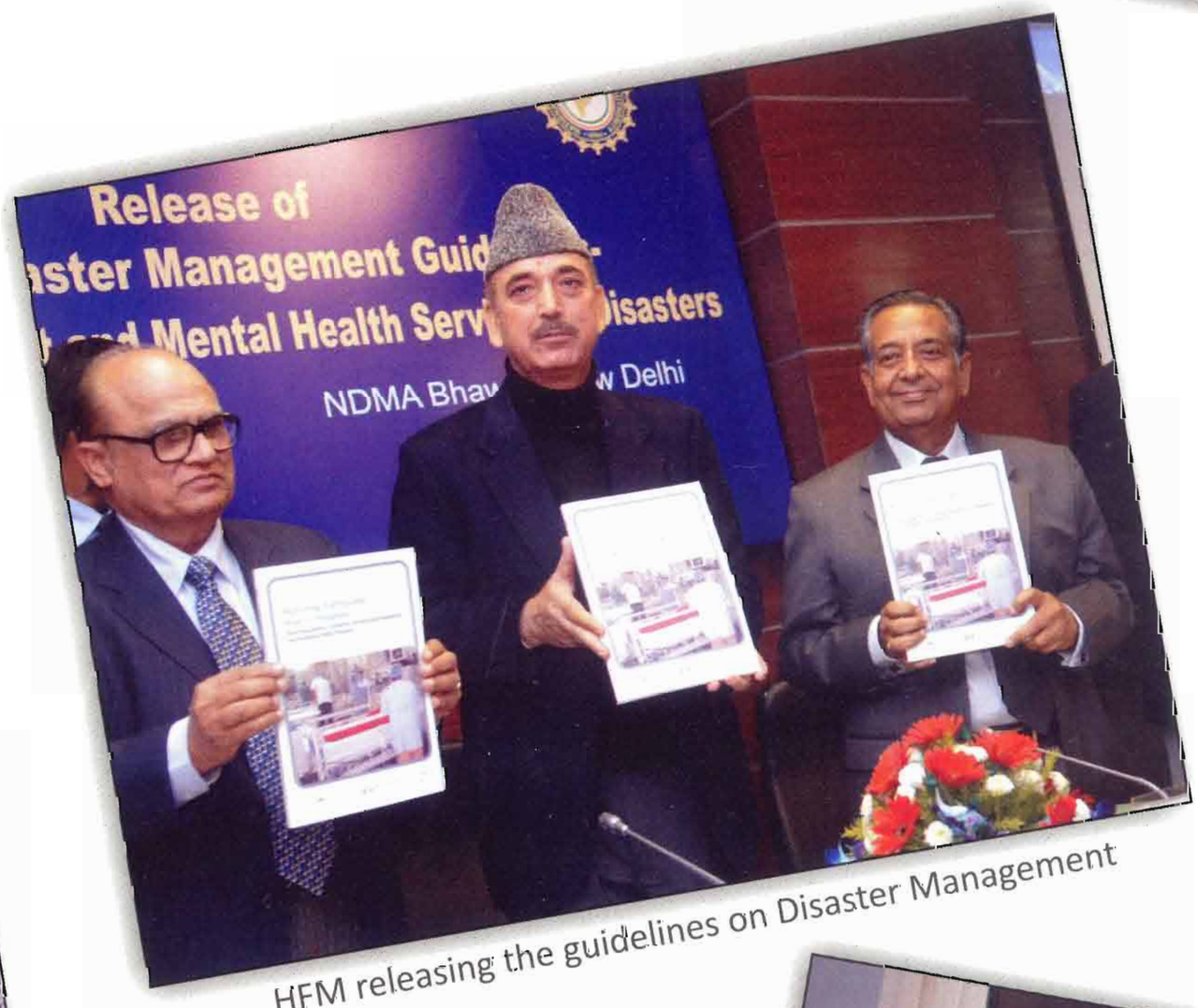


Health Minister Shri Azad and MOS Shri Gandhiselvan.

Union Health Minister addressing

eaking on NRHM initiatives

MOS Shri Dinesh Trivedi speaking on Tobacco Control.



HFM releasing the guidelines on Disaster Management

cial Editors conference in New Delhi.

Health Minister of Turkey with Union Health Minister.

More funds for making of 6 New AIIMS & 13 upgraded medical colleges

The Union Cabinet today approved the Revised Cost Estimates (RCE) for setting up of six new AIIMS like Institutions and upgradation of 13 existing Government Medical College Institutions under Prime Minister's Swasthya Suraksha Yojana (Phase I) for an outlay of Rs.9307.62 crore. The Cabinet Committee on Economic Affairs had earlier approved the Scheme for Rs.3975.99 crore. Due to substantial changes in the cost and scope of the works the requirement of funds has trebled necessitating a fresh Cabinet approval.

The allocation made for the PMSSY-Phase I projects for the XI Plan was Rs.3955 crore. Additional expenditure involved would be Rs.5535.62 crore. However, the allocation of XI Plan is sufficient to meet the expenditure in the remaining two years of the plan period .

The new institutions/upgraded facilities in the existing medical colleges would provide tertiary health care facilities in and around the location and adjoining districts/States in the country.

The projects under Phase-I of PMSSY are spread over 19 locations in the 16 States of the country. The new AIIMS-like institutions are located at Bhopal (Madhya Pradesh), Bhubaneswar (Orissa), Jodhpur (Rajasthan), Patna (Bihar), Raipur (Chhattisgarh) and Rishikesh (Uttarakhand). The AIIMS-like institutions will be completed by the end of 2012. The upgradation components in Phase-I involves upgradation of Government Medical Colleges at Trivandrum, Salem, Bangalore, Kolkata, Jammu and Srinagar; NIMS, Hyderabad; SGPGIMS, Lucknow; B.J. Medical College, Ahmedabad; RIMS, Ranchi; IMS, BHU, Varanasi; SVIMS, Tirupati; and Grants Medical College, Mumbai.

Background:

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) was initially started in March, 2006 with the object of correcting regional imbalances in the availability of affordable/reliable tertiary healthcare services and also to augment facilities for quality medical education in the country. PMSSY has two components in its first phase - (i) setting up of six AIIMS-like institutions and (ii) upgradation of thirteen existing Government medical college institutions. CCE approved the proposal for setting up AIIMS-like institutions in March 2006 and upgrdation proposal in June 2006.

A file picture of AIIMS, New Delhi.

KNOW OUR ASHA –
Mrs. DILLIGI DIFOESA

Mrs. Dilligi Difoesa has been working since 2007 as the ASHA of Dhansiripar village, Dimapur, a village with a population of 1561 (Male – 761: Female – 800). Ever since, she has shown dedication and sincerity in her duties. Mrs. Dilligi is a role model for all ASHAs, her inspiring story, a commendable case in point...

When it comes to Ante-Natal Care (ANC), Mrs. Dilligi encourages pregnant women in her village to get at least 3 ANCs. She makes it a point to personally accompany them, and till date, she has taken 108 pregnant women for ANC check-ups and escorted 71 of them for institutional delivery.

Mrs. Dilligi was mentored by a retired Staff Nurse of her village in conducting home deliveries, because of which she now can deliver a baby unassisted and administer necessary drugs for safe deliveries. She also makes sure mothers who avail institutional deliveries as well as those who had home deliveries receive Post natal Care.

Her tireless efforts in promoting small family norms as well as use of contraceptive methods has now seen many eligible couples in her village aware of various Family Planning methods (permanent & temporary) and the most suitable methods they can opt for. In her own subtle ways, Mrs. Dilligi tries to promote Adolescent Reproductive and Sexual Health (ARSH) among the youth in her village by talking about stories and incidents with health and moral implications. She takes part in cleanliness drives which are regularly carried out in her colony and also advocates safe disposal of human wastes. Any sick person in her village can be sure of getting advice from her on first aid, home remedies and visiting health centres for further check-ups. She also advices patients who are under Direct Observation Treatment (DOT) to follow their regimented dosage of medications.

Thanks to her diligent efforts, her community's thinking about health issues is slowly changing. The villagers are now eager to learn more about their ailments and are more open to discuss them with health workers. Talking about family planning methods is no longer a taboo, myths and superstitions are giving way to modern methods of medication and treatment.

By Ms. Kimnei, District Media Officer, NRHM News Nagaland, Dimapur.

What To Eat To Be Healthy

Excerpts from the Indian adaptation of ***Where There is No Doctor,*** recently brought out by the Ministry of Health & Family Welfare, Govt. of India, for the use of field Health workers.

SICKNESSES CAUSED BY NOT EATING WELL

Good food is needed for a person to grow well, work hard, and stay healthy. Many common sickness come from not eating enough of the food the body needs. Eating as many different types of foods in good as different foods provide variety of nutrients.

MALNUTRITION

Among poor people, Malnutrition is often most severe in children, who need lots of nutritious food to grow well and stay healthy.

1. This child does not get enough of any kind of food, especially energy foods. In other words, he is starved. His body is small, very thin, and wasted. He is little more than skin and bones.
   This child needs more food - especially energy foods.

face of an old man
always hungry
potbelly
very underweight
very thin

This child is just skin and bones

2. This child has not been eating enough body-building foods, or proteins, although he may be getting enough energy foods, because his feet, hands, and face are swollen.
   Although he may look somewhat fat, he has very little muscle left. He is little more than skin, bones, and water.
   This child needs more foods rich in protein.

Protein energy malnutrition often appears first when a child has diarrhea or another infection. It is seen most often in babies who have stopped breast feeding and who are given foods made with rice, corn, sugar, or other energy foods, without enough milk or other protein-rich-food.

Because of swelling, and because he may even have some fat, the child with malnutrition may look plump rather than thin. But his muscles are wasted, and if you look at his upper arms, you will find them surprisingly thin.

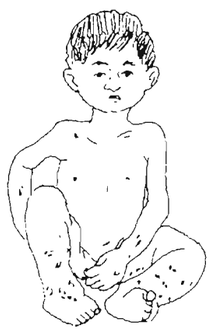
swollen 'moon' face

miserable

stopped growing

sores and pooling skin

swollen hands and feet



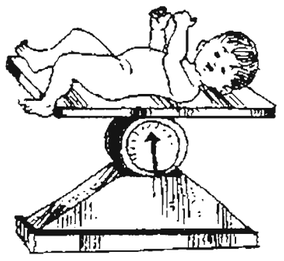
color loss in hair and skin

thin upper arm

wasted muscles (but he may have some fat)

This child is just skin, bones and water

Protein energy malnutrition develops all at once. A child may already be fairly malnourished and still show few signs. A good way to check if child is poorly nourished is to measure the distance around the upper arm and appropriate weight for age.



CHECKING FOR MALNUTRITION

A good way to tell if a child is well nourished or poorly nourished is to weigh him once a month. A healthy, well-nourished child gains weight regularly.

MALNUTRITION IN PREGNANT WOMEN

Malnutrition in a pregnant woman can be suspected if :

a) She comes from a poor family.
b) She was left by her husband.
c) She has many babies within a short period of time.
d) She has TB or anemia.
e) She gains very little weight during pregnancy.

You can tell if a woman is malnourished by her appearance. If she is thin, with loose folds of skin over the arm, chest or abdomen or if her arms and legs are very thin, then she is suffering from malnutrition. Visit a malnourished woman often and encourage her to eat as much nutritious food as possible.

The patches on the mother's arms are a sith or pellagra, a type of malnutrition. She is mostly eating one kind of food and not a mixture of different kinds of foods such as beans, vegetables, dark green leafy vegetables.

Malnourishment during pregnancy can lead to stillbirth, high maternal and infant mortality.

Because she was not eating well, her breasts did not produce milk for her baby. As a result, the child suffers from extreme malnutrition.

To prevent this, mothers and their children must eat better.

The patches on the mother's arms are a sith of pellagra, a type of malnutrition. She eats mostly one kind of food and not a mixture of different kinds of foods such as beans, darkgreen leafy vegetables

GETTING ENOUGH GOOD FOOD

Some children are weak and underweight and begin to swell or show other signs of 'wet' malnutrition even though they are getting some milk and other body-building foods. This is often because they are not getting enough energy foods, so they 'burn up' the protein they should be using to grow and make their bodies strong.

Certain bulky foods like plantains (cooked green bananas) and roots (yams, cassava, taro, etc.) have so much water and fiber in them that the child gets full without getting enough food to meet his energy needs. His belly cannot hold more, but he is still starving.

It is very important that such children eat at least 3 times a day, **and also snack between meals**. Mixing a little vegetable oil with a child's food also helps. Whenever possible he should eat other less bulky, more nutritious foods-both energy foods and proteins.

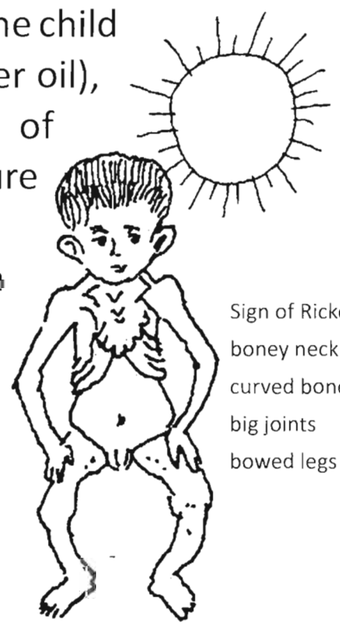
Prevention and treatment of malnutrition :

Malnutrition can be prevented or treated by eating a balance of nutritious foods and by eating enough. For babies, breast milk is the best complete food. Only breast feeding should be given for first 6 months. Some mothers breast feed their babies for 2 years or longer. After 6 months the baby should begin to get her nutritious foods in addition to breast milk.

Other forms of malnutrition :

Among poor people the most common forms of malnutrition are due either to hunger or lack of protein. However, other forms of malnutrition may result when certain vitamins and minerals are missing from the foods people eat. For example :

- Young children who eat no yellow or dark green fruits and vegetables or other foods rich in vitamin A may develop night blindness, dry eyes, and eventually go blind.
- Children who do not drink milk and whose skin is almost never exposed to the sunlight may become bowlegged and develop other bone deformities (rickets). While this problem can be corrected by giving the child milk and vitamin D (found in fish liver oil), the easiest and cheapest form of prevention and treatment is to be sure sunlight reaches the child's skin.
- Persons who do not eat enough foods with iron, such as eggs, dark green leafy vegetables, or meat, may develop anemia.
- A number of skin problems, sores on the lips and mouth, or bleeding gums may come from not eating fruits, vegetables, and other foods containing certain vitamins.



Sign of Rickets :
boney neckless
curved bones
big joints
bowed legs

SUNLIGHT IS THE BEST PREVENTIONAND TREATMENT OF RICKETS

WAY OF EATING BETTER IF YOU ARE POOR & DO NOT HAVE RESOURCES

There are many reasons for hunger and poor nutrition. One reason is poverty. In many parts of the world, a few people own most of the wealth and the land. They may grow crops like coffee or tobacco, which they sell to make more money, but which have no nutritional value. Or the poor may farm small plots of borrowed land, while the owners take a big share of the harvest. **The problem of hunger and poor nutrition will never be completely solved until people learn to share with each other fairly.**

But there are many things poor persons can do to eat better at low cost - and by eating well gain strength to stand up for their rights. In 'Words to the Village Health Worker' you will find several suggestions for achieving better nutrition. these include improved use of land through **rotating crops, contour ditches**, and **irrigation;** also **breeding fish, beekeeping**, improved **grain storage** and planting **family gardens.** If the whole village or a group of families work together on some of these things, a lot can be done to improve nutrition.

When considering the question of food and land, it is important to remember that **a given amount of land can feed only a certain number of persons.** If the amount of land and other resources you family has is limited, it is wise to plan and only have the number of children that you can feed well. More children may mean more hands to do work, but it does not necessarily mean more land to work.

Hungry children do not work well, and many of them die.

Small family size is becoming increasingly important for good nutrition. Think about this and plan ahead.

When money is limited, it is important to use it wisely. This means cooperation and looking ahead. Too often the father of a poor family will spend the little bit of money he has on alcohol and tobacco rather than on buying nutritious food : a hen to lay eggs, or something to improve the family's health. Men who drink together would do well to get together sometime when they are sober, to discuss these problems and look for a healthy solution.

Also, mothers sometimes buy sweets or soft drinks (fizzy drinks) for their children when they could spend the same money buying eggs, milk or other nutritious foods. This way their children could become more healthy for the same amount of money.

No

IF YOU HAVE A LITTLE MONEY AND WANT TO HELP YOU CHILD GROW STRONG :

DO NOT BUY HIM A SOFT DRINK OR SWEETS - BUY HIM A COUPLE OF EGGS / MILK / FRUITS.

Yes

BETTER FOODS AT LOW COST

Many of the world's people eat a lot of starchy foods. or carbohydrates, and not enough foods rich in protein, vitamins, and minerals.

A large number of people in India are vegetarians. A combination of foods - Like beans, peas, lentils, groundnuts, and dark green leafy vegetables, with fruits make a balanced diet including the desired protein.

People can be strong and healthy when a combination of foods is taken.

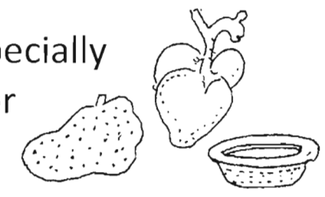
Try to **eat a variety of plant foods** rather than mostly one or two. Different plants supply the body with different proteins, vitamins and minerals. For example, beans and maize together meet the body's needs much better than either beans of maize alone. And if other vegetables and fruits are added, this is even better.

Here are some suggestions for getting more proteins, vitamins, and minerals at low cost.

1. Breast milk : This is the healthiest. and most complete food for a baby. it is very nutritious and just right for the baby as it contains nutrients in the correct proportion as required by the baby. The mother can eat plenty of plant protein and turn it into the perfect baby food-breast milk. Breast feeding is not only best for the baby, it saves money !

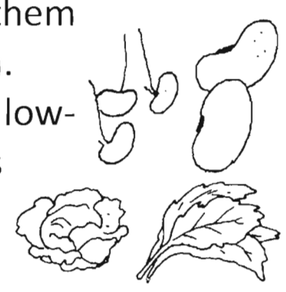
2. Eggs and chicken : In many places eggs are one of the best forms of animal protein. They can be mixed with foods given to babies who cannot get breast milk. Or they can be given along with breast milk as the baby grows older.

Eggshells, ground up and mixed with food, can provide needed calcium for pregnant women who develop sore, loose teeth or muscle cramps.



3. Liver, heart and kidney : These are especially high in protein, vitamins and iron (for anemia). Fish is often cheaper than other meat but is just as nutritious.

4. Beans and other legumes (peas, lentils etc.) are a good cheap source of protein especially soybeans. If allowed to sprout before cooking and eating, they are higher in vitamins. Baby food can be made from beans by cooking them well, peeling off their skins, and mashing them. Beans, peas, and other legumes are not only a low-cost form of protein, growing these crops makes the soil richer so that other crops will grow better afterwards. For this reason, crop rotation is a good idea.



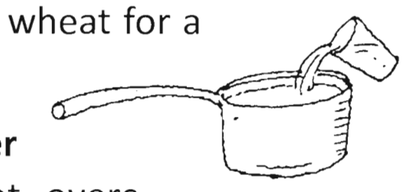
5. Dark green leafy vegetables are good source of iron, calcium, vitamin C and B-Carotene. The leaves of sweet potatoes, beans and peas, pumpkins and squash, and spinach are especially nutritious. They can be dried, powdered, and mixed with babies gruel to add to the protein and vitamin content. Green Leaves or root vegetables like are very nutritious and cheap.

6. Rice, wheat and other grains. They are more nutritious if they are not polished. Moderately polished. Moderately polished rice, and whole wheat contain more vitamins than the white, over-polished product. (Parboiling causes and important in the husk to move deep into the grain). Parboiled, hand-pound rice is better than the over-polished rice.

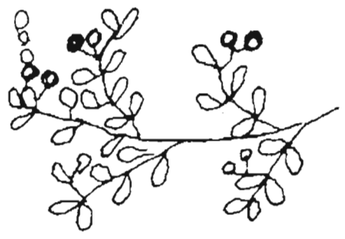
Note : The protein in wheat, rice or maize and other grains can be better used by the body when they are eaten with beans or lentils.

7. Dried maize : (corn) when soaked in slaked lime before cooking, changes the protein into a form which can be mor easily used up by the body.

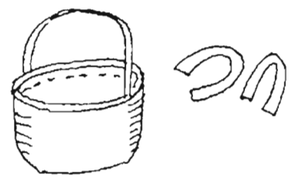
8. Ragi and bajra. These are very rich in minerals, especially calcium and iron. They are cheaper than rice or wheat, and are also more nutritious. These can be used instead of rice or wheat for a good diet.



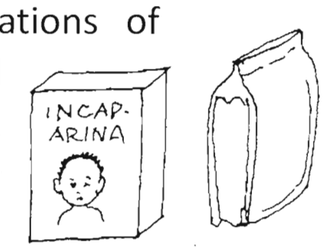
9. Cook vegetables, rice, and other Foods in little water and do not overc ook. This way fewer vitamins and proteins are lost. Be sure to drink the leftover water, or use it for soups.



10. Many wild fruits and berries are rich in vitamin C as well as natural sugars. They can provide a good vitamin and food supplement. (Be sure to eat only those which are not poisonous.)



11. Cooking food in iron pots adds iron to food and helps prevent anemia.



12. Low- Cost Infant food preparations can be made from a combination of roasted flour, dal, sooji etc. as available, made from different combinations of soybean, cotton seed, skim milk, or dried fish. Some taste better than protein foods. When mixed with gruel, cooked cereal, or other baby food, they add to its nutrition content-at low cost.

Letters

Dear Sir,

I am a retired Health Education Officer from Kerala Health Services Department and a regular reader of NRHM Newsletter since its beginning. It is really very informative and gives authentic knowledge on various health programmes and its progress in all different states of our country. As retired public health personnel, still I am very happy to extend strong support and possible help to the PHC Staff to carry out all health programmes successfully under its jurisdiction. I am proudly saying that the NRHM provides an excellent health care service to the needy rural people of India. Kindly try to include more articles on both communicable and non-communicable diseases, which will help all category staff to update their knowledge. I will be grateful if you kindly include my name in your mailing list.

Shri K.M. Usman Koya,
Health Education Officer (Retd.),
PO Achooranam Pozhuthana, Wayanad, Kerala – 673 575

Dear Sir,

I am very much impressed by NRHM Newsletter which I read very recently. It was useful for me to teach undergraduate and postgraduate students of Community Medicine. I also found the usefulness of the book to common man. I will suggest publishing and distributing the Newsletter in all local languages. I congratulate the Editor and publishers for their contribution to public health.

Dr. Prof. D.K. Mahabalaraju,
Professor, Community Medicine,
J.J.M. Medical College, Davangere – 577 004

Dear Sir,

I went through the NRHM Newsletter March – April 2009 issue wherein the fact of community monitoring system is highlighted. This plan is good to activate the present inactive administrative system in health department. I request you to enroll my name in the mailing list.

Shri Waman Rao,
Sri. Datta Nilaya, 11th Cross, Jayanagar East, Tumkur – 572 102

Dear Sir,

Our association – Ashish Educational and Health Promotional Organization, Gujarat has been working since last 20 years in the field of women, child health, health promotional activities etc and care for older persons in the rural areas of Gujarat. The NRHM Newsletter is very useful to our quality works as well as for the enhancement of our performance for the activities in our areas. I request you to kindly send me a copy of the Newsletter regularly to our office address.

Dr. Shyamal Purani,
M.D. (PSM), DGO, CCN,
66, "EKTRA", Vinay Vihar Hsg. Society,
Baherampura, Ahmedabad – 22.

Dear Sir,

I am posted as District Child Survival Officer in Bhagalpur. I am a regular reader of NRHM Newsletter which I take from District Health Society, Bhagalpur. NRHM Newsletter is very informative. Kindly put my name in the subscriber list of NRHM Newsletter.

Dr. Riyaz Ahmad,
DCSO, UNICEF, Bhagalpur,
Bihar

Dear Sir,

I am working as Assistant Accountant in UP Rural Institute of Medical Sciences & Ressearch, Saifai in Etawah District of Uttar Pradesh. I have read your NRHM Newsletter. It is very resourceful to all the medical staff. Kindly put me on your mailing list for Hindi edition and also request you to send all previous issues.

Shri Prafulla Saxena,
Church Lane,
Ganga Enclave Colony,
Banna Devi,
G.T. Road,
Aligarh (UP)

Dear Sir,

I am working as a Block Extension Educator in Govt. Block Primary Health Centre, Rayapuram, Tiruvarur District, Tamil Nadu. I read NRHM Newsletter regularly at PHC. It is very useful and the information in the Newsletter is very helpful for taking training classes and conducting awareness meeting i.e. it helps to improve my skills and update by knowledge. Nearly 50 field level staff is working in our Needamanglam Bock, so I miss reading your Newsletter continuously and timely. Do kindly include my name and address in your mailing list.

Shri V. Swaminathan,
Block Extension Educator,
Govt. Block Primary Health Centre,
Rayapuram 612 803
Needamangalam Block,
Tiruvarur Dsitt,
Tamil Nadu

Dear Sir,

I am working as Medical Officer (Community Health) at New PHC, Rani Bazar, Faizabad (UP). Fortunately I came to see your NRHM Newsletter in Hindi version. I found this Newsletter very much informative and helpful for Doctors and health workers. No doubt, this magazine with its valuable information is playing great role in providing preventive, promotive and curative health care. Kindly enroll me in your mailing list for English version.

Dr. Qamrul Hasan Lari,
Medical Officer,
C/o Naushad Hussain,
House No. 95,
Near Railway Masjid,
Mohalla PO Bargaon,
Distt. Gonda (UP) – 271 002

Dear Sir,

Kindly share with us NRHM Newsletter for usefulness of our Institute. Please put our institute in your mailing list.

Ms. Geeta,
Librarian
International Instt. of Health Management Research (IIHMR),
Plot No. 3, HAF Pocket,
Sector-18A, Phase II,
Near Veer Awas/Kargil Appts,
Sector 12 Metro Station,
Dwarka, New Delhi

Letters

Dear Sir,

I read your newsletter regularly which you send in bulk to our college. The issue of NRHM newsletter Vol.4 No.4 Oct- Feb 2009 was indeed informative and quite useful in providing and implementing ideas and working pattern of health care machinery at grass root levels. The article, " How to take care of a sick person" was very good and essential in a country like ours where the doctor population ratio is poor and where there is meagre penetration of health services in our villages. Keep on publishing such articles which make the newsletter an enriching experience. My good wishes to you in your endeavours.

Dr. E. Ravi Kiran, M.D., MIPHA,Professor,
Department of Community Medicine,
Konaseema Institute of Medical Sciences,
Chaitanyanagar NH 214,
Amalpuram - 533 201
East Godavari District (A.P)

Dear Sir,

I would like to request you to enroll the name of Deputy Director of Health Services (District Health Society) in the mailing list for sending NRHM Newsletter regularly. The Newsletter would be definitely useful to all the staff members of IDSP, VBDC, SBHI & RCH etc. to keep themselves update of different activities of NRHM at the national level.

Dr. K Sadasivam, MBBS, DPH,
Deputy Director of Health Services & Family Welfare,
District Health society,
Department of Public Health Services,
74, Collectorate Campus,
Dindigul Road, Karur – 639 007

Dear Sir,

I am working as a Medical Officer at PHC, Gujarat. I am regularly reading your Newsletter which is really beneficial and informative to me and all medical staff. Through this newsletter, I came to know which programmes are conducted by NRHM all over the country.

Dr. Khyati H. Shah,
Medical Officer, PHC,
Gujarat

Dear Sir,

I am working as an ANM at Benipur Sub Centre, Distt. Kendrapara. I have gone through your NRHM Newsletter (Oriya). It is very informative to us. Kindly put me on your mailing list for NRHM Newsletter (Oriya version).

Smt. Pramila Sahu,
ANM, Benipur Sub-Centre,
At/PO Benipur,
Via Charinangal,
Distt. Kendrapara.

Dear Sir,

I am Subhash Nain, G.N.M at P.H.C Ramgarh, Distt Hanumangarh, Rajasthan. I found the Newsletter very useful for everybody. Please include my name in your mailing list.

Shri Subhash Nain,
G.N.M., PHC, Ramgarh,
Distt. Hanumangarh, Rajasthan.

Dear Sir,

I am working as a District Programme Manager for National Rural Health Mission at East Champaran, Motihari, Bihar. I have seen monthly magazine which published from your organization and I feel that this magazine give us latest working knowledge. So please empanel our name in your mailing list.

Shri Rana P.K. Solanki (D.P.M.),
Sadar Hospital Campus,
District Health Society,
East Champaran,
Motihari,
Bihar – 845 401

Dear Sir,

I am working as an Ayush Medical Officer under Mobile Health Unit at PHC, Pithagola and I have joined recently to this post. I read NRHM Newsletter regularly. It is a very useful source to learn about all the health programmes in India. It is my sincere hope that you would include article on integration of Ayush Doctor especially from Ayurveda. Kindly send me the Newsletter (English version) on regular basis.

Dr. Surani Ranjan Samal, BAMS,
Ayush Medical Officer under Mobile Health Unit,
C/o Sankarsam Samal,
At/PO Palimi,
Via Gobindapur (Kutcheri)
Distt. Kendrapara – 755 061 (Orissa.)

Dear Sir,

I am working as Senior Assistant in the District Medical & Health office, Sri Potti Sriramulu Nellore District of Andhra Pradesh. I am very much thankful to you sir, if my name has to be enrolled for mailing list receiving the NRHM News letter in English. You have communicated the latest edition March April, 2009 it is much useful to conduct the monitoring meeting involving the community and to strengthen the Gram Health Committees. It is more useful to develop the awareness on Public Health under NRHM. The newsletter is the right platform to know the practices and exchange the views of community on Health activities. Kindly send the Newsletter regularly to me to the following address.

Shri Narasimah Charyulu.B.
B.Lakshmi Narasimha Charyulu
16-3-1376,
Beside RACE school
Haranathapuram 2nd lane
Nellore,
Andhra Pradesh

Dear Sir,

I am Dr. Roshan R. Doddamai working in a PHC. My PHC is getting regular supply of your newsletter. I found it very useful. There was no single article regarding AYUSH. As mainstreaming of AYUSH is one among the major goal of NRHM. Please add articles regarding AYUSH especially AYURVEDA. Hope you will do the same. Please add me in your mailing list. Also publish Newsletter in all State languages.

Dr. Roshan R. Doddamani,
'ROSHAN-RESHMA'
Gourishankar Nagar, 1st Main,
Ranebennur – 581115
Haveri distt. Karnataka

Letters

Dear Sir,
I have gone through your NRHM Newsletter. It is very good. Please send this to us regularly along with your other periodicals. The publications will be very useful for my Centre's 500 members.

Ch. Pardha Saradhi,
Nodal Prerak,
Nodal Continuing Education Centre,
5-200, Gurazala,
Guntur (A.P).

Dear Sir,
All Kerala Youth Centre is a Non-Governmental Organization working in Kollam distt. of Kerala State since 1986. The Centre is working in the field of Health & Family Welfare, Women & youth empowerment, Social Welfare, Rural Development etc. The Centre has implemented Partnership in Sexual Health Project (PSH Project) from 2001-2006 and working as a FNGO for implementing RCH Project. The NRHM Newsletter is very informative for our work. I request you to kindly put us in your regular mailing list and send us the publications related with Health & Family Welfare.

Shri K.R. Ullas,
Director,
All Kerala Youth Centre,
Eliyodu, Edaikkadom P.O.,
Ezhukone – Via,
Kollam Distt. Kerala – 691 505

Dear Sir,
I am working as Principal of G.S.L. College of Nursing. Our Institute offers the courses of G.N.M., B.Sc. (N) and M.Sc. (N). I have gone through your NRHM Newsletter. It is very informative and useful to all medical and paramedical staff and students. I want our institute to be in your mailing list.

Prof. Mrs. Jyothi Tiwari,
Principal,
G.S.L. College of Nursing,
Rajahmundry (A.P).

Dear Sir,
I am working as Block Health Education Officer in a Rural Primary Health Centre in the Lokapur, Bagalkot Distt. of Karnataka. I read your Newsletter and was enriched by the information. I keep others informed about the various issues of NRHM. Kindly send me the Newsletter regularly.

Shri K.K. Chavan,
Block Health Education Officer,
Primary Health Centre, Lokapur,
Tal. Mudhol, Distt. Bagalkot
Karnataka – 587 122

Dear Sir,
I am working in Primay Health Centre in Bhojpur Distt. (Rural area). My work covers mostly programmes under NRHM (2005-2012). As such I am interested in subscribing to NRHM Newsletter (English) which is published every 2 months. I request you to kindly send the publication at the following address.

Dr. Niraj Rohatgi,
House No. 13, CDA Colony,
North Shastri Nagar
Patna – 899 913

Dear Sir,
I am working as a Medico Social Worker at Deptt. of Community Medicine in Siddhartha Medical College, Vijayawada, Krishna Distt., Andhra Pradesh. I have read your National Rural Health Mission Newsletter Oct-Feb 2009 from my friend. I found this newsletter very informative for my routine duties like surveys, research activities, health trainings etc. I am also in charge of library. It is useful for undergraduate and postgraduate students. Kindly put us in your mailing list.

Shri V. Visweswarayya,
Medico Social Worker Gr. I,
Deptt. of Community Medicine,
Siddhartha Medical College,
Vijayawada, Krishna Distt. (A.P)

Dear Sir,
I have received a copy of the NRHM Newsletter from the Civil Surgeon Office at Hoshiarpur (Punjab). I request you to ask the Mailing Unit to keep our name in the mailing list and dispatch us one copy of English and one copy of Hindi regularly.

Dr. D.B. Kapur,
Chairman,
All India Medicos Society
Kotwali Bazar,
Hospiarpur – 146 001 (Punjab)

Dear Sir,
I am working as a District Public Health Entomologist, O/o the Deputy Director of Health Services, Karur District, Tamil Nadu. I have read your NRHM Newsletter which is very resourceful to all the medical staff, paramedical staff and NGOs. NRHM Newsletter helps me in improving skills, and community participation. Kindly keep me on your mailing list and also request you to send Newsletter regularly.

Shri A. Sivakumar,
District Entomologist,
O/o the Deputy Director of Health Services,
Karur, Tamil Nadu

Editor's Note : Readers may send their valid e-mail address to receive a web edition of the News Letter

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सत्यमेव जयते

NATIONAL RURAL HEALTH MISSION

Save your child from Pneumonia

Pneumonia is preventable. Pneumonia is treatable.

Early diagnosis and appropriate case management by rational use of antibiotics is the most effective intervention to prevent deaths due to pneumonia.

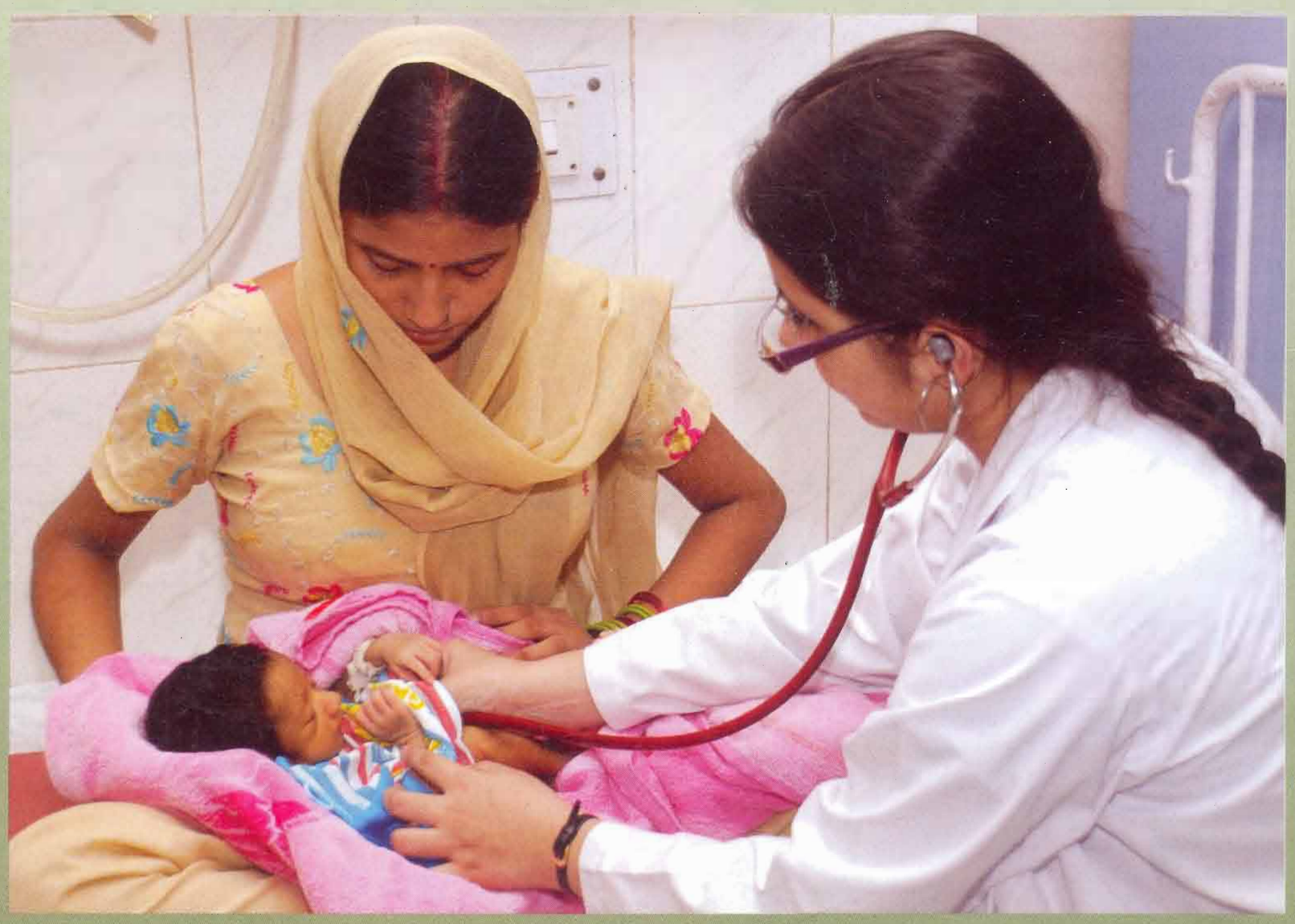
Delay in seeking medical attention is dangerous. It puts the child at risk.

Look for the first signs: Fever, Cough and Fast breathing (*pasli chalna*) in a child is a sign of Pneumonia. Take the child to the nearest health centre/ hospital.

Look for Danger signs: Inability to feed, lethargy, breathing trouble (Head nodding) , grunting in a child with fever and cough are danger signs. Seek medical care immediately.

Use warm clothes to cover children during winter. Keep newborn babies especially wrapped with warm clothes during all seasons.

Protect your children from smoke (from Angithi, stove, tobacco etc.)



Issued by Ministry of Health & Family Welfare, Govt.of India

Hand washing is the best prevention for many diseases including Pneumonia