सत्यमेव जयते

NATIONAL TRAINING STRATEGY

for

IN-SERVICE TRAINING UNDER NATIONAL RURAL HEALTH MISSION

NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

(2005–2012)

Ministry of Health and Family Welfare
Government of India
2008

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MINISTRY OF HEALTH AND FAMILY WELFARE
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Ministry of Health & Family Welfare
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Foreword

The major focus of NRHM is to provide all promotive, preventive and curative services needed by the people in an integrated fashion, so that services are provided through a single window. In order to achieve this, it is imperative that Health, Family Welfare and AYUSH programmes are effectively integrated and delivered through an effectively functioning primary health care infrastructure. NRHM also envisages convergence of services with relevant ministries/departments like Women & Child Development, Rural Development (Drinking Water/Sanitation) and Education. It also recognizes that community and Panchayati Raj Institutions have a major responsibility in planning, monitoring and assisting service providers as also in awareness building and improving utilisation of available facilities.

Realising the importance of NRHM as central to national development, sufficient resources both human and financial, have been allocated to ensure effective implementation of the paradigm shift envisaged at all levels starting from people themselves and PRI up to policy makers and programme planners. In order to rapidly orient all the stakeholders, MOHFW has decided to bring out a concise document outlining training strategy for service providers at district and below. This document would also be useful for state and central officials and policy makers to understand the training for effective integrated Health, Family Welfare and AYUSH service delivery at below district level. The efforts of the Mission Director, Joint Secretary (Training), Director NIHFW and his team, representatives of UNFPA, UNICEF, World Bank, WHO, State Program Officers, Directors of SIHFW and members of the Training Division in the preparation of this document is praiseworthy.

Naresh Dayal

(NARESH DAYAL)
Secretary to the Government of India

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Executive Summary

National Rural Health Mission (NRHM) launched in April, 2005 envisages to provide affordable, equitable and quality health care to the population of India, especially vulnerable groups. A major strategy in NRHM is horizontal integration of vertical health and family welfare programmes as well as convergence with activities of related departments like Ministry of Women and Child Development (MWCD), Drinking Water and Sanitation, PRI etc., so that there is provision of Integrated Health and Family Welfare, Nutrition and sanitation services for the community.

A major pre-requisite for providing quality health care service is upgrading the skills and knowledge of all health personnel as well as key personnel of related sectors. The mandate for in-service training is to improve performance of Health and Family Welfare Programmes. The operationalisation of National Rural Health Mission has set in motion a process of decentralised and horizontally integrated implementation of the disease control as well as administration of the programmes of the Ministry. It has laid for itself the goals of reducing MMR to less than 100 per 100,000 live births, IMR to less than 30 and TFR to 2.1 by 2012.

The operationalisation of National Rural Health Mission has set in motion a process of decentralised and horizontally integrated implementation of the disease control as well as administration of the programmes of the Ministry.

The National Training Strategy will ensure integrated training programmes to encompass the vast training needs and the expanded trainee universe, address the issues of planning and operationalisation of health facilities, synchrony of supplies, gender, quality issues and fund flow mechanism of all trainings. It will clearly define the role of each of the stakeholders involved in training like the State Programme Managers, Directors of State Institute of Health & Family Welfare, State Directorate of Health & Family Welfare, I/c of District Training Centres and District Programme Managers in preparation of Comprehensive Training Plans and Training Calendars for the state/district, so that the health facilities particularly at sub-district & primary level could be operationalised with improved quality of care by the providers .

Existing policy for training is:

- Vertical training for each H & FW programmes.
- Focus on transfer of knowledge without ensuring local needs and integration.

Paradigm Shift

In order to improve efficiency and effectiveness of training and to improve the quality and coverage of services enabling operationalisation of health facility, paradigm shift is envisaged under NRHM. It is essential to update all health personnel, personnel of related sectors and all stakeholders about the paradigm shift under NRHM and its implications.

The present policy looks at paradigm shift in wake of following core issues:

- From vertical training to integrated training
- From knowledge transfer to skill upgradation
- Training being linked to facilities which are functional/being made functional
- Convergence with PRI, WCD, AYUSH & Department. of Drinking Water & Sanitation
- Institutionalise training planning from sub-centre upwards.

Types of Training under NRHM: It is being envisaged that four weeks of induction training and every two years, in-service training will be provided to all categories of health workers.

The district must ensure that all personnel are exposed to the training programmes at regular specified intervals.

Role of Stakeholders

At National level, Training Division in MOHFW will issue broad guidelines on training and matters related to policy decisions & NIHFW being the nodal institute will co-ordinate all types of training activities.

At State level, SIHFW/CTIs will conduct TOTs for all types of training and co-ordinate trainings for districts along with State Training Coordinator/State Nodal Officer & State Programme Managers.

At District level, District Medical Officers & District Programme Managers will prepare the training calendar for conducting training of peripheral health functionaries i.e Medical officers, Nurses, LHV, ANMs, Health Assistant (Male) & Health Worker (Male), Lab Tech. etc.

Preparation of District Training Plan

District should be taken as a unit of training. The states are to be encouraged to develop strategy so that there is ownership. The district must ensure that all personnel are exposed to the training programmes at regular specified intervals. Since the responsibility of arranging for the training would be at the district level, stress should be laid on capacity building at the district itself to train peripheral health care providers. Districts plans need to be made keeping in view the following:

- Training-need assessment to be done before preparation of plan
- Planning for training needs to be done from sub-centre upwards
- Total training load to be calculated keeping in view the facilities which are functional or which are to be made functional
- Batch size, duration & venue of training to be as per guidelines
- RCH-II, NRHM additionalities, NACP, NDCP & IDSP to be included
- Skill training to be categorised in core skills, and specialised skills
- To have a specific time frame for completion of each training
- All training institutions in district to be used
- All training institutions to have continuous supplies
- Financial plan for training to be developed as per guidelines
- District training plan to be part of District Action Plan.

State Training Plan

District training plans should be compiled and collated after ensuring their appropriateness. A plan for training of trainers will be prepared at state level so as to undertake all the training planned by the districts. Database of trained manpower must be available in the state. The state should prepare & project the resources (financial as well as otherwise) in their PIP for their TOT and training of state level officials. Quality Assurance Guidelines should be formulated and implemented. A plan should be developed which could give thrust on utilisation of trained personnel.

District training plans should be compiled and collated after ensuring their appropriateness. A plan for training of trainers to be prepared at state level so as to undertake all the training planned by the districts.

Mechanism to Strengthen Training

- Standing Committee to be constituted at state level to address training issues & Mission Director (NRHM) to chair the Committee
- State Training Coordinator/State Nodal Officer to be nominated by the Committee to steer all trainings under NRHM
- Coordination between all stakeholders for trainings (NRHM Societies, Department of H&FW services & SIHFW/CTIs)
- Sensitisation of trainers at medical colleges & nursing colleges
- Develop linkages with neighbouring states/regional institutes (for small states/UTs if needed)
- Training institute to have a catchment area
- Accreditation of other health facilities for conducting training
- Database of guest faculty
- Training to be synchronised with provision of supplies
- Timely nomination of trainees.

Distance Learning could be by e-learning/web based training, teleconferencing etc. Medical colleges can develop e-curriculum. District hospitals may be linked to super specialty hospitals/medical colleges.

Monitoring of Training is the most important aspect of training. It should be done by using check lists for monitoring. Post training follow up is essential at the place of posting over a period of 3-6 months for validation of skills acquisition. Evaluation of outcome of training needs to be done after each training cycle.

Introduction

India has played a pioneering role in conceptualising and planning for holistic integrated primary health care to all its citizens. The focus of India's health services right from the early 1950s has been on health care to tackle common health problems in the country with focus on vulnerable groups. Improvement in the health and nutritional status of the population has been one of the major thrust areas for the social development programmes of the country.

The Bhore Committee Report (1946) which laid the foundation for planning of health service in India, emphasised the importance of providing not only integrated preventive, promotive and curative primary health care services but also tackling the causative factors for ill health. Management of deficiency diseases was a part of primary health care; the public health engineering division of health department dealt with lack of access to safe drinking water and poor environmental sanitation.

National Rural Health Mission (NRHM) launched in April, 2005 envisages provision of affordable, equitable and quality health care to the population of India, especially vulnerable groups. A major strategy in NRHM is horizontal integration of vertical health and family welfare programmes as well as convergence with activities of related ministries/departments like AYUSH, Ministry of Women and Child Development (MWCD), Drinking Water and Sanitation, PRI etc., so that there is provision of integrated health and family welfare, nutrition and sanitation services for the community.

National Rural Health Mission launched in April, 2005 envisages to provide affordable, equitable and quality health care to the population of India, especially vulnerable groups.

Objectives of In-service Training

A major pre-requisite for providing quality health care service is upgrading the skills and knowledge of all health personnel as well as key personnel of related sectors. The mandate for in service training is to improve performance of Health and Family Welfare Programmes. It is imperative that all health functionaries in the district acquire the knowledge and skills (technical, communication and managerial capabilities) to provide the health care services effectively and efficiently. In addition, all health personnel should have the knowledge of the linkages between the various sectors dealing with health determinants for provision of integrated services. All these should not only be given during, induction but also

The goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

through in-service training, which is one of the mechanisms, whereby the skills and knowledge of health care providers can be upgraded as a continuous process.

Rationale for National Training Strategy

The operationalisation of National Rural Health Mission has set in motion a process of decentralised and horizontally integrated implementation of the disease control and RCH programmes as well as administration of the programmes of the Ministry. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. It has laid for itself the following goals and strategies:

(a) Goals for 2012

- To reduce maternal mortality to less than 100 per 100,000 live births
- To reduce IMR to less than 30
- To reduce TFR to 2.1
- Reduction of prevalence and morality of diseases like Malaria, TB etc.

(b) Strategy

- Horizontal integration of Health & Family Welfare programmes
- Convergence with health related activities of ministries/departments like Ministry of Women and Child Development (MWCD), Drinking Water and Sanitation, PRI, AYUSH etc.

The National Training Strategy will

- ensure integrated training programmes to encompass the vast training needs and the expanded trainee universe under NRHM.
- address the issues of training in synchrony with planning and operationalisation of health facilities
- address the issues of synchrony of supplies, gender, quality issues and fund flow mechanism of all trainings
- clearly define the role of each of the stakeholders involved in training like the State Directorate of Health & Family Welfare, State Programme Managers, Directors of State Institute of Health & Family Welfare, District CMO and PMU I/c of District Training Centres in preparation of Comprehensive Training Plans and Training Calendars for the state/district, so that the health facilities particularly at sub-district & primary level could be operationalised with improved quality of care by the providers.

Existing Policy

- Vertical training for all H&FW programmes

- Focus on transfer of knowledge without ensuring local needs and integration.

The gaps identified in the existing policy for training are as under:

- Existing training programmes vertical in nature
- State and district training plans not as per need of the state
- Training not synchronised with need of health facilities, supplies & referral linkages
- Poor monitoring of post training follow up
- Data bank of trained manpower not maintained
- Lack of coordination between the Health Societies, Department of Health Services and SIHFW/CTIs in the states.

The present strategy looks at paradigm shift on the following core issues:

- From vertical training to integrated training
- From knowledge transfer to skill upgradation
- Training being linked to facilities which are functional/being made functional
- Convergence with PRI, WCD, AYUSH & Dept. of Drinking Water & Sanitation
- Institutionalise training planning from sub-centre upwards.

Paradigm Shift

In order to improve efficiency and effectiveness of training and to improve the quality and coverage of services enabling operationalisation of health facility, paradigm shift is envisaged under NRHM. It is essential to update all health personnel, personnel of related sectors and all stakeholders about the paradigm shift under NRHM and its implications.

The Village Health and Sanitation Committee will be formed in each village within the overall framework of Gram Sabha. It will help in adequate representation from disadvantaged categories so that they can have proper equitable access to the health services.

The major paradigm shift in training are:

- Integrated training programmes for all programmes in health and family welfare/nutrition instead of repeated training for vertical health programmes.
- Training of all functionaries in an area/institution in a synchronous manner
- From focus on transfer of only knowledge to focus on skill upgradation for delivery of services (technical, managerial & communication)
- Training should be seen as an exercise for health personnel to provide better quality health services and to make the facilities functional
- Training of each level to be done by one level above to promote referral linkages.

Need for Convergence with other Sectors

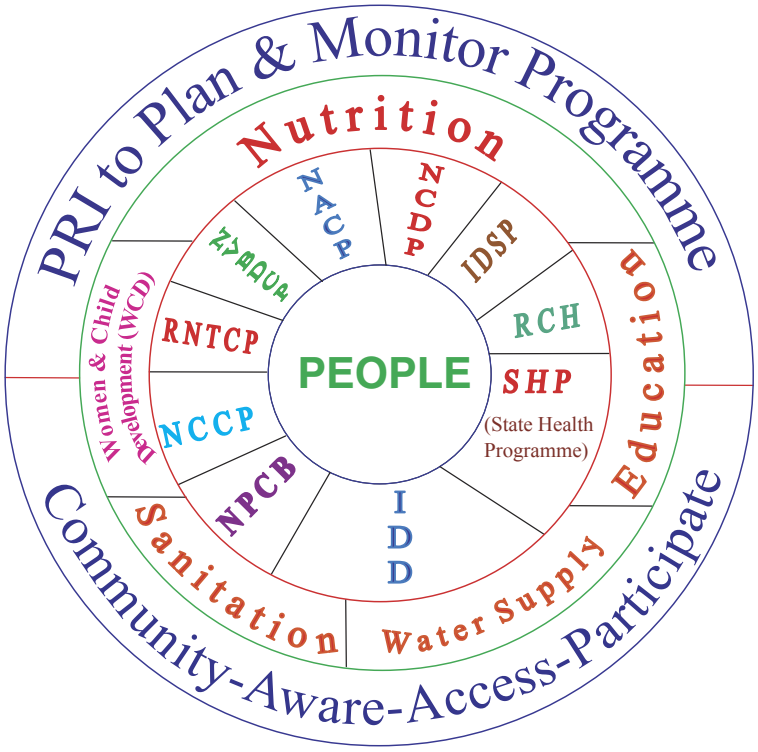
Under NRHM the convergence of H&FW is especially important with WCD, AYUSH and Department of Drinking Water & Sanitation and PRI. The trained health functionaries have to provide the services at facilities with a holistic approach. Convergence with PRIs can be at each level for example:

- **The Village Health and Sanitation Committee** will be formed in each village within the overall framework of Gram Sabha. It will help in adequate representation from disadvantaged categories so that they can have proper equitable access to the health services. The committee members can also help ASHA, AWW & ANM in holding Village Health & Nutrition Day (VHND).
- **At sub-centre level,** the accountability can be with the Gram Panchayat. The un-tied fund @ Rs. 10,000/- per sub-centre is in the joint account of ANM & Sarpanch.
- **At the Primary Health Centre,** all the Gram Panchayats covered by the PHC would be suitably represented in its management.

- **At the CHC/Block PHC,** the involvement of elected leaders of PRI is through their representatives in Rogi Kalyan Samitis, Swasthya Kalyan Samitis or equivalent.
- **At the district level,** the Zila Parishad will be directly responsible for the budgets of health sector along with District Health Societies.

Mainstreaming of AYUSH is one of the core strategies of NRHM to facilitate provisioning of AYUSH facilities under one roof with facilities of modern system of medicine at PHC, CHC and district levels. Provision has been made for state specific proposals for mainstreaming AYUSH, including appointment of AYUSH doctors/paramedical staff on contractual basis, and providing AYUSH wings in PHCs and CHCs. The Department of AYUSH will support the states for strengthening AYUSH infrastructure and functional capacity by developing Teaching Institutions and supply of essential AYUSH drugs.

Integrated Service Delivery under NRHM



The guaranteed services, as envisaged under NRHM, at sub centre, PHC and CHC are given in Framework for Implementation (2005-2012) from Ministry of Health & Family Welfare (GOI) on page no.79-85.

Types of Training under NRHM

1. Induction Training
2. In-service Training
3. Refresher Training.

At the time of entry into service, **Induction Training** of at least four weeks duration must be made mandatory for all categories of health care workers. This must have components of requisite skill enhancement, management and knowledge about the drugs/equipment and services offered at all levels of health care. This must be completed in a fixed time frame.

In-service Training is the major component of training. It must be provided to all categories of health care workers to upgrade their knowledge and skills in technical and management fields at least once every two years. The trainee universe can be categorised in the following groups:

Doctors (MO, Specialist)

Paramedics: SN, ANM, Pharmacist, Lab. Technician, etc.

Matrix of training under RCH–II, ASHA, PDC, PMU, Rogi Kalyan Samiti (RKS) and National Disease Control Programme is given in Annexure I - IV. Detailed training of RKS, PRI & VHSC will be dealt separately.

Refresher Training and system of continuous education for health providers needs to be institutionalised. Knowledge and skills of every health provider should be upgraded after every two years.

Role of Stakeholders

I. National Level

a. Training Division, MOHFW

- Issue broad guidelines on training and matters related to policy decisions. The guidelines should incorporate all aspects for training under National Rural Health Mission including Disease Control Programmes & RCH programme with sufficient flexibility built-in for adaptation by district/states as per their needs.
- Develop standards for in-service training programme implementation.
- Facilitate the implementation of training in state by providing support:
  - Capacity building at state/regional level.
  - Providing support through the Nodal Agency.
- Ensure that there is no duplication of training under various programmes.
- Ensure that training is need-based.
- Ensuring uniformity in financial guidelines for training of same category of personnel under various programmes. The states should have flexibility to modify the guidelines as per their needs.
- Include training as agenda item in all national level meetings with state officials.
- Ensure emphasis for monitoring, follow up and reinforcement of training.

b. National Institute of Health & Family Welfare (NIHFW)

- Coordination of all types of training activities (administrative, technical, and monitoring) for all health and health related personnel under NRHM including both disease control & RCH Programme in the entire country and to avoid duplication of training under various programmes. In order to undertake its role of coordination/facilitation of training in the states, the following tasks will be required:
  i. Constitute Expert Committees/consortium, ensuring appropriate inputs from MOHFW, states, relevant experts from NGOs, public and private sector institutions, representatives of potential trainee groups and donor representatives.
  ii. Develop guidelines for identification of peripheral training institutions by the State/CTI based on infrastructure, faculty, caseload etc.

Coordination of all types of training activities (administrative, technical, and monitoring) for all health and health related personnel under NRHM including both disease control & RCH Programme in the entire country to avoid duplication of training under various programmes.

iii. Help the states in identification of regional/state level collaborating training institutions in the various states, based on guidelines developed and ratified by Expert Committee.

- Coordinate (a) development of model training curricula in accordance with the MOHFW/Training Guidelines; (b) review and upgrading of training manual/materials currently used, integrating best practice materials produced and used for state specific training programmes. Aspects of gender/social equity to be included in all curricula/training material/training contents.
- Conduct orientation courses for master trainers of collaborating agencies/institutions and specialised training institutions appointed for the purpose and also to organise some training of trainers.
- Review of training material adapted by the states for appropriateness.
- Develop a system of proficiency/validation certification for trainees, by (a) establishing criteria for proficiency certificate for clinical skills training of different categories of health providers; (b) designing prototype formats for such certification with the assistance of collaborating centres, and (c) providing orientation as required on the certification process.

Assist states in facilitation of synchronous training of all health personnel in a block, district and state.

- Assist states in facilitation of synchronous training of all health personnel in a block, district and state.
- Develop guidelines for periodic accreditation of all training institutions (including those in private/NGO sector) based on facilities and also expertise in skill transfer.
- Develop a check-list for monitoring of training by national, regional and/or state level training institutions; based on periodic reports by state/CTIs, course reports as well as field visits give feedback to state/district to ensure that training is as per guidelines.
- Apprise MOHFW of progress and problems of training and assist MOHFW in evolving appropriate corrective actions.
- Evolve guidelines to evaluate the effect of training imparted, by following up the performance of persons trained in the field from time to time.
- Evolve guidelines for developing district wise database of trained manpower in the state.
- Assisting states/districts in preparing quarterly data on trained manpower and its utilisation by the state and also about the persons being trained and their linkage with operationalisation of facility.

II. State/Regional Level

a. State Training Coordinator/State Nodal Officer

- Facilitate in preparing database of training centres and health care service delivery institutions in all sectors, the services provided in

them and case load to enable optimum utilisation of all available facilities for training.

- Planning and implementation of State Training Plan.
- Liaison with State Programme Officer/District Programme Officer, Director of Training Institution, Medical Colleges and Nursing Colleges.
- Liaison with Director of State Institute of Health and Family Welfare/ Collaborating Training Institute to steer all TOTs and Orientation training.
- Funds to be made available for training under different components of NRHM (both Disease Control Programme and RCH).
- Ensure completion of training within a fixed time frame.
- Ensure that each training is synchronised with provision of necessary supplies and development of referral linkages.
- Ensure that report on training is an integral part of routine reporting of RCH (as per prescribed format).
- Ensure that training is an agenda item in all meetings with District and State Officials to discuss programme issues.
- Ensure the linkages of training with operationalisation of health facilities.
- Build a system for monitoring and evaluation of in-service training using available training infrastructure in the district.
- Ensure periodic accreditation of all training institutions including those in private/NGO sector.
- Develop a district wise database of trained manpower to prevent duplication and gaps in training of personnel and perhaps facilitate their posting in appropriate health facility.

Assist the state in listing of training centres and health care service delivery institutions in all sectors (district-wise), the services provided in these and the case load.

b. State Level Training Institution (State Institute of Health & Family Welfare & Collaborating Training Institution)

- Identification of training centres and hospitals for various types of training based on case load/faculty position.
- Specify clearly the activities to be undertaken by each along with specific deliverables and time frame for each activity.
- Assist the state in listing of training centres and health care service delivery institutions in all sectors (district-wise), the services provided in these and the case load. Link with Medical colleges for providing technical guidance and referral support.
- Assist the state government and provide guidance to the districts in preparation of district training plans in accordance with the MOHFW's guidelines such that health facilities with skilled manpower could be made operational at the earliest.
- Procure training materials from nodal agency, adapt/translate and reproduce as per requirement of the state.

Monitor training based on monthly progress reports, course reports, SOEs etc. as well as field visits and suggest corrective action to ensure appropriate implementation of skill training and proficiency/ validation system.

- Distribute the training material to all selected training institutions.
- Conduct training of trainers of appropriate categories from the selected training institutions in accordance with the approved plans. Gender and equity issues to be included in all training courses.
- Assist the state to ensure synchronous training of all health personnel in block, district and state.
- Monitor training based on monthly progress reports, course reports, SOEs etc. as well as field visits and suggest corrective action to ensure appropriate implementation of skill training and proficiency/ validation system.
- Assist/Train the State/District Officers in collation of report for appropriateness of referral (both time and place) received from various districts/blocks and to identify lacunae in supplies, referral or training for appropriate correction.
- Assist state in ensuring the quality of training.
- Conduct evaluation of training to assess the need for re-training, newer training to be planned if required. Guidelines developed by National Nodal Institute for evaluation of trainees need to be followed.
- Assist the state and districts in developing a district wise database of trained manpower adapting as needed the guidelines developed by National Nodal Agency.

c. Role of State Programme Manager (SPM)

- Overseeing the development and implementation of all District Action Plans including trainings.
- Designing systems and procedures for independent feedback mechanisms for assessing access to and quality of services and updating of database of trainings.
- Liaison with SIHFW/CTIs, State Programme Officers and District Programme Officers.
- Monitoring appropriate utilisation of trained personnel.
- Ensuring up-to-date data of persons trained and being trained.

III. District Level

District Level Institutions

a. Role of District Training Officer

- Prepare a training calendar for the trainings to be conducted in the district.
- Ensure the proper implementation of district training programme.
- Develop database of personnel and update the same from time to time.
- Planning implementation and monitoring of in-service training of all health functionaries at regular intervals.

- Ensure that best options be given to the poor people by providing skills appropriate to the job functions of health personnel and available facilities in the various institutions.
- Ensure maximum utilisation of resources within the district for training like ANM schools, district training centres, district hospitals, sub-district hospitals/FRUs/PHCs/hospitals in other sectors.
- Arrange adequate funds, modules and materials from the State/ Central Government.
- Ensure training of trainers of district in consultation with the State Government/State Training Institution.
- Ensure completion of training within a time frame of one year after initiation of district level training of peripheral health personnel.
- The district level trainer will use and interpret standardised training material and ensure appropriate skill upgradation.
- Ensure synchronous training of all health personnel in all blocks, within the district.
- Ensure synchrony also of supplies and referral linkages along with training.
- Assess performance at the place of posting over a period of 3-6 months after training for validation of skills acquired.
- An illustrative sample matrix for developing a district plan is given in Annexure-V. Modifications can be built as per need. Matrix is devised merely to draw attention to important issues like optimal number of days needed for training different categories of personnel, training sites, and identification of trainers. This could be utilised as a tool for working out the total training load in the district and for formulating the annual calendar for training.

Ensure synchronous training of all health personnel in all blocks, within the district.

b. Role of District Programme Manager (DPM)

- Assist DMO in preparing work plans.
- Create and maintain district resource database for the health sector.
- Procurement of supplies, logistics and inventory management to dovetail with training.
- Develop strategies/plan to improve the quality of services.
- Liasion links with SIHFW, State Programme Officers and District Programme Officers.

c. Peripheral Health Care Functionaries: (Medical Officer, Nurses, LHV, ANM, HW(M) & HA(M))

i. **Acquire knowledge of:**

- prevailing health problems including local endemic diseases in the area
- currently operational disease control programmes

- type of services available, relevant health facilities (including AYUSH) and referral linkages (through resource mapping) for facilitating the provision of cross referral system
- type of skills required to deliver the required services
- ensuring infection prevention and quality improvement for provision of services required
- recording and reporting (required at each level)
- logistics of supplies including management of equipment & consumables and financial reporting.

ii. **Acquire relevant skills:** Clinical, managerial and communication skills required for provision of services for maternal and child health care as well as prevention and management of diseases (as relevant in the area) need be acquired as necessary in their place of posting.

iii. **Conduct outreach services:** Planning and executing responsibilities for conducting Village Health & Nutrition Day (VHND) at each level for providing integrated service delivery at the village level. The guidelines for conducting the VHND have been circulated by GOI.

iv. **Provide on-the-job supervision:** Health personnel at each level will be supervised and trained by personnel of one level above them/Team leader/supervisor.

v. **Maintain inter-sectoral coordination for convergence:** Inter-sectoral coordination with officials of different departments including PRI will be maintained for rendering programme specific services required in their area.

IV Academic Institutions & Non-Governmental Organisations (NGOs)

Academic Institutions

Academic Institutions like Medical Colleges, Nursing Colleges & Schools and Para-Medical Training Centres are very important resources for in Service Training. The Medical Colleges are the intellectual capital and think tanks at state level & need to be fully utilised for knowledge up gradation; Medical Colleges and the Medical College Hospitals given their vast and diverse case load and the experienced expert faculty would be the best skill upgradation training centres. The Medical and Nursing Colleges and schools can ensure that their undergraduate and postgraduate students as well as participants in training courses understand the rationale, components as well as strategies of all the programmes and what needs to be done by who and how are communicated clearly so as to enable appropriate implementation of the programmes and provide good quality health care. The Medical College Hospitals would act as Apex Training Centres by practising the programme components in

their routine service delivery, thereby, enabling the post graduate and under graduate students to practice & achieve all the skills required pre-service; similarly the service trainees would also get adequate opportunity to practice all the skills needed under excellent supervision. Medical Colleges would, therefore, show how precept and practice are one & the same thing.

Voluntary/not-for-profit/NGO & Private Sector institutions

The partnership with Non-Governmental Organisations has been an important priority for NRHM. Investments by these organisations are critical for the success of NRHM. The partnership can be in the field of advocacy, building capacity, monitoring and evaluation of the health sector and delivery of health services. The Private Sector and NGO are increasingly providing services for the people. Their participation in Training Programmes for National Diseases Control & RCH Programmes would benefit them by knowledge upgradation regarding programme components, and also information on facilities and inputs available from the Government Machinery for providing services. These facilities and supplies would enable these institutions to provide better quality service at an affordable cost which in turn will increase the demand for the utilisation of such services in these hospitals. This would help the population, state and country to attain their health goals. As their caseloads improve these institutions could perhaps also undertake skill training for Peripheral Health Care Personnel. However, it must be ensured that

- The presence of trainees does not in any way hinder their service provision to the public.
- The requirement of hands on training and requirement of skills to be performed by the trainees are in no way diluted in these institutions.

Preparation of District Training Plan

District should be taken as a unit of training. The training is to be seen as a responsibility of the district administration. The states are to be encouraged to develop strategy so that there is ownership. The district must ensure that all personnel are exposed to the training programmes at regular specified intervals. Since the responsibility of arranging for the training would be at the district level, stress should be laid on capacity building at the district itself to train peripheral health care providers. The district would need to adhere to the uniform package of training but may have sufficient flexibility to take into consideration their own requirements and particular conditions within certain uniform norms.

The training plan needs to be prepared keeping in view the existing functional facilities and services being provided in them.

The training plan needs to be prepared keeping in view the existing functional facilities and services being provided in them. The district training capacity should be built up to meet the training needs of the district based on the following guidelines:-

- Training need assessment to be done to know which type of training is to be prioritised.
- Total training load to be calculated on the basis of in-position health functionaries of the existing health facilities and the facilities which are going to be made operational in the mission period. This is applicable especially for Medical Officers.
- Batch size to be decided according to the skills which are to be provided to the health functionaries or as per the National Guidelines on specific trainings.
- Duration of training courses to be as per norms.
- Venue of training. Clinical training institutions to have adequate case load.
- Training in RCH–II, National Disease Control Programmes and additionalities under NRHM need to be included in the training plan.
- Skill training could be divided into Core Skills, which need to be possessed by all personnel of each category and specialised skills which are dependent on job responsibility and place of posting. The training for specialised skills is to be imparted as per institutions where the specialised services are being provided.

- All available facilities, NGOs, govt. sectors, PSUs, ESI, armed forces, railways, corporation/municipality hospitals and hospitals of faith based organisations need to be involved in conducting skill based trainings.
- District training plan should also have a time frame for the trainings. An annual training calendar giving details of the work plan with dates need to be prepared. Barring any emergencies the training plan should be adhered to.
- The training institution needs to have continuous supply of drugs and equipment so that the trainees can practice the skills.
- The financial plans for the trainings based on the financial guidelines to be issued by the states need to be a part of District Training Plan.
- District Training Plan should include the plan for monitoring the quality of training and also the utilisation of trained personnel.

District training plan needs to be a part of District Action Plan, which should have a two-day consultative workshop for planning.

District training plan needs to be a part of District Action Plan, which should have a two-day consultative workshop for planning. It should take into account community needs, epidemiological needs, National Health Programmes, state population policies and other state policy instruments. It should also address local level operational problems and seek central or state support for them. Emphasis should be on optimum utilisation of available resources and programmes. Thus, the indicators would change from being input oriented to process and to outcome oriented. District Planning Process should be based on prior collection and review of district literature and compilation of data, including previous project and programme experiences, Census, NSSO Surveys, CNAA Plans, District Level Household Survey, Facility Survey Reports, NFHS Reports, SRS Reports, previous project review reports, etc.

A sample work plan for a hypothetical model district has been worked out and is given in Annexure V

State Training Plan

The states need to:

- Compile and collate the various district training plans after ensuring their appropriateness.
- Plan for training of trainers to enable the districts to undertake all the training planned by them.
- Prepare database of available trained manpower in the state for various skills.
- Project the resources (financial as well as otherwise) in their PIP for their TOT and training of state level officials.
- Formulate and implement the guidelines for quality assurance.
- Develop a plan which should give thrust on utilisation of trained personnel.

Mechanisms for Strengthening Training

- A Standing Committee should be formed at the state level comprising Mission Director, Director(s) Health & Family Welfare, Director State Institute of Health & Family Welfare & Member from State Nursing Council, to address the training issues. (Order in this regard was issued on 2nd June, 2006 by the Secretary H&FW, GOI).
- Mission Director (NRHM) to chair the Standing Committee.
- A State Training Coordinator to be nominated by the committee to steer all NRHM trainings.
- Each training institute to be given a catchment area with specific mandate of providing in-service training.
- States where there is no training institution should have linkages with other states.
- Accreditation of private health facilities, Mission Hospitals, Trust Hospitals and Public Sector Undertaking Hospitals for conducting the training needs to be done.
- Database of guest faculty to support the in-house faculty must be available with the State Institute of Health & Family Welfare/CTI.
- Trainers/Faculty to have adequate training and pedagogy skills.
- TOT and master trainer's training: Faculty of state level institutions and medical Colleges need to update their skills on a continuous basis to be able to provide quality training.
- Training must be synchronised with provision of supplies and development of referral linkages.
- Timely nomination of trainees for the training courses is essential to upscale the training.
- Training load should be realistic and time frame should be fixed.
- Database of trained manpower must be available in the district/ state.
- Fund-flow should be timely.
- Timely reporting of training conducted, SOEs submission and utilisation certificate (UC) need to be ensured.
- Skill training could be divided into Core Skills, which need to be possessed by all personnel of each category. The training for specialised skills is to be imparted as per institutions where trainees are posted

Accreditation of private health facilities, Mission Hospitals, Trust Hospitals and Public Sector Undertaking Hospitals for conducting the training needs be to done.

to take care of changes due to transfer/promotion/taking up higher studies/retirement etc.

- As far as possible specialised skills training could be integrated e.g., MTP & mini-lap training for MO (PHC); SBA & Newborn care and IUCD training for ANM & LHV. Newborn care with EmOC training for MOs, RTI/STI training could be done in convergence with NACO (HIV/AIDS).
- Mannequins are being used in all states for Anaesthesia and EmOC training. Similarly, Zoë model is being used for Family Planning Trainings especially IUCD. Female pelvic models are being given to all district hospitals and centrally sponsored ANM Training Schools.
- Networking between Regional Training Institute & District Institutions and periodical interface will help in exchange of ideas and experiences.
- Well developed distance learning programmes are needed for regional institutes which are catering to large geographic areas.
- Training must link up with state/district human resource development plans.
- Clear roadmap for development of capacities of states and districts for identifying needs and creating district level database, developing their training programmes and action plans, their implementation, monitoring and follow up.
- Good coordination between programme officers, service providers & training officers at district and state level is essential.
- Sensitisation of trainers at medical colleges & nursing colleges and involvement of bigger hospitals, PSUs etc. will help in improvement of the pace of training.

The partnerships with Non-Governmental Organisations has been an important priority for NRHM. Investments by these organisations are critical for the success for NRHM. The partnership can be in the field of advocacy, building capacity, monitoring and evaluation of the health sector and delivery of health services.

Distance Learning

- Distance learning can be by e-learning/web-based training, teleconferencing etc. It can help in development of niche expertise on additional subject(s) for existing manpower, as also follow up training for specialist. It can be available as and when needed without any disturbance to the work schedule of the trainee.
- Medical colleges could develop e-curriculum for the training of health personnel (Community Medicine Persons, Epidemiologist, DEOs, Statisticians, etc.).
- District hospital may be linked to one or the other super specialty hospital or medical college for higher level of care, especially for remote areas. This network can also be used for training and e-referrals, e.g. tele-medicine in Chhattisgarh connects 14 district Hospitals to Raipur Medical College.
- Selection of appropriate format.
- Selected participants to have right technology.
- Mode of delivery depends on the instructions given to achieve the goals of the course.
- Desired level of interaction between instructor and participants.
- Cost effective use of multiple technologies.
- Dedicated technical support to assist participants and instructor in resolving technical problems is fundamental to success.
- Post training follow-up and support.
- Quality assurance by participants' support, faculty support, evaluation and assessment.

Quality Assurance: Key Processes

Pre-Training Activities

- Training needs assessment to be done prior to preparation of a training plan. The training need should depend on the IMR/MMR/TFR/ Disease prevalence of the state and its linkage with plan for making its facilities operational. It will be more appropriate to have district specific training needs which will help in prioritising the training activities needed in the particular district.
- Identification of training institutes. Minimum essential infrastructure required for training to be made available in the training institutes and attached hospitals. Identified hospitals shall have adequate infrastructure, availability of trained trainers and case load for training.
- Periodic accreditation of training institutes as well as clinical training sites needs to be done to maintain the quality of training.
- Identification of categories of trainees and types of training.
- Supplies, equipment and drugs required for training should be made available continuously.
- Training material to be kept ready.
- Planning and developing strategies/tools e.g. check lists for monitoring quality of trainings.

Periodic accreditation of training institutes as well as clinical training sites needs to be done to maintain the quality of training.

During Training

- Health personnel at each level will be trained by personnel of one level above them/team leader/supervisor.
- The training of primary health care functionaries eg. HW (M&F) and HS (M&F), Lab Tech, etc should be within the district.
- Residential facilities including basic amenities in the hospitals and transport facilities for field visit need to be provided.
- Training material to be made available to trainers/trainees as per the type of training being conducted. The training material for RCH–II has already been provided by the respective programme divisions.
- The trainers conducting training should be practicing the skills as per protocols which are to be taught to trainees. Necessary supplies need to be continuously provided in training institutions.

- Adequate opportunity needs to be provided to the trainees practicing the skills.
- Assessment of skills should be done by the immediate supervisor (PHC MO) and also by the functionaries of FRUs/District hospitals (appropriateness and timeliness of referral. This needs to be collated at district level for identification of lacunae and appropriate correction).
- Proficiency certification of trainees by the trainers based on norms (whether the trainee has acquired the skills) should be mandatory.
- The proficiency certificate will be validated after assessing performance at the place of posting over a period of 3-6 months after the training.
- Regular monitoring needs to be done for assessing extent of adherence to norms as per course reports.

Post Training

- Database of trained personnel should be maintained at state/district level.
- Follow-up of trained persons to assess extent of utilisation of skills is essential.
- Mentoring as a mechanism, of supportive supervision for bringing attitudinal change in health care providers, needs to be restored. Team leaders need to be provided with skills for mentoring and supportive supervision on the job. These will include proficiency in technical skills and ability to observe and identify mistakes and correct them.
- After each training cycle the outcome of the training should be evaluated at the field level in terms of improvement of service delivery.

Mentoring as a mechanism, of supportive supervision for bringing attitudinal change in health care providers, needs to be restored. Team leaders need to be provided with skills for mentoring and supportive supervision on the job.

Quality Assurance Committee (QAC)

As per the guidelines laid down by Honorable Supreme Court of India, QACs are to be formed at the state/district level to ensure that the standards for female and male sterilisation as laid down by GOI are being followed. At facility level, Quality Circles are to be formed. The composition of these Committees/Quality Circles should be as per the guidelines given in 'Quality Assurance Manual for Sterilisation Services' published by RSS (FP) Division, MOHFW, October 2006.

These QACs could be further strengthened to also look into the entire quality issues of training under NRHM.

Matrix of Skills for Service Provision

Skill up-gradation for improved service delivery

Skill up-gradation is an essential component of in-service training programmes. The skill up-gradation required varies enormously depending upon the qualifications of the personnel and the institution where he/she is working. While the core components will be the same whether it is primary, secondary or tertiary care institution, there will be substantial variation in skills required for management of complications. For example core components of antenatal screening is same at all levels; however women with severe PIH will be referred to secondary care institutions for further management and referral to tertiary care institutions will be done if there are added problems like renal failure. There will also be variations depending on the services being provided in the institution. For example an MO in an ordinary PHC may not need skills for performing tubectomy, vasectomy or MTP; all these will be needed if the MO is working in 24 hour PHC. Some broad guidelines are available regarding the type of services that should be provided in different institutions. A matrix has been prepared for skill required for various personnel in different institutions which could be used for both training need assessment as well as for identifying potential trainers and training venues.

MATRIX FOR SKILL TRAINING

Guaranteed services at each level As per NRHM Framework for Implementation of MOHFW

Categories of Manpower		Facility	RCH Programme		Disease Control Programmes						IDSP	Prog. Mgt.
			MH including FP	CH	NVBDCP	RNTCP	NACP	NBCP	NLEP	NCD		
	ANM	All Villages in Sub Centre Area	1-23, 36-42, 44-49, 52-56, 60	1-9, 12, 13, 15-21, 25-34 36-41, B1, U1	1-3, B1,B5	1-4,6, B1,U1	1-4, 9	1-3, B1,U1	1, 2, 4, 5, 7, 8	1-5, 8, B1, U1	1 to 2	1 to 8
	HW (M)	All Villages in Sub Centre Area	3-5, 10, 11, 16, 17, 21, 46, 53, 54	1, 2, 4-6, 13, 18, 26,32, 34, 36-41, B1, B5, U1	1-11, 14, 15, B 5	1 to 10	1-5, 9	1-3,5-7,9	1-5, 7-9	1-5, 8, B1, U1	1 to 4	
	STAFF NURSE	PHO	2-23, 26, 36-42, 45-49, 52-55	2, 4, 5, 8, 13, 16-23, 25, 26-41	9-11, 15	10, 12	1 to 3	1-3, 6, 8	1, 4, 5	1-4, 6, 7		
		24 x 7 PHC	2-23, 26-31, 36-41, 44-49, 51-55	1-13, 16-23, 25-41								
		FRU	2-28, 30-34, 36-48, 54, B7, B9	1-13, 16-42								
	MO	PHO	2-23, 26, 36-42, 44-49, 52-60	2, 4-9, 11-13, 16-23, 25, 26-42	1 to 15	1-5, 7-11	1-4, 7	1-7, 10	1 to 10	1-5, 9	1 to 4	
		24 x 7 PHC	2-23, 26-31, 36-60	1-13, 16-23, 25-42	1 to 15	1-5, 7-11	1-5, 7	1-7, 10	1 to 10	1 to 9	1 to 4	
		FRU	2 to 60	1-14, 16-42	1-3, 9-11, 15	1-5, 9-12	1 to 8	1 to 10	1 to 10	1 to 9	1, 2, 4	
	Lab Tech.	PHO	B1-6, D1,2	B 1-6, D1, 2	B 1-6, D1, 2	B 1-5, D1, 2	B 1-5, D1, 2	B1-5, D1, 2	B 1-5, D1, 2	B1-5, D1, 2	W 1-2, D1,2	
			U1-3, D1, 2	U 1, D1, 2	U 1-3, D1, 2	U 1, D1, 2	U 1-2, D1, 2	U1, D1, 2	U 1, D1, 2	U 1, D1, 2		
			Vm1-2, D1, 2	St 1, D1, 2		Sp 1-2, D1, 2				W 1-2, D1, 2		
			St 1, D1, 2									
		24 x 7 PHC	B1-6, D1, 2	B 1-6, D1, 2	B 1-6, D1, 2	B 1-5, D1, 2	B 1-5, 12-13, D1, 2	B 1-5, D1, 2	SK 1, D1, 2	B 1-6, D1, 2	W 1-2, D1, 2	
			U1-3, D1, 2	St 1-2, D1, 2	U 1-3, D1, 2	Sp 1-2, D1, 2						
			St 1-2, D1, 2	U 1-3, D1, 2		U 1-3, D1, 2	U 1-3, D1, 2	U 1-3, D1, 2		U 1-3, D1, 2		
			Vm1-2, D1, 2									
		FRU	B 1-14, D1, 2	B 1-14, D1, 2	B1-7, D1, 2	B 1-14, D1, 2	B 1-14, D1, 2	B 1-5, D1, 2	SK 1, D1, 2	B 1-14, D1, 2	W 1-2, D1, 2	
			U 1-3, D1, 2	St 1-5, D, 2	U 1-3, D1, 2	U 1-3, D1, 2	Vm1-2, D1, 2	U 1-3, D1, 2	U1-3, D1, 2	U 1-3, D1, 2		
			St 1-5, Se 1, Vm 1-2, D1, 2				U 1-3, D1, 2					
	SO		SO 1-8									
	Pharm.		Pharma 1-6									

NOTE:

1. These grids will enable : individual health care personnel to identify WHAT skills be knowledge they need to acquire.
2. Colour codes given for requirement of skills at various level for manpower posted at that level :

All Villages in Sub Centre Area

24 x 7 PHC

PHO (PHC Ordinary)

FRU

Skills for Reproductive and Child Health Programme

Maternal Health Care	
Care during pregnancy including identification of women with complications and Mgmt./Referral of those with complications	(1) Universal registration of all pregnant women before 12 weeks, (2) ascertain LMP and calculation of EDD, (3) History taking of past pregnancy, past history, family history etc, (to identify women at risk of complications), (4) record height, (5) record wt., (6) recognising underweight pregnant women (below 45 kg), and Referral to AWW for supplementary feeding, (7) identifying poor weight gain <5 kg throughout pregnancy (8) identifying Abnormal wt gain, (9) identification of anaemic women, (10) General examination, (11) Recording blood pressure, (12) systemic examination, (13) Abd examn.: Gestational assessment, Fundal height, abdominal girth, position, presentation, (14) Assessment of Intrauterine growth and growth retardation (15) detection of abnormalities eg. mal-presentations & referral, (16) Hb estimation, (17) urine examination, (18) IFA prophylaxis for non anaemic women, (19) treatment for those with mild anaemia, (20) administering Injection TT, (21) recognising indications for referral-when & where, (22) treatment/referral of those with moderate anaemia, (23) treatment/referral of severe anaemia, (24) observing Precautions while transfusing blood or blood products, (25) identification of transfusion reactions and its management
Mgmt.	(26) Management of OPD, indoor and outreach services
Intra Partum Care appropriate mgmt. of complications	(27) Use of Partogram, (28) conducting normal delivery (Diagnosis & management of I, II, III stages of labour), (29) administering Anti-retroviral drugs to HIV positive mother during labour and newborn soon after delivery (PPTCT), (30) Identification of complications of labour and appropriate management including referral, (31) suturing episiotomy/perineal tears, (32) Conducting operative delivery (LSCS, instrumental delivery), (33) Laparotomy, (34) EmoC, (35) Post operative care & follow up
Post natal care	(36) Counseling for early initiation of breast feeding & exclusive breast feeding, (37) Counseling for regular check up, (38) Follow up, (39) identification of complications during puerperium and its management or referral,
Safe abortion Services	(40) Counseling for safe abortion & concurrent contraception, (41) screening for fitness for MTP, (42) referral for MTP & concurrent contraception, (43) performing Vacuum aspiration, (44) follow up (45) identification & mgt of post abortal complications
Prevention of unwanted pregnancy	(46) Counseling for contraception, (47) screening for fitness for various contraceptives, (48) P/V examn., (49) IUD insertion (50) performing sterilisation, (51) pre & post operative care, (52) identification & management/referral of complications.
Prevention, Mgmt., of RTI/STI	(53) Counseling for prevention STI/RTI, (54) identification of suspected RTI/STI by history taking, (55) referral for diagnosis and treatment, (56) diagnosis of RTI/STI/HIV: history, genital examination (discharge, ulcers/warts) speculum examination, (57) microscopic examination of discharge, (58) Management of RTI/STI including partner identification and treatment, (59) Follow up, (60) identification & management/referral of complications for RTI/STI.

Child Health Care	
Care at birth	(1) Prevention of sepsis, (2) Temperature maintenance, (3) suction by use of Mucous Sucker, (4) weighing, (5) identification of LBW and preterm infants, (6) Mgt. of low birth weight babies including referral where required, (7) initiation of breast feeding, (8) Counseling and guidance for exclusive breast feeding, (9) diagnosis and treatment/referral of hypothermic babies, (10) Assisted ventilation: Use of bag & mask, (11) Management of neonatal jaundice, (12) detection and management of infection including referral, (13) detection of congenital abnormalities, management and referral as required, (14) Incubation procedure for assisted ventilation and resuscitation
Immunization	(15) Ensuring universal immunisation, (16) Administering correctly I/M & S/C injections (17) ensuring infection prevention & maintaining universal precautions, (18) counseling mother for expected side effects & next dose, (19) maintaining & monitoring cold chain, (20) reporting of AFP cases, Neonatal tetanus & other VPDs, (21) Identification and appropriate management of complication of vaccination, (22) storage of vaccines, (23) operationalising ILR, (24) operationalising deep freezer, (25) disinfection & maintenance of equipment
Nutrition Counseling	(26) Counseling for appropriate IYCF practices, (27) weighing of children (28) identification of growth faltering and referral to AWW for supplementary nutrition, (29) management/ referral of children with growth faltering in spite of supplementary nutrition
ARI, Diarrhoea	(30) History taking in children for ARI, diarrhoea, fever and other diseases, (31) Diagnosis of severity of ARI & diarrhoea, (32) recognising indications for referral-when & where, (33) management/referral of diarrhoea, ARI/fever etc, (34) preparation and use of ORS, (35) diagnosis and management of complications of ARI, diarrhoea etc. including administering I/V injections correctly
Care of sick children	(36) Prevention, detection and Treatment for minor ailments, (37) Health education, (38) Counseling
Adolescent health care	(39) Health education, (40) counseling, (41) IFA prophylaxis, (42) treatment for anaemia.

Skills for Disease Control Programme

NVBDCP	(1) History taking and examn. of fever cases, (2) Counseling regarding investigation for fever to diagnose Malaria/Kalaazar, etc and for appropriate treatment, (3) Health education, (4) chlorination of wells, (5) inter-sectoral coordination, (6) identification of source of stagnant water collection and appropriate activities to prevent mosquito breeding, (7) elimination of waste water collection, (8) promotion of environmental sanitation (toilets and garbage disposal), (9) Diagnosis of malaria/kalaazar/JE & treatment, (10) Diagnosis of Dengue & treatment, (11) Diagnosis of Filaria & treatment, (12) Supervision of workers undertaking spray operations for timeliness correctness, (13) training and supervision of HW/HA Male & Female on prevention for Malaria/Kalaazar etc., (14) Follow up of identified cases, (15) Diagnosis & mgt. of complications of Malaria/Kalaazar, Dengue etc. including referral, (16) vaccination for JE where necessary.
RNTCP	(1) History taking & examination for chest symptomatics, (2) referral of chest symptomatics with prolonged cough or spitting blood, (3) Health education to prevent the spread of these diseases, (4) Counseling, (5) Diagnosis and treatment of chest symptomatics, (6) Follow up of patients on ATT for compliance, (7) identify & guide community DOTS providers, tracking defaulters and reporting, (8) coordination with STS and STLS to update follow-up of all patients, (9) identify complications of treatment & referral, (10) identification of complications of disease & management including referral, (11) History and examination of suspected extra pulmonary TB, (12) diagnosis & management of drug-resistant patients.

NACP	(1) History taking for identification of high-risk behaviour, (2) Counseling to protect against RTI/STI including HIV, (3) Health education to prevent HIV, (4) referral to Integrated Counseling Treatment Centre (ICTC) for screening for HIV in pregnancy and PPTCT, (5) linkage with sputum microscopy centre for HIV-TB coordination, (6) Diagnosis and management of complications of disease, (7) Identification of complications of treatment and management/referral, (8) Follow up.
NBCP	(1) History taking to identify people with loss of vision/vision defects and refer, (2) Health education, (3) Counseling to protect eye-sight, (4) Testing of acuity of vision, (5) identifying abnormalities of vision & referral, (6) Treatment for minor ophthalmic problems, (7) Referring for specialised treatment, (8) Diagnosis & mgt./referral of complications of disease eg. glaucoma, (9) Follow up, (10) Identification of complications of treatment & referral.
NLEP	(1) History taking to find out people with skin patches, (2) Refer those with skin patches & loss of sensation to SET centres/control unit/MO, (3) follow-up of positive cases for regular & complete treatment, (4) Health education, (5) Counseling, (6) Diagnosis of Leprosy & treatment, (7) Follow up, (8) Advising patient on prevention of deformity, disability & rehabilitation, (9) Diagnosis of disability, management of disability including referral to specialised institutions, (10) management of leprosy reaction cases.
NCD	(1) History taking & examination to detect non-communicable diseases/lifestyle diseases, (2) Health education, (3) Counseling, (4) IEC about prevention & early detection of cancers & other NCDs, (5) appropriate & prompt referral of suspect cases, (6) Management of NCD including referral (7) Diagnosis of complications of disease/treatment & referral or management (8) Diagnosis of complications of treatment & management including referral, (9) Follow up.
IDSP	(1) Reporting unusual no. of occurrences of diseases, (2) reporting any unusual health events, (3) water quality test for chlorination & rapid test for fecal contamination, (4) Surveillance for diseases & appropriate corrective steps.

Skills for Laboratory Technician

(B)	Blood	(1) Hb., (2) TC, (3) DC, (4) ESR, (5) peripheral smear for MP & MF, (6) peripheral smear for type of anaemia, (7) blood grouping and Rh typing, (8) Blood storage, (9) Cross matching, (10) Blood sugar, (11) blood urea, (12) VDRL, (13) HIV ELISA, (14) Liver Function tests.
(U)	Urine	(1) Albumin, sugar, microscopy, (2) Bile salts & pigments, (3) ketone bodies.
(St)	Stool	(1) Microscopy for ova & cyst, (2) entamoeba, (3) cholera, (4) giardia, (5) occult blood.
(Sp)	Sputum	(1) For AFB, (2) Gram stain.
(Vm)	Vaginal Smear	(1) Wet mount for identification of TV & monilia, (2) gram stain.
(Sk)	Skin	(1) Skin smear for AFB.
(Se)	Semen	(1) Semen analysis (sperm count, motility, abnormalities and pus cells).
(W)	Water	(1) Water quality test for chlorination, (2) rapid test (kit) for fecal contamination.
(Al)	Aldehyde	(1) Microscopic/aldehyde test in kala azar endemic areas.
(Q)	Quality issues	(1) Infection prevention, (2) quality assurance.

Skills for Statistical Officer (SO)

(1) Preparation of monthly progress report in prescribed integrated formats given by GOI (timely & complete), (2) Programme specific collection of data from each level, compiling and sending timely, complete, reports from all units to higher level, (3) Continuous obtaining of information required for all programmes including AYUSH- (Timeliness of reporting, reports received from all units, completeness of reporting), (4) Tracking change in performance/unusual events/inconsistencies/identifying outliers for mid course corrections, (5) Validation of data, (6) Feedback on performance including corrections required.

Skills for Pharmaceutical Work (Pharma)

(1) Communication with patient for advising how to take the medicines as per prescription and report adverse effects, (2) Procurement of medicines (including maintenance of required stock), as per specifications of all medicines, chemicals, antibiotics, biologicals & pharmaceutical preparations, (3) Inventory control as per specification and storage of medicines/ devices etc. as per norms, (4) Programme specific information on dispensing of medicines, chemicals and pharmaceutical preparations, (5) Recording and Reporting (preparing periodic reports & returns of utilisation of pharmacy services).

Programme Management Skills Common for All Health Programmes at Each Level (PM)

(1) Disinfection, (2) Infection prevention and waste management, (3) Quality Assurance, (4) Supportive Supervision, (5) Management of logistics of supplies, (6) Maintenance of adequate stock of lab material, medicines, (7) Maintenance of facility, (8) Recording and reporting.

ANNEXURES

Matrix of RCH – II Training

	Maternal Health						Child Health		Family Planning						
Category of Trainees	SBA	EmOC	Life Saving Skills in Obs. Anaesthesia	Blood Storage	RTI/ STI	MTP/ MVA	IMNCI	Immunisation	Mini Lap.	Lap. Sterilisation	IUCD	NSV	Adolescent Health	PDC	PMU
MO	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	
Staff Nurse	✓				✓		✓	✓	✓ as team	✓ as team	✓		✓		
ANM/LHV	✓				✓		✓	✓			✓		✓		
Health Worker(M)															
Lab. Technician				✓	✓										
Specialist (Gynaec./ Surgeon)										✓					
Dermatologist					✓										

Annexure-I

Sl. No.	Type of Trg.	Category of Participants	Duration	Batch Size	Venue	Trainers	Responsibility
1.	SBA	SN/ANM/LHV	3 – 6 Weeks	2 – 4	Identified District Hospitals	TOT trained Obstetrician/MO/ SN& Paed. M.O.	MH Division/NIHFW
2.	EmOC	MOs	16 Weeks	Up to 8	Identified Medical Colleges	Faculty Med. College (Gyn)/Dist Gynaecologist.	MH Division/FOGSI
3.	Life Saving Skills in Obs. Anesthesia	MOs	18 Weeks	Up to 8	Identified Medical Colleges	Faculty Med. Coll. (Anes)/Distt. Anaes	MH Division
4.	Blood Storage	MOs, Lab. Tech.	3 Days	2 – 3	Instt. where Blood Banks are available	I/c of trg. instt.	State/SIHFW
5.	RTI/STI	MO/SN/ANM/ LHV	2 Days	5	Identified Medical Colleges/RHFWTC	Oriented team of trainers at State Level	MH Division
6.	MTP including MVA	MOs	15 Days	5	Identified Trg. Institutes	Gynaecologist from Medical Colleges	MH Division
7.	IMNCI	MO/ANM/LHV/ AWW, etc.	8 days	24	National/State/District Trg. Centers	Faculty of Paediatrics and P&SM deptt.	CH Division/State
8.	Immunisation	Health Workers	2 days	20-25	District Trg. Centers	Trained Trainers	Imm. Division
9.	Mini Lap	MOs for CHCs/ FRU & DH	12 Working Days	1 - 2	Identified Trg. Institutes	Gynaecologist	FP Division
10.	Lap. Ster.	Gynaecol./Surgeon with OT Nurse & Assistant	12 Working Days	1 team at a time	Identified Trg. Institutes	Gynaecologist	FP Division
11.	IUCD	ANM/LHV	5 days	5 – 10	Identified Trg. Institutes		FP Division
12.	NSV	MOs	5 days	4		Master/State Level Trainers	FP Division
13.	Adolescent Health	MOs/ANM	5 Days	25 – 30			IEC Division
14.	PDC	CMO/Civil Sur./ Hosp. Suptd.	10 Weeks	20 - 25	Identified 13 Trg. Institutes	Faculty of NIHFW	NIHFW & Trg. Div
15.	PMU		5 Days	20 – 25	NIHFW/SIHFW	Faculty of NIHFW	NIHFW & DC Div.

Matrix for Training of ASHA

Category of Participants	Duration	Batch Size	Venue	Trainers	Responsibility
State Training Team (STT)	3 days in module 1	25 – 30	NIHFW	Faculty of NIHFW/ MOHFW and related departments	Training Division/ NIHFW
	3 days in module 2,3 & 4	25 – 30			
District Training Team (DTT)	3 days in module 1	25 – 30	SIHFW	State Trainer (STT)	State Level NRHM Committee/Director SIHFW
	3 days in module 2,3 & 4	25 – 30			
Block Training Team (BTT)	7 days in module 1	20 – 25	DTC	District Trainers (DTT)	District Health Society
	4 days in module 2 & 3	20 – 25			
	4 days in module 4	20 – 25			
	4 days in module 5	20 – 25			
ASHA	7 days in module 1	20 – 25	CHC/PHC/ NGO, etc.	Block Trainers (BTT)	Block Co-ordinators Committee
	4 days in module 2 & 3	20 – 25			
	4 days in module 4	20 – 25			
	4 days in module 5	20 – 25			

Module V – Role of ASHA as an Activist has been printed. Dissemination and training will follow.

Annexure-III

Training for Rogi Kalyan Samiti (RKS)/Swasthya Kalyan Samitis/Equivalent

Rogi Kaliyan Samitis (RKS) are major strategic interventions under NRHM for providing the improved quality of health and family welfare services at the health facility. It is essential to provide the members of RKS/SKS/equivalent and its governing bodies with requisite knowledge. The various areas that need to be included in the training are:-

- Monitoring and evaluation
- Record keeping
- Accounting and stock keeping
- Private partnership
- Procurement of medicine supplies
- Data collection
- MIS to monitor performance and feedback
- Inventory management
- Monitoring of national programmes
- Survey for patient satisfaction
- Financial management
    - Standard accounting protocol
    - Fund utilisation guidelines
    - Financial reporting mechanism.

Annexure-IV

Training under National Disease Control Programmes

Sl. No.	Types of Training	Category	Duration	Batch Size	Venue	Responsibility
1.	**National Leprosy Elimination Programme (NLEP)**					
	Orientation Training	MO/HA (M)/HA (F), MPW	3 days	30	District/Block Level	State/District Leprosy Officer
	Refresher Training	MO/HA (M)/HA (F), MPW	1 day	30	District/Block Level	State/District Leprosy Officer
2.	**Revised National Tuberculosis Control Programme (RNTCP)**					
	Initial Training	STD/DTO MO – TC MO STS/TO/SA/ IEC STLS Lab. Tech. MPHS MPHW/ TBHV Pharmacist Trg. of Staff Drug Mgt. Accountant Community Volunteer Private Practitioner Pvt. LTs	14 days 12 days 5 days 6 days 15 days 10 days 3 days 2 days 2 days 1 day 1 day 2 days	20 20 20 12 6 8 25 25 25 25 25 25 20 8	Identified Central Instt. Identified Central Instt. STDC STDC STDC Dist. Trg. Centre (DTC) DTC DTC DTC DTC DTC DTC DTC	Director Central Instt. Director STDC I/c DTC

Sl. No.	Types of Training	Category	Duration	Batch Size	Venue	Responsibility
	Update Training EQA Trg.	Master Trainers & Microbiologist IRL & LTs STDC (Dir.)/STD DTO/ MO – TC STLS LTs	2 days 14 days 2 days 2 days 2 days 1 day	10 6 15 25 6 25	Identified Central Instt. Identified Central Instt. STDC STDC STDC DTC	Director Central Instt Director STDC
	Update Training TB - HIV	Master Trainers DTO/MO – TC MO STLS/STS		10 10 30 10	Identified Central Instt. STDC DTC STDC	Director Central Instt. Director STDC I/c DTC
	Retraining	STO DTO/MO – TC MO STLS STS/TO/SA/IEC Off. Lab. Tech. MPHS MPW/TBHV Pharmacist	5 days 5 days 3 days 3 days 2 days 2 days 1 day 1 day 1 day	20 20 20 6 20 8 25 25 15	Identified Central Instt. STDC STDC STDC DTC DTC Dt/TU Dt/TU Dt/TU	Director Central Instt. Director STDC I/c DTC MO-TU
3.	**Training under National Iodine Deficiency Disease Control Programme (NIDDCP)**	State Programme Officer, State Technical Officer & Lab. Tech.	4 days	-	NICD – New Delhi/AIIHPH - Kolkata	GOI
		District Level Programme Officers, MO (PHC) & ANM	1 day	-		

Sl. No.	Types of Training	Category	Duration	Batch Size	Venue	Responsibility
4.	**Training under National Programme for Control of Blindness (NPCB)**	Dt. Ophthalmic Surgeons/Medical College Faculty in IOL implantation, SICS, PHACO, Emulsification & other specialties	8 weeks	1-2	10 NGO Hospitals & Medical Colleges	GOI
		Training in Ophthalmic Nursing (Induction)	4 weeks	10-15	Base Hospital (District Hospital/Medical College)	State
		Refresher Training for PHC MO	3 days	15-20	Medical College	State
		Refresher Training of PMOAs	5 days	15-20	District Hospital	State
		Trg. of Health Workers/MPWs/Link workers etc.	1 day	25-30	District Hospital	DBCS
		Trg. of Teachers	1 day	25-30	DTC/other places	DBCS
		Trg. of DPMs	2 days	15-20	State HQ	GOI

National Vector Borne Disease Control Programme (NVBDCP)

National Level Training Courses

Sl. No.	Name of Training Courses/ Workshop	Category	Duration	Batch Size	Name of the Institution/ Venue	Responsibility
1	Tertiary level training for medical college faculty	Medical College Faculty	2 days	25	Medical Colleges	Concerned Regional Director
2	Rapid Response Team on management of VBD	Members of State/Distt Rapid Response Teams	2 days	25	AIIMS/NICD	Concerned Institute
3	Trg. on Laboratory Diagnosis of JE & Dengue/DHF	Microbiologists/Lab. Technicians.	2 days	25	Apex Referral Labs./ NICD/NIMHANS	Concerned Institute
4	Trg. on Prevention & Control of VBDs	State/District Level Officers.	20 working days	25	NICD	NICD
5	Trg. for Entomologists & Biologists	Entomologists/Biologists	20 working days	25	NIMR/IVCZ Hosur	Concerned Institute
6	Trg. for Laboratory Technicians for Military/Para Military Forces.	Lab. Technicians	5 days	25	To be conducted in coordination with respective organisations.	Concerned Institute
7	Trg. for Medical Officers/Military/Para Military forces	Medical Officers	2 days	25	To be conducted in coordination with respective organisations.	Concerned Institute
8	Trg./Workshop on QA of District Level Programme Managers	Distt. Level Programme Managers	2 days	25	NVBDCP (Regional Level)	NIMR
9	Trg. for Programme Managers on M&E	State/Distt. Level Staff	2 days	25	NVBDCP HQ/States	Specific Regional Directors
10	Entonolgical Assistants	AMOs, Insect Collectors	12 days	20	IVCZ Hosur/DMRC Jodhpur	Concerned Institute
11	Trg. for Private Practitioners	Private Practitioners	1 days	50	IMA HQ/States	IMA concerned

12	Regional Training of State Core Team of Trainers on Clinical Management of Malaria/Dengue Japanese Encephalitis	Medical College Faculty	2 days	25	AIIMS	Concerned Institute
13	Medical Officers (Secondary level) on Clinical Management of Malaria/Dengue/JE	Distt/CHC Medical Officers.	2 days	25	Medical College in Endemic areas	Concerned Medical College
State Level Training						
1	Training of Medical Officers (secondary level)	Medical Officers in Districts	3 days	25	State Training Institutes	State
2	Trg of Laboratory Technicians (induction level)	Lab. Technicians.	10 days	20	State Laboratories/ RO H&FW Lab./ ICMR Institutes	State
3	Trg of Lab. Technicians (re-orientation level)	Lab. Technicians.	5 days	20	State Laboratories/ RO H&FW Lab./ ICMR Institutes	State
4	Trg of Health Supervisors, Health Workers	Health Supervisors/ Health Workers	2 days	25	Block level PHC	MO of block PHC
5	Trg of Community Health Workers	Community Health Workers	1 day	50	PHC	MO of PHC
6	Trg of ASHAs (Proposed)	ASHA	3 days	25	Block level PHC	MO of block PHC

Annexure-V

Model District Training Plan

(20 lakh population)

Sl. No.	Type of Facility	No. of Facilities	No. of Staff required as per the NRHM Framework for Implementation	Desired Training Load
1.	Sub – Centre	400	@ 2 ANM per SC	800
2.	Primary Health Centre (PHC)	60 – 70	@ 1 MO @ 3 SN @ 1 PHN Practitioner @ 1 Lab. Technician @ 1 Pharmacist	60 180 - 200 60 – 70 60 - 70 60 – 70
3.	Community Health Centre (CHC)/First Referral Unit (FRU)	15 – 20	@ 7 Specialist MOs (Paed., Obs. & Gynae., Surgeon, Anaes. & 3 MOs) @ 10 SN @ 1 Lab. Technician @ 1 Pharmacist @ 1 BEE @ 1 Radiographer	45 – 60 150 – 200 15 – 20 15 – 20 15 – 20 15 – 20
4.	District Hospital (DH)	1		

50% of PHCs have to be made 24 x 7 PHCs, hence the training load for all categories will be 50% of the given training load.

All CHCs have to be made operational. At CHC/FRU if the specialists are not available then the MOs can be accordingly given multi-skilled training (EmOC, Life Saving Skills in Anaesthesia). If the specialists are posted at CHC/FRU, then the MOs can be given core skill training.

List of Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BEE	Block Extension Educator
CHC	Community Health Centre
CNAA	Community Need Assessment Approach
CTI	Collaborating Training Institute
DEO	District Education Officer
DMO	District Medical Officer
DPM	District Programme Manager
DTC	District Tuberculosis Centre
DTO	District Tuberculosis Officer
EmOC	Emergency Obstetric Care
ESI	Employees' State Insurance
FP	Family Planning
FRU	First Referral Unit
GOI	Government of India
HIV	Human Immunodeficiency Virus
IDD	Iodine Deficiency Disease
IDSP	Integrated Disease Surveillance Programme
IEC	Information, Education and Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IOL	Intraocular Lens
IRL	Intermediate Reference Lab.
IUCD	Intra Uterine Contraceptive Device
LBW	Low Birth Weight
LHV	Lady Health Visitor
LT	Laboratory Technician
MH	Maternal Health
MMR	Maternal Mortality Ratio
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
MWCD	Ministry of Women and Child Development

NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NDCP	National Disease Control Programme
NSSO	National Sample Survey Organisation
NGO	Non Governmental Organisation
NICD	National Institute of Communicable Diseases
NIHFW	National Institute of Health and Family Welfare
NLEP	National Leprosy Elimination Programme
NPCB	National Programme for Control of Blindness
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
NVBDCP	National Vector Borne Disease Control Programme
PDC	Professional Development Course
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PRI	Panchayati Raj Institution
PSU	Public Sector Undertaking
QAC	Quality Assurance Committee
RCH	Reproductive Child Health
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
RSS	Research Studies and Standards
RTI	Right to Information
RTI/STIs	Reproductive Tract Infections/Sexually Transmitted Infections
SA	Secretarial Assistance
SBA	Skilled Birth Attendant
SC	Sub-Centre
SICS	Small Incision Cataract Surgery
SIHFW	State Institute of Health and Family Welfare
SHP	State Health Programme
SOE	Statement of Expenditure
SPM	State Programme Manager
SRS	Sample Registration System
STDC	State Tuberculosis Training and Demonstration Centre
STLS	State Tuberculosis Laboratory Supervisor
STS	Senior Treatment Supervisor
TBHV	Tuberculosis Health Visitor
TFR	Total Fertility Rate
TOT	Training of Trainers
VHND	Village Health and Nutrition Day