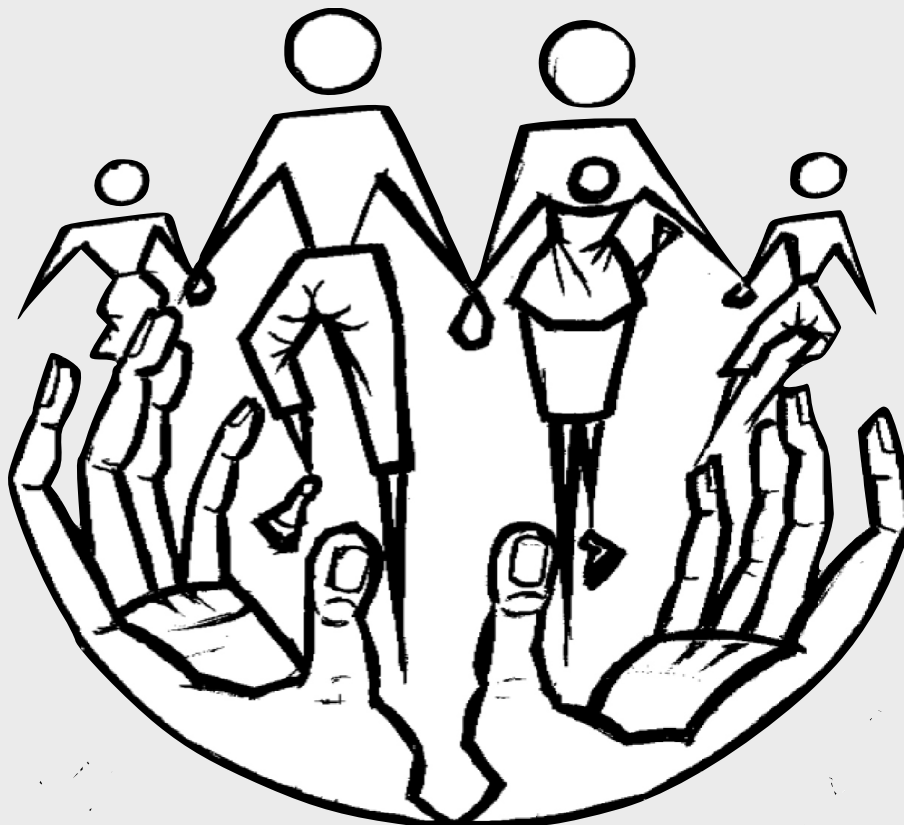


**Technical and Operational Guidelines for
Rural and Urban Health Training Centre
attached with
Community Medicine Department of
Medical Colleges as per the Guidelines of
Medical Council of India**



IAPSM

Indian Association of
Preventive & Social Medicine



Foreword


All subjects in medical graduate education are important but Community Medicine discipline is special as it keeps the student focused on the basics of health i.e. social determinants of health, dynamics of the disease transmission, principles and methods of prevention and control of disease and primary curative care for common ailments. While all subjects teaching inwardly i.e. deeper from macro to micro, community medicine discipline teaches the medical graduates to look outwardly, i.e. beyond human body to socio-economical-behaviour-cultural milieu. While other subject teaches by fragmenting the body, it trains by connecting to human body with cosmos making it a whole. All medical subjects are to be taught in the hospital, it can be taught in the community. For the same as a part of Medical Education, Urban Health Training Centre(UHTC) and Rural Health Training Centre (RHTC) are at heart of the teaching/training to Medical Students. Medical Council of India at numerous places in its document, as in the Medical Education Regulation 1997 has mentioned that real teaching must take place in the community setting, so that students can understand role of social factors in health and disease outcomes, learn the preventive, promotive, curative and rehabilitative care. As there was neither single model nor any guidelines for UHTC and RHTC, thus it has resulted in to different and variety of unsuccessful trials attaining key goals and objectives for Indian Medical Graduates education.

Currently more than 465+ medical colleges are operating in the country. However, it is seen that there is no uniform and universal model of UHTC and RHTC. Few models are wonderful but it is not replicable at the other medical colleges as majority of medical colleges are not having at par resources and support from the Management/Government. In addition, many models are great in outlook but it is felt that it is beyond the scope and role of the Community Medicine. At majority of places, patchy and varied activities are carried out which are insufficient and hazily focused. Cause behind such variation in models and weak UHTC/RHTC is absence of guideline on the infrastructure, functions and roles of the Community Medicine Department at UHTC and RHTC.

There was a long-standing need of a guideline for UHTC and RHTC, which can help all Medical College in establishing good UHTC and RHTC. This need is discussed at large at various platforms under the banner of IAPSM which has led to the formulation of this document. I am sure; this document will bridge the long-standing gap between MCI guidelines and good functioning UHTC/RHTC. With availability of this guideline, clouds surrounding models and functioning of UHTC/RHTC will be over. It will help in establishment of the uniform and universal model with minimum sets of activities as described in this guideline and help the subject to graduate successfully from "Preventive & Social Medicine" to "Community Medicine" phase, where UHTC AND RHTC are the basic units of Community Medicine practices and department is involved in Community oriented Health Care.

I urge all the medical colleges to use this guideline to establish and run the UHTC and RHTC in their medical colleges so that goals and objectives of medical education can be fulfilled for undergraduates and postgraduates in the subject of Community Medicine.

March 2018


Dr. Ratan Srivastava
President (IAPSM)



PREFACE

Community Medicine subject has been evolved over the period from Sanitation & Hygiene to current status where it is expected that Community Medicine experts shall work in close association with the health care delivery system especially “Primary Health Care Delivery” and health related programs. Community Medicine Department is pivotal in shaping the mind of undergraduate students and building the skills of Post Graduates in Community Medicine subject in preventive, promotive, primary clinical care. In its “avatar” as a Preventive and Social Medicine, Community Medicine experts have graduated remarkably in epidemiological studies but when it comes to the application of the knowledge and skills of epidemiology in the field, their skills are found a bit blunt. The reason for this seems to be the disconnection of the Community Medicine Department from the field. This can be partly attributed to “weak” Urban Health Training Centre (UHTC) and Rural Health Training Centre (RHTC).

RHTC and UHTC are integral part of department of Community Medicine of any medical college and provide learning opportunity to medical students, interns and postgraduates. MCI documents provide a working guideline for its functioning but do not clearly define its organizational structure and functioning. Due to lack of any guidelines, they are not functioning as it is envisaged in Medical Education Regulation of Medical Council of India. As an apex professional body in the subject; Indian Association of Preventive and Social Medicine (IAPSM) has shouldered the responsibility to bridge this gap and develop “A Technical and Operational guidelines for UHTC and RHTC” A national consultation meet for developing norms for the UHTC and RHTC was held at KGMC, Lucknow, Uttar Pradesh in October 2016. This document is the extension of the action based on the deliberation in aforementioned consultations.

The first part of this document covers the technical aspects of the UHTC and RHTC. This part mentions basic reasoning and understanding about the UHTC and RHTC and its four domains. Second part describes how the aims and objectives pointed out in the first part for all the four domains can be realized. It also describes general norms about infrastructure, human resource & their job charts, instrument and equipment, functioning of the Centre etc. Primary health care (Community Oriented health care) and health programs are the heart of the UHTC & RHTC functioning. This can be achieved only if collaboration between medical colleges and primary health care system is developed. At the end of the document, the collaboration mechanism and roles of medical college and general health care system are suggested so that a mutual beneficial relationship can be developed, where it is win win situation for both, the stakeholders and overall community.

We urge, to all medical colleges, to use this document in establishment of the UHTC and RHTC. In addition, we are requesting to share their experiences, challenges and innovations in implementing this guideline so that we can improve and prepare better guidelines in second edition.



Dr. A M Kadri
Secretary General (IAPSM)

March 2018



ACKNOWLEDGEMENT

At the outset, I express my gratitude to Conveners and Members of National Consultative Meet held at KGMU, Lucknow for defining norms of RHTC and UHTC, which formed the base over which this document is constructed and more elaborate technical and operational guidelines suggested. I am indebted to Dr. Sanjiv Kumar (Ex Director, NHSRC) and Dr. V K Srivastava (Past President, IAPSM) on behalf of IAPSM, for conducting this meeting and initiation of reform in this domain.

I am also heartily grateful to IAPSM members; Dr. Anil Purty, Dr. Ashok Bhardwaj, Dr. Mohan Doibale, Dr. Paramita Sen Gupta, Dr. Rashmi Kundapur, Dr. Subhash Elango, Dr. Suneela Garg, Dr. Uday Shankar Singh, Dr. Umed Patel and Dr. Vinod Srivastava for their time and timely technical inputs. Each of the member has contributed with their valuable knowledge and experience, which led to improved version of this document.

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My special thanks to Dr. Ankit Sheth who worked actively for overall co-ordination, timely inputs and editing this document.

I am sure this document prepared on behalf of IAPSM will be useful for establishing uniform and universal model for UHTC and RHTC with minimum set of standards as suggested.



Dr. A M Kadri
Secretary General (IAPSM)



TABLE OF CONTENTS

Content	Page no.
<u>Preamble:</u>	1
<u>Need to prepare guideline for UHTC/RHTC</u>	2
<u>Scope of the Document</u>	4
<u>Section I: Technical guidelines for UHTC/RHTC</u>	5
<u>Approach and Principles at UHTC/RHTC</u>	5
A. <u>Teaching and training at UHTC/RHTC</u>	7
B. <u>Research and Innovations</u>	9
C. <u>Primary Health Care (Preventive, Promotive and Primary Clinical Care)</u>	10
D. <u>Inter-sectoral coordination & Community Mobilization</u>	12
<u>Section II: Operational Guidelines for UHTC/RHTC</u>	14
A <u>Number of UHTC and RHTC under a medical college</u>	14
B <u>Administrative control</u>	14
C <u>In-charge of the Centres</u>	16
D <u>Activity Plan (Functioning of UG/PG training at RHTC/UHTC)</u>	16
E <u>Physical standards for RHTC/UHTC</u>	17
F <u>Prescribed qualifications and job responsibilities of staff</u>	18
G <u>Vehicle for transport</u>	20
H <u>Equipment/Instruments and furniture</u>	21
I <u>Functioning of RHTC/UHTC</u>	
1. <u>Teaching and training</u>	21
2. <u>Research and Innovations</u>	25
3. <u>Primary health care related services</u>	26
4. <u>Inter-sectoral coordination and community mobilization</u>	30
<u>Section III: Collaboration Model to strengthen medical education and primary health care by developing mutually beneficial relation at UHTC and RHTC</u>	37
<u>Concept note for Centre of Excellence at UHTC/RHTC (U-PHC/R-PHC)</u>	41
<u>Annexures</u>	
I) <u>Goal and objectives as per Medical Graduates Education Regulation, MCI 1997</u>	42
II) <u>Learning objectives of Community Medicine for undergraduate and internship as per Graduate Medical Education Regulation (MCI)</u>	44
III) <u>National Consultative Meet on Defining Norms for RHTC and UHTC of Medical Colleges in India</u>	47
IV) <u>Staffing pattern at Primary Health Center (PHC) under IPHS, 2012</u>	55
V) <u>Village Orientation Programme</u>	56
VI) <u>Indicative list of activities/project work for PGs</u>	63

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Preamble:

Overall National and Institutional goal of Medical graduates for India is that they should be competent basic doctor at the end of MBBS course. Overall goal of Medical Graduate Education and specific goal of Community Medicine are largely linked with following three areas.

1. To train medical graduates in preventive, promotive and rehabilitative services besides curative care for common health problems.
2. To teach them about socio cultural demographic factors and their role in health outcomes.
3. To orient about national health program and health care services and sensitize them about health care activity for preventive, promotive, curative and rehabilitative services in the country under primary health care.

Under Indian Medical Graduate Education, it is envisaged that medical graduates learn the health outcomes with holistic understanding than limiting to just diseases management. The 'Vision 2015' document of Medical Council of India (MCI) emphasizes the need to reform medical education so that we create health practitioners who 'understand and provide preventive, promotive, curative, rehabilitative, palliative and holistic care with compassion' in the larger interest of society. Developing knowledge resource is a crucial element of building institutional capacity and a commitment under National Health Policy-2017.

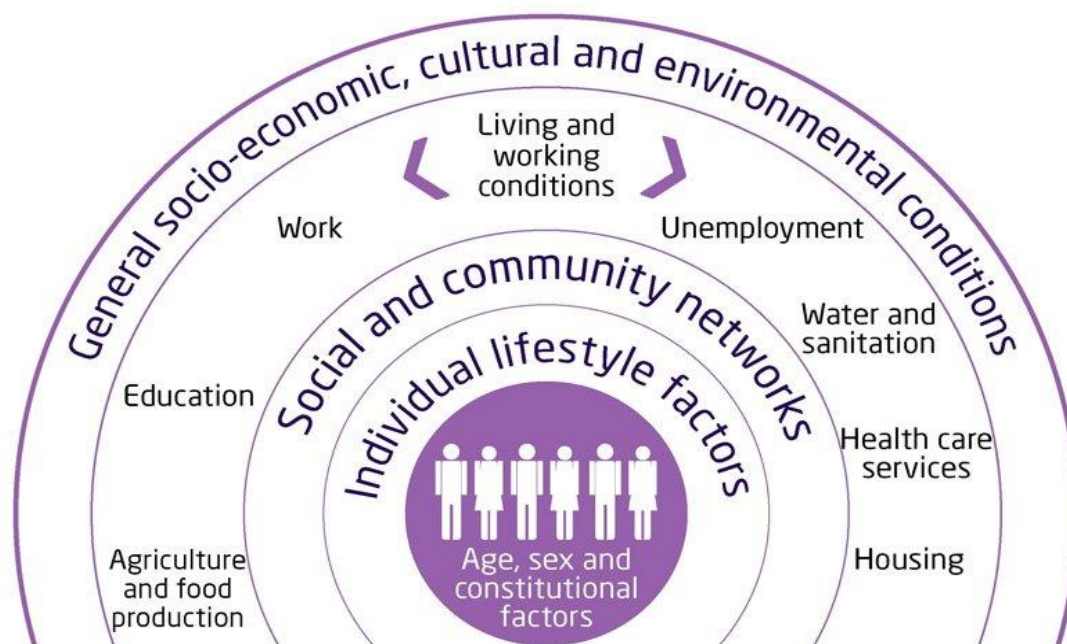
The details of National and Institutional goals of Medical Education Regulation, MCI 1997, are given at annexure I. It is evident from it that objectives of Indian Medical Graduate Education are in line of the country's health needs and health goals to support the country. Thus, role of medical colleges is not only to produce medical graduates but also to produce them as per the need of the country. It is highly desirable therefore, that medical colleges, which are centre for higher learning and research, should more actively participate and support implementation of National health and development program and provide medical education to students that is sensitive to the changing health needs of the community and health care delivery system. Medical colleges, as a higher learning and training institutes in medical and health sciences, play a critical role in shaping the mindset of future generations of medical practitioners, who form an integral part of National health program and healthcare delivery system as managers, planners or actual health care providers. Medical colleges associated with tertiary care institutes are the apex institutions for imparting technical knowledge and skills so that they produce best quality medical professionals to address health problems in an effective manner.

When the learning objectives (annexure II) of subject Community Medicine are referred, it can be seen that Community Medicine subject has to play the biggest role in achieving core objectives of Indian Medical Graduates.

For attaining many learning objectives, it is recommended under Medical Education Regulation, MCI 1997; that learning activities must be carried out in community settings.

To support teachings in community settings and for fulfillment of objectives related with preventive, promotive and curative health care services, it is recommended that there must be field level service units in urban and rural areas as Urban Health Training Center (UHTC) and Rural Health Training Center (RHTC) respectively. Primary objective of Rural/Urban

Health Training Centre is to develop a connection between future clinicians and masses so that the medical students can understand dynamics of individual and community health with other vital determinants of health i.e. Socio-economic and cultural status, environment and demography. Students should develop expanded concept from disease free individual to healthy community. Health outcomes are influenced by various socio-economical-environmental factors over and above biological determinants. It can be better described in diagram given below.



Need to prepare guideline for UHTC/RHTC:

RHTC and UHTC are integral part of department of Community Medicine of a medical college and provide learning opportunities to medical students, interns and postgraduates. Community Medicine is the specialist branch of medicine, which is concerned with the health of all the people living in defined area. Aim of Community Medicine is to promote, protect and preserve the health of the people. It requires more of preventive medicine, special care for those at risk and primary health care to everyone. It includes managing community health through community diagnosis and varied actions ranging from community interventions to individual. Thus, Community Medicine is the branch, which works to create healthy community. UHTC and RHTC are the practicing areas for Community Medicine Department where it works to promote, protect and preserve the health of the community. UHTC and RHTC are the settings where medical students can be taught about the healthy community and managing community health.

When the goal and objectives for Indian Medical Graduate teaching are linked with the UHTC and RHTC, it is evident that RHTC and UHTC is nothing but the upgraded U-PHC and R-PHC with additional staff, infrastructure and support where along with health services,

teaching/training are being carried out. In other words, responsibilities of one U-PHC and R-PHC from primary health care network must be taken over by medical colleges to upgrade them as UHTC and RHTC respectively. For the same, it is specifically mentioned under Minimum Standard Regulation and Medical Education Regulation for undergraduates that RHTC and UHTC shall be owned by the college or it should be affiliated with Government owned Health Centre, and academic control for teaching and training at these centers shall be with the Dean.

However; because of lack of detailing or clarity, and lack of enthusiasm in general health system to hand over primary health care set up i.e. U-PHC and R-PHC to medical colleges which are tertiary care center by nature; good functioning UHTC and RHTC could not be established at a large. This has adversely affected key teaching objectives for the Indian Medical Graduates (IMG) envisaged by MCI. At some places, satellite dispensaries are created to fulfill the mandatory requirement of a UHTC & RHTC under MCI regulation, but it could not achieve teaching goals as per Medical Graduate Education as;

- i. they are not having a community base,
- ii. preventive, promotive activities are not being carried out there and
- iii. there is complete absence of services under the National Health Programs at such places.

UHTC and RHTC: Teaching-learning opportunities for Medical Graduates and Postgraduates.

As per the Guidelines of Medical Council of India at UHTC and RHTC “training of students and interns in community oriented primary health care and community based (urban and rural) health education for the community attached are to be carried out. For fulfillment of this objective following teaching and training benefits shall be used by the Medical Colleges at UHTC and RHTC and Community attached to it.

- Exposure of medical students to the rural/urban communities through which they can better understand the dynamics between health issues of the communities & determinants (socio-economic, cultural and demographic) of health.
- Opportunities to interns to sharpen their clinical and managerial skills
- Orientation and hands on training in practical aspects of various national health programs & health administrative systems, thus understanding the future role to be played by them to achieve national health goals.
- Participation in wide range of community-based research and getting hands on training in the same.
- Orientation about planning, organizing and monitoring various health programs/services in the community settings.

Looking to the ambiguity and inadequacy coupled with some administrative and motivational issues; the functioning of RHTC & UHTC has been always remained major weakness across the India. But, it is an undisputed fact that for sensitizing the students towards social dimension of health and diseases, for developing the holistic vision in dealing a patient and knowing the community level intervention for health promotion and disease prevention as well as for orientating them about Primary Health Care/program delivered by General Health System, a good functioning UHTC/RHTC must be there in every Medical college.

To discuss this issue, a national consultation meet for developing norms for the UHTC/RHTC was held at KGMU, Lucknow, UP (annexure III). Two key recommendations from this meet were as below.

1. Health centers with capacities of OPD, IPD and outreach services (preventive, promotive and primary care) should be developed as an UHTC-RHTC and under full administrative and financial control of Community Medicine Department with overall control of Dean of the medical college.
2. For the same, a collaboration mechanism between General Health System/Local urban body and medical colleges may be developed. As a part of it, a MoU shall be signed between medical college management and State/local urban body for smooth functioning of the health centers and guarding the interest of involved stakeholders.

Hence, there is a dire need to have uniform, realistic and acceptable standards and guidelines for better and effective implementation of undergraduate training. This guideline has been prepared keeping above two recommendations at the center.

Scope of the Document

The document is prepared with the aim to guide the Medical Colleges and Community Medicine Department, so that effective operationalization of the RHTC/UHTC can be done to attain learning objectives successfully for medical graduates as per the GME regulation 1997 and MD (Community Medicine), and at the same time to address the concerns of the General Health System.

The guidelines are covering following points....

1. Technical guidelines

- A. Approach and Principles at UHTC/RHTC
- B. Teaching and training at UHTC and RHTC
- C. Research and Innovations
- D. Primary Health Care (Preventive, Promotive and Primary Clinical Care)
- E. Inter-sectoral Coordination & Community Mobilization

2. Operational guidelines

- A. Number of UHTC and RHTC under a medical college
- B. In-charge of UHTC and RHTC
- C. Administrative control of UHTC and RHTC
- D. Activity plan (Functioning and UG & PG Training at the UHTC and RHTC)
- E. Physical standards for UHTC and RHTC
- F. Prescribed qualifications and job responsibilities of staff
- G. Transport Support
- H. Equipment/instruments and furniture
- I. Functioning of RHTC/UHTC – teaching & training, research & innovations, primary health care related services, inter-sectoral coordination & community mobilization

3. Collaboration mechanism between health department (State and Local Self-Government/Corporation) and community medicine department

Section I: Technical guidelines for UHTC and RHTC

A. Approach and Principles at UHTC and RHTC:

The aim of Community Medicine is to create and maintain healthy community in their field area. It can be attained through promoting, protecting and preserving the people's health living in the defined area. In India, typically two diverse community settings, with different sets of the health situation are present; urban and rural. Urban Health Training Centre and Rural Health Training Centre are two community medicine practicing areas for teaching and training of medical undergraduates and postgraduates in Community Medicine.

Country is facing quadruple burden of disease; communicable and infectious diseases (TB, malaria, HIV, pneumonia etc.), non-communicable diseases (diabetes, hypertension, and cancers), nutritional health problems (anemia, obesity etc.) and mental health problems (stress, anxiety, depression, substance abuse) because of interaction of various environmental, socio-cultural-behavioral and economic factors. When attribution of various factors for health outcomes is viewed, it is seen that there is much more beyond the clinical care and biological determinants.

WHO's declaration of "Health for All" at Alma Ata through primary health care approach is beyond traditional treatment of illness. It also includes health promotion and illness prevention, promotion of community and individual, self-reliance and participation, and intersectoral action to address social determinants of health (i.e. issues such as poverty, housing, education, and food supply, which underlie the health of populations). The "comprehensive" view of primary health care is different from "selective" (disease-focused) approaches to primary health care, or to those approaches that concentrate more exclusively on the treatment of illness.

Primary health care approach understands the burden of diseases, their determinants and aims to respond through integrated preventive, promotive and curative care approaches along with addressing social determinants through Urban/Rural Primary Health Center. The provision of Comprehensive Primary Health Care (CPHC) is the country's approach to reduce morbidity, disability and mortality at much lower cost and significantly reduce the need for secondary and tertiary care. Medical college is a tertiary care center but UHTC/RHTC are its units which work on the principle of the Comprehensive Primary Health Care and they are playing pivotal role in ensuring the learning of Comprehensive Primary Health Care, which is an expected skill as principal role of medical graduates. Thus, UHTC and RHTC are based on three goals:

1. **Teaching/training goal:**

Teaching goal for medical graduates is to make them a competent 'Basic Doctors' who can provide promotive & preventive health services to the patient and community along with the curative services, keeping existent socio-economic & cultural environment in mind.

Goal of the training to postgraduates in Community Medicine is to create a Community Physician who has acquired knowledge and skills in identifying health

needs, prioritize them, able to do resource mapping and manage community health by use of principles and techniques of epidemiology, health management and preventive, promotive and primary clinical care.

2. Research goal:

The research goal is to carry out various community and health system based studies and innovations that can contribute to the knowledge and skills for better community health management.

3. Service goal:

Service goal of UHTC/RHTC is to “improve the health status of the population served under the PHC in general, and the poor and other disadvantaged sections particular, by facilitating equitable access to quality healthcare through primary health care, with active involvement of the communities and other stakeholders”.

Thus, UHTC and RHTC can be viewed as “an upgraded urban-PHC and rural-PHC” respectively. These centers are having following additional features over and above conventional Primary Health Centre. They are as below.

- a) Teaching and training sites for health professionals
- b) “Center of Excellence” for primary health care
- c) Incubators for newer innovations and interventions
- d) Community research centers

Based on the above three goals, the functions of UHTC/RHTC can be described in four domains:



A. Teaching and training at UHTC/RHTC

This is most vital goal of the UHTC and RHTC. These are the teaching and training hub for medical undergraduate and postgraduate students.

Learning objectives for medical graduates are:

- I) In the area of health care services;
 - 1) Understand the health care delivery system in urban and rural areas.
 - 2) Develop skills in diagnosis, treatment and prevention of common illness prevailing in the community.
 - 3) Understand the practical aspects of national health programs/ services and their objectives, strategies and activities.
- II) In the area of field epidemiology;
 - 1) Get acquainted with various socio-economic, cultural-behavioral, environmental and demographic factors, and understand their relationship with health outcomes of urban and rural communities.
 - 2) Able to measure various epidemiological parameters and interpret them.
 - 3) Assist in investigation of outbreaks and applying measures for its prevention and control.
 - 4) Get acquainted with the different field activities of PHC/UHC.
- III) In the area of health system and management;
 - 1) Understand different components of health systems management viz. logistics, financial, communication skills, leadership.
 - 2) Assist in monitoring and evaluation of functioning of UHC/PHC as well as national health programs/services.
 - 3) Able to compile, analyze, interpret and present health related data based on Health Management Information System (HMIS).
 - 4) Understand innovations and use of IT in health care.

Internship training

During internship of Community Medicine, an internee should have first-hand learning experience about community health situation, health care delivery system especially, preventive, promotive and primary clinical care under primary health care and various health programs/services.

Learning Objectives for interns:

- I) In the area of health care services;
 - 1) Understand the principles of primary health care and role of Primary Health Center (PHC) in delivering primary health care.
 - 2) Get acquainted with the functions of UHC/PHC, staffing pattern and roles and responsibilities of each staff.
 - 3) Understand the role of sub-center in delivery of primary health care.
 - 4) Proficiency in diagnosis and treatment of common illness.
 - 5) Acquire skill of carrying out basic laboratory tests of common diseases.
 - 6) Get oriented about implementation of various national health programs/ services.
 - 7) Learn first-hand skills in common family welfare procedures.

-
- II) In the area of field epidemiology;
 - 1) Able to independently conduct survey and utilize its findings towards arriving at a community diagnosis.
 - 2) Able to independently investigate outbreak and initiate control measures.
 - 3) Understand about various determinants of community health viz. socio-economic, cultural-behavioral, psychological and physical environment, and develop social angle for occurrence, transmission and treatment-prevention of the diseases.
 - 4) Know about the utilization of national health programs/ services through direct interaction with beneficiaries; e.g. applied aspect of nutritional care of mother and child, health or other problems of school going children etc.
 - III) In the area of health system and management;
 - 1) Get oriented about different registers and record system used at PHC/UHC.
 - 2) Develop skills to compile, analyze and make meaningful interpretations on the health status of the community based on records/registers and other health related data (HMIS).
 - 3) Develop organizational and communication skills for health education, social-behavioral change communication as well as to extract vital information from families.
 - 4) Develop skills in managerial dimensions – supportive supervision, monitoring and evaluation, management of human resource, logistics and finance - to be used in PHC/UHC as well as sub-centers.
 - 5) Capable of establishing linkages with other sectors like water supply, food distribution and other environmental/social agencies and NGOs.

PG training:

During postgraduate training in the Community Medicine, UHTC and RHTC are the most crucial in building the competences. Adequate period of posting with meaningful involvement of PGs in health care service provision are key pillars in PG studies. During this period, PG must get involved in preventive, promotive and primary clinical care under primary health care approach in UHTC/RHTC areas. They are expected to be involved in planning, organizing, monitoring and mentoring all health programs/services in the areas. Further, they are expected to work for community mobilization and inter-sectoral coordination under the guidance of faculties of Community Medicine Department.

Specific Learning Objective for post-graduates:

- I) In the area of health care services;
 - 1) Able to diagnose, treat and prevent the common illness prevailing in the community.
 - 2) Interpret common laboratory investigations
 - 3) Set objectives, prepare action plan and implement national health programs and its services.
- II) In the area of field epidemiology and research;
 - 1) Understand and correlate epidemiological triads in local endemic/epidemic diseases context.
 - 2) Identify health problems of the community in context of the socio-cultural milieu.
 - 3) Identify specific groups, which require special attention in the community.
 - 4) Make community diagnosis in general and during epidemics in particular, with effective use of tools of epidemiology, and draw prevention and control plan.

-
- 5) Conduct epidemiological investigation and present situational analysis of communicable, non – communicable, nutritional and other diseases of public health importance and suggest appropriate solutions.
 - 6) Carry out community based research study as a part of thesis/ dissertation.
- III) In the area of health system and management;
- 1) Define structure and functions of different health related institutions.
 - 2) Critically evaluate the different health programs’ design and its implementation.
 - 3) Monitor and assure quality in health program implementation.
 - 4) Critically review the records, registers and reports for correctness and timeliness.
 - 5) Analyze the data from HMIS and present the findings.
 - 6) Perform managerial functions – i) assess costs and carry out program budgeting, ii) manage logistics effectively, iii) anticipate and prepare for resource development etc.
 - a. As a team leader, he/she should be able to,
 - i. Build and motivate the team, guide and direct the team
 - ii. Nurture team spirit and harmonize activities of various members
 - iii. Facilitate inter-sectoral co-ordination, co-operation and collaboration
 - iv. Promote and establish partnerships between different stakeholders
 - v. Conflicts management
 - b. As a health educator/ communicator, he/she should be able to,
 - i. Interact and educate effectively to persons from diverse backgrounds, and promote healthy behavior in them through community participation
 - ii. Assess the needs of community through effective communication
 - iii. Provide need based counseling to specific sets of individual or group
 - iv. Critically evaluate existing health education strategies
 - v. Effectively communicate the findings of the community (health information) to different stakeholders and policy makers, leaders etc.
 - vi. Effectively use different techniques for advocacy, community mobilization, awareness generation and social-behavior change communication.

Additionally, RHTC and UHTC can be a training centre for nursing students, Auxiliary Nurse Midwives students and front-line health workers.

B. Research and Innovations:

Like two sides of the coin, UHTC/RHTC are wards as well as research laboratories for Community Medicine department. Community Medicine experts can generate evidences through developing research protocol, which may contribute in epidemiology/health system/public health. Opportunities for research are as below.

1. Simple case studies
2. Epidemiological studies and situational analysis of various diseases.
3. Community Interventional studies.
4. Health System research
5. Communication
6. Social science

C. Primary Health Care (Preventive, Promotive and Primary Clinical Care)

Medical educational institutes play dual roles, one producing medical graduates/postgraduates and second providing health care to the people. Skills of medical teachers are upgraded by way of getting involved in health/medical practices (services at hospitals/community) while students are exposed to the cases and gain hands on exposure. Thus, medical profession being a service-oriented profession, “learning by serving” is at center of teaching/training strategies especially in postgraduate training. Medical college affiliated hospital is nothing but upgraded district hospitals. Similarly, UHTC and RHTC are upgraded U-PHC and R-PHC. Thus, for good teaching/training, CM department must be involved in services to the community. UHTC and RHTC are the “wards” of Community Medicine department where it is managing community health through community diagnosis and community oriented primary health care. The models of involvement of Community Medicine Department is given under the section – Operational guidelines.

In India, “community health” is being managed through primary health care approach as it is signatory to the WHO’s “Health for All”. Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. It includes preventive, promotive and primary clinical care to the defined community. Primary health care addresses a wide range of health determinants, such as poverty, illiteracy (especially among women), increased population growth, unemployment, and migration from rural to urban areas, drug addiction, environmental issues and epidemics.

The primary health care is delivery of a defined minimum package of services delivered to individual clients and/or families, in both clinic and home / community settings. It is aimed to needy group, accessible, acceptable and affordable to community so that it can contribute to the self-reliance and self-determination of the community.

It includes:

- a) Treatment of locally common diseases and injuries.
- b) Provision of essential drugs and laboratory investigation
- c) Reproductive, sexual health and family welfare
- d) Maternal and child health
- e) Adolescent health
- f) Geriatric health
- g) Mental health
- h) Prevention and control of locally endemic diseases (including non-communicable)
- i) Water, Hygiene and Sanitation(WASH)
- j) Health education and behavior change communication.

Primary Health care has three approaches:

I) Primary Clinical Care: Every community is having a list of commonly prevailing diseases and injuries. These may be trivial to life threatening. These ailments are also immediate health needs of the community. Under primary health care approach, it is envisaged to provide clinical care. Creation of essential diagnostic services and provision of drugs as essential drugs come under primary clinical care. For India, under IPHS and primary health care, list of health

problems, diagnostic and services are given. Every UHTC/RHTC must be a service outlet as per this guideline. Some primary clinical care under different health programs are given further.

II) Preventive Care: Breaking the chain of transmission is the principle of the disease prevention and control. In India, under various health programs, various preventive services are being carried out under primary health care.

Preventive care is aimed to...

- a) Preventing locally endemic diseases,
- b) Controlling diseases with epidemic potentiality and
- c) Protecting specific vulnerable groups.

III) Health Promotion: Health promotion recognizes that health is influenced by more than genetics, lifestyle and health services and takes steps to influence broader environmental and socioeconomic conditions that influence people's health and quality of life. It recognizes that social inequities and injustice have a profound impact on people's health. Health promotion is explicitly concerned with a vision of a preferred future that includes a viable natural environment, a sustainable economic environment, a sufficient economy, an equitable social environment, a convivial community and a livable built environment. Health promotion is "the process of enabling people to increase control over and to improve their health" (WHO, 1986). Health promotion is the combination of educational and environmental supports for actions and conditions of living conducive to health" (Green & Kreuter, 1991, 1999). The term "health promotion" connotes both individual and societal action for health (Tarimo et al., 1995).

Health promotion in primary care should manifest itself as a pervasive, overarching philosophy and process, not just as a specific program. It focuses on achieving equity in health and reducing differences in health status. Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health.

Along with delivering preventive and primary clinical care, UHTC/RHTC shall take up the responsibilities for health promotion in the community. It has three core interrelated strategies to act in ways that promote people's health:

- 1. Health education and promoting healthy life
- 2. Advocacy for health
- 3. Building social support

1) Health Education: A common strategy for health promotion is health education. It aims to promote healthy life in individual and community as a whole. Health education strategies are an effective means of changing knowledge, attitudes and health behaviours. Effectiveness of health education can be improved through use of multifaceted interventions. UHTC/RHTC shall develop communication strategies for the community. Some of the activities expected to be carried out in UHTC/RHTC area are listed below...

- a. Communication Need Assessment
- b. Health days celebrations
- c. Health talks/health competitions
- d. Interpersonal communication with special groups
- e. School/College health awareness programme

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- 2) Advocacy for health: Health is influenced by various factors. Health promotion in primary care is participatory (involves stakeholder participation) (WHO, 1978). Health promotion demands coordinated action by governments, by health and social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and the media. To promote individual and community health, inter-sectoral collaboration and coordinated efforts are required. Advocacy is the first step toward building inter-sectoral collaboration. UHTC/RHTC shall proactively get involved in carrying out advocacy with the different stakeholders in the community for health with the aim to put health on the agenda of all sectors and at all levels and generate a coordinated, multi-sector effort for promoting people's health. It is described in detail in the next domain of UHTC/RHTC.
- 3) Building social support: Health promotion recognizes the prerequisites for health (i.e. shelter, education, food, equal opportunity, etc.). Health promotion focuses on achieving equity in health and reducing differences in health status. It recognizes that social inequities and injustice have a profound impact on people's health. It is about community development and empowering the people. Health promotion aims to enabling the people to increase control over their own health. Hence, it is about empowering and encouraging individuals and communities to take greater responsibility for their health (WHO, 1978). It overlaps with inter-sectoral coordination and community mobilization.

UHTC/RHTC may not be required to be directly involved in the social support building activities but it can facilitate them. Some of the suggested activities are given below.

- a. Village Health and Sanitation Committee
- b. Formation of Self Help Groups/Mahila Arogya Samiti etc.
- c. Livelihood projects
- d. Linking the people with various social welfare and social security schemes.

D. Inter-sectoral Coordination & Community Mobilization

The factors that influence health outcomes are complex and extend well beyond the provision of health care services. Many also fall outside the authority of the health sector. Effective disease prevention strategies require action to be taken outside the health sector in order to promote healthy living, to improve access to information, to reduce risk factors for disease, and to improve the quality of the environments in which people live. As a result, responsibility for realization of health must be shared across various sectors as a whole including the participation of community.

- a) Inter-sectoral Coordination: It refers to the promotion and co-ordination of the activities of different sectors of health care system to enhance and to provide qualitative services to community. Coordinated, inter-sectoral action to improve health, including between different sectors, and with stakeholders outside government, is necessary in order to address complex and persistent health challenges. In the Alma Ata Declaration (1978), inter-sectoral action was recognized as a key to improving primary health care, through coordinated action across a range of sectors, including agriculture, animal husbandry, food, industry, education, public works and communications. In 1986, the Ottawa Charter for Health Promotion recognized that inter-sectoral action is fundamental to reducing inequalities in health status within the population.

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- b) Community mobilization: Community participation in health is important because communities can play vital role in promotion of healthy behaviours and prevention of diseases. People have a right and a duty to be involved in the decisions affecting their lives. The experience of participation in improving their health system makes them more confident and empowers them to act on many other areas that affect their lives. Communities possess several resources-human and financial that can be used to enhance the quality of health care and effectiveness of health care services. The community is most capable of acting on all the social determinants of health. Active community's participation leads to correction of, the mismatch between people's needs and services delivered and leads to increase to utilization of health services.

The main agenda of community mobilization for health for all includes development and health; helping people to help themselves (centering on people); the development of primary health care infrastructure; integration; bridging the gap between community and health services; and sustainability of health care and sound financing. Community mobilization is an attempt to bring both human and non-human resources together to undertake developmental activities in order to achieve sustainable development. Community mobilization can play an important role in this and in making the primary health care system effective in tackling the determinants. Once community mobilization is well established, the primary health care infrastructure will be equitable, sustainable, adequate, continuous and transparent.

Community mobilization is more than simply motivation to participate in a particular health activity. Community mobilization may be thought of as a process of empowerment of the community and of building up its capacity to decide and experience its full rights in overseeing the formulation of policies, planning, development, implementation, achievements and progress in all activities that concern and affect the quality of its health.

- c) Development and health: Poverty, the most important factor affecting health, has to be addressed through long-term and medium-term development approaches. The experience gained and methodologies developed so far in community development show the strong links between health and development.

Section II: Operational Guidelines for UHTC/RHTC:

A. Number of UHTC and RHTC under a medical college

MCI recommends there shall be one UHTC and RHTC. AS per the MCI education regulation, one UHTC and one RHTC are mandatory but IAPSM recommends that with increase in the number of the medical seats, it needs to be increased as the case in other clinical subjects are. This will ensure adequate opportunity and quality of teaching to students. The recommended number of required UHTC and RHTC with increase in the number of UG seats by IAPSM are as below.

Sr.	Strength	Requirements
1	Till 150 students	One unit each of UHTC and RHTC
2	200 students	Additional one unit (RHTC)
3	250 students	Additional one each of UHTC AND RHTC)

B. Administrative control:

MCI recommends that every medical college shall have one Rural Health Training Center and Urban Health Training Centers. These Training Centers shall be owned by the college or it should be affiliated to Government owned Health Center. Academic control shall be with the Dean of the college. Thus, there are two proposed approaches recommended by Medical Council of India for Control of UHTC and RHTC, which can have three models of operation. The brief of three models is described below.

Models for RHTC & UHTC:

1. Sole Rural Health and Training Centre & Urban Health and Training Centre
2. Affiliated with Primary Health Centre (run by General Health System) & Urban Health Centre (run by local urban body) respectively
3. Full administrative control of Rural Primary Health Centre & Urban Primary Health Centre.

The merits and demerits of all three models are given.

Sr.	Models	Advantages	Challenges
1	<u>Sole Training Centres owned by the Medical College:</u> Rural Health and Training Centre (without affiliation with any R-PHC) & Urban Health and Training Centre Principle: No connection with primary health system functioning at community. Carry out few community based activities.	<ul style="list-style-type: none">• No additional responsibility of running PHC or UHC as per the General Health System and Health Program.• Hence limited accountability.	<ul style="list-style-type: none">• Building Rapport with the community.• Student/Interns/PG will not have exposure to General Health System and Health Programs or Community Oriented Primary Health Care.• Uninterrupted clinical services at the RHTC/UHTC.• Day to day management of UHTC/RHTC.

2	<p>Affiliation: Rural and Urban Health Training Centre in coordination with Primary Health Centre (run by General Health System) & Urban Health Centre (run by local urban body)</p> <p>Principle: Technical support to improve the performance of services at the affiliated centre.</p>	<ul style="list-style-type: none"> • Can have better rapport with Community. • No additional responsibility of running PHC or UHC. • Student/Interns/PG will be having exposure to General Health System and Health Programs. • Clinical and field services will be the responsibility of the General Health system team. 	<ul style="list-style-type: none"> • Coordination and understanding with General Health System authorities/team. • Day to day management of UHTC/RHTC building.
3	<p>Full control of U-PHC and R-PHC</p> <p>Rural and Urban Health Training Centre with full control of R-Primary Health Centre & U-Primary Health Centre.</p> <p>Principle: Direct involvement in the services delivery.</p>	<ul style="list-style-type: none"> • A good rapport with the Community. • A very good exposure to functioning of General Health System and Health programs. • Enhanced quality of UG and PG teaching. PG in Community Medicine department will have hand on skill of running, monitoring General Health System, Health Program. 	<ul style="list-style-type: none"> • Additional Budget and staff management for PHC & UHC. • Day to day management of all issues pertaining to the PHC/UHC management as well. • Direct responsibility of clinical services and field health services. • Additional answerability to district/corporation health authorities for performance of the Primary Health Care/programs.

First model i.e. sole Rural Health and Training Centre & Urban Health and Training Centre without contact with any primary health care delivery system is most ineffective model as it contains dispensaries in a village or urban ward areas. It does not have any relationship with Primary Health Centre in the area hence the objective of Community Oriented Primary Health Care can never be achieved as envisaged in MCI guidelines. Thus, it is neither suited as per the recommendation of Medical Council of India nor recommended by the Indian Association of Preventive & Social Medicine.

Second model is the affiliation model, which is one of a feasible model where the training centre building and staff for UHTC & RHTC (academic activities) are under full control of Dean, Medical Colleges, but at the same time there is good partnership between General Health System and Medical Colleges where role of the team from Community Medicine department shall be to provide technical support. Thus, students from the Medical College will have full access to the health facilities, services, programs etc. while general health system will get technical support from medical team.

Third model, which suggests full administrative control of the PHC & UHC, by taking control of all staff, budget and services under the control of Dean, Medical College and directly involved in the primary health care delivery will provide highest level of learning and most ideal model.

Second and the third models of UHTC and RHTC are recommended by the IAPSM.

For second and third model, one of the R-PHC and U-PHC should be owned by the college or it should be affiliated with Government owned Health Centre respectively. These should be enhanced to training centers. R-PHCs fall under State Health Department; U-PHCs are managed by Local Urban Body while medical colleges are Government, Corporation or private. For effective implementation, better understanding may be needed between medical college authorities and authorities involved in primary health care through Memorandum of Understanding (MoU). Effective collaborative mechanism is to be given an additional importance. However, in any model, Community Medicine Department shall be nodal department on the behalf of the Dean of medical college in managing activities at UHTC and RHTC.

However, in both the models it is the expected final output at the centres are same.

C. In-charge of the Centers:

MCI recommends that one Assistant Professor shall be in-charge of the UHTC and RHTC each. However, for better functioning and quality output IAPSM recommends that these are two different “Units” of Community Medicine department similar to “Units” of other clinical subjects in the hospital. These units shall be headed by Professor/Associate Professor and supported by the Assistant professor and Senior Residents (SR)/Junior Residents (JR)/tutors/demonstrators. Unit heads shall be reporting to the Head of the Department. The entire unit shall be responsible for overall Community Health Management either directly as add on team to existing team at Primary Health Centre or as technical support team to the affiliated Health Centre, as per the models adopted.

D. Activity Plan (Functioning of UG/PG training at RHTC/UHTC):

Broadly, activities can be planned at three areas.

1. **In RHTC/PHC/UHTC building:** Clinical & specific protection related services, in-house training, and health programs related services.
2. **In community, i.e. Villages/ Slums having sizeable population at RHTC and UHTC**
Direct outreach, community based activities.
3. **In field areas covered by the health system i.e. PHC and its sub-center areas, UHC and its served areas:** Field related activities

Proposed activities:

1. General OPD at RHTC and UHTC with proper referral to hospital attached to the medical college.
2. Specialized comprehensive care clinics for special health problems or vulnerable groups.
3. Observing the implementation of various national programs and interacting with beneficiaries under various programs.
4. Carrying out various activities under School Health Program.

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5. Get orientation about, staff, infrastructure and functioning of RHTC/PHC and UHTC/UHC.
 6. Conducting field survey, health environment study, family studies, case study and mini projects to understand the field epidemiology including physical and social environment of the urban and rural areas.
 7. Outreach health camps in the field area.
 8. Interacting with various communities, political, social, government, formal-informal groups - institutions and key stakeholders.
 9. Carry out health communication session with local people, women, youth, adolescent, school and college students etc.
 10. Observance of various health-related days and weeks at RHTC/UHTC. Some of these days/weeks are already observed by Community Medicine Departments of many medical colleges. Regular observance of World Health Day, World AIDS Day, Malaria fortnight, Nutrition week (list is endless) at RHTC and UHTC.
 - a. Skill building of local staff by faculty of Community Medicine.
 11. Additional activities for PG students
 - a) Running the specialized clinic
 - b) Carrying out community diagnosis, outbreak investigations
 - c) Prepare epidemiological, managerial and social case studies.
 - d) Assist in verbal autopsy of maternal death, infant death or death due to specific reasons like Dengue, Falciparum etc.
 - e) Community based or health system research.
 - f) Technical monthly/quarterly review meeting carried out at PHC/taluka/districts.
 - g) Monitoring/Supportive supervision of VHSNC (Village Health Sanitation & Nutrition Committee) meeting, VH&ND (Village Health & Nutrition Day) in the RHTC area.
 12. Any other activities, which helps in the accomplishment of the learning objectives of RHTC/UHTC.

Specialized clinics at RHTC / UHTC

It is desirable that at UHTC and RHTC along with various preventive and promotive outreach services, specialized clinics imparting comprehensive care-preventive, promotive and primary clinical care for selected health problems or vulnerable groups are also managed. The suggested clinics are below.

1. Maternal health clinic (ANC /PNC)
2. Child health clinic
3. Immunization center (child + adult)
4. NCD clinic
5. Fever clinic
6. Geriatric care clinic
7. Wellness clinic & health education / Guideline center
8. Family wellness center (reproductive, sexual health & family welfare)

E. Physical standards for RHTC/UHTC

Infrastructure:

UHTC and RHTC should have one-two OPD rooms, rooms for specialized clinics, health related services rooms, office rooms, teaching rooms, staff-faculty rooms over and above infrastructure requirements for routine Primary Health Centre under NHM norms.

Additionally, RHTC must be having guest rooms, hostels (rooms) for boys/girls/interns/PG, common (recreation room) and mess facilities as recommended by the Medical Council of India.

Staff:

There shall be a unit for RHTC and UHTC each, headed by the Professor/Associate professor and supported by the Assistant professor and SR/Tutor

Along with the above-mentioned staff, staff proposed under MCI and staff as per the Primary Health Centre norm will be there supporting teaching, training and services at center. Some additional staff like security, cooks etc. may be additionally required. The suggested staff list and their requirement for both UHTC & RHTC is given in annexure IV.

F. Prescribed qualifications and job responsibilities of staff.

(A) Professor/Associate Professor (Unit Head), Assistant Professors and SR/tutor

(One of each cadre for each unit of UHTC and RHTC)

Qualification:

1. As per the teacher's eligibility criteria of medical council of India.

Job description of Unit Head:

1. Unit Head will be overall in charge of the UHTC/ RHTC on the behalf of Head of Community Medicine department and other unit members will assist him/her.
2. Will be supervising the overall funding of the UHTC/ RHTC under the guideline of Head of the department.
3. Will coordinate UG/ PG teaching, training and examination activities between the field staff & in charge of concerned divisions of the department.
4. Will support and monitor the services being delivered at UHTC/ RHTC on behalf of the Head of the department.
5. Will coordinate with local urban/Rural health team on the behalf of Head of department.
6. Will coordinate with concerned in charge of health education / research /Projects for field activities at UHTC/RHTC area.
7. Training and technical support to the frontline health professional.
8. Any activity deemed to be in the capacity and assigned by the Head of department.

Note:

Associate Professor/ Assistant Professor in-charge will be over all in-charge of the centre similar to the in-charge of various divisions in the department and need not stay there by

24×7. However, she/he needs to regularly visit the centres to oversee its functioning and support the Head/Associate Professor respectively.

(B) Health Educators and Medical Social Workers (MSWs)

Qualification:

1. B.Sc. (Nursing), post-graduation degree in social sciences (i.e. Master in Social Workers, Sociology, Psychology, Anthropology)

Job Description:

1. Prepare health and social profile of community in UHTC/RHTC area
2. Family folder preparation and updates in UHTC/ RHTC areas
3. Health communication / literacy need assessment
4. Identifying social health determinants and organizing various activities addressing them
5. Developing (planning/ executing) communication strategies
6. Organizing advocacy meeting with important stakeholders of the community, for improving community health.
7. Field investigators for health survey in community research projects by the community medicine department.
8. Planning &organizing various health education sessions in community for special groups or institute.
9. Facilitators for UG/ PG field visits in the community for teaching/ training and examinations.
10. Facilitation of community mobilization by supporting community group like Self-Help Groups (SHGs), Mahila Aarogya Samiti (MAS), Youth Mandal, NSS, urban/village Health & Sanitation Committee.
11. Facilitate the updates of various health services in the community provided under National/ State health programmes.
12. Facilitate the linkage of the eligible beneficiaries with various social welfare/ security schemes.
13. Developing partnership linkages with various voluntary agencies, which can contribute in enhancing community health.
14. Any activities, which deems to be of the capacity of HE/MSW and assigned by superiors.

(C) Health Inspector

Qualifications:

1. Degree in environmental health, sanitary sciences.
2. Diploma in environmental health, sanitary sciences with one year experience in the public health

Job Description:

1. Preparing environmental health profile of the community in UHTC/RHTC area

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2. Mobilizing community for the improving environmental health with aim to prevent and control common diseases in the community
 3. Organizing advocacy meeting with important stakes holders of the community for improving environmental health condition.
 4. Facilitating UG/ PG field visits in the community for the teaching/ training and examination
 5. Participation as field investigators for various health surveys in community research projects by the community medicine department.
 6. Organizing various health education sessions in the community, for special groups or in institute, on various topics related with environmental health.
 7. Developing partnership linkages with various local voluntary agencies/ Government agencies, which can contribute in improving environmental health.
 8. Advocacy / education/ community mobilization/ behavior changes in the community on various issues related with environmental health.
 9. Facilitate implementation and uptake of various environmental health related services/ schemes in the community.
 10. Any actively assigned by the superior and deems to be of the capacity of health inspector.

(D) Public Health Nurse

Qualification:

1. Post graduate/degree of diploma public health nursing/ B.Sc. (Nursing) with one-year experience in public health.
2. Degree in midwifery/Public Health Nurse with two years of experience in public health field

Job description:

1. Preparing health profile of community in UHTC/RHTC area.
2. Preparing list of special groups like children with malnutrition, TB/HIV/DM/cancer & facilitate health education and counseling.
3. Participating in advocacy/education/community mobilization/change in community on various health issues.
4. Facilitating UG/PG field visit in the community for teaching/ training.
5. Training and technical support to the front-line health workers.
6. Any activity deemed to be in the capacity and assigned by superior

G. Transport support:

Vehicle is most essential “equipment” for the Community Medicine Department. Its availability determines the extent of field movements of Community Medicine Department. MCI recommends that adequate transport (for both staff and students) shall be provided for carrying out fieldwork and teaching and training activities by the department of Community Medicine. It is important that purchase/ hiring and use of vehicle should be judicious as it is cost intensive. Depending upon the UG & PG students’ intake and outreach activities, required numbers of vehicle should be made available. Additionally, vehicle can be counted

in total pool of the departmental vehicle as certain UG/PG field visits and other visits etc. can be taken into account for optimum utilization of the vehicle. Below is the minimum requirement of vehicle for Community Medicine Department with admission capacity of 150 UG students.

Sr.	Vehicles	Requirements	Remarks
Bare minimum requirements			
1	Mini bus (35 Seaters)	02	Community Posting and field visits
2	Small Vehicle (7 Seaters)	03	One each for fieldwork at UHTC and RHTC fieldwork and one for supervision/staff movements.

* If RHTC & UHTC are yet to be fully functional then one or two vehicles will suffice and gradually reach to the requirements level.

H. Equipment/Instruments and furniture:

All equipment and instruments as per the essential list of equipment for Primary Health Centre (including all attached sub-center) must be there. Additionally, for teaching/training following equipment must be there at UHTC/RHTC.

An indicative list is given below keeping the services and facilities at UHTC/RHTC.

Item	UHTC	RHTC
LCD Projector	1	1
Lap top	1	1
Computer- Desktop with Printer	2	2
Public Address System	1	1
Exhibition Display Panels	1	1
Tablets (10") for on field health education	3	3

There may be other instruments/equipment required, which can be procured with full justification.

Besides that, adequate number of furniture for all faculties, hostel, and mess facilities must be available at RHTC/UHTC.

I. Functioning of RHTC/UHTC:

- 1) Teaching and training
- 2) Research and Innovations
- 3) Primary health care related services
- 4) Inter-sectoral co-ordination and Community Mobilization

1) Teaching and training:

UHTC and RHTC are the training and training centre for the undergraduates and postgraduates of Community Medicine. The recommended teaching methods and activities are described below.

a) Undergraduate teaching:

There are three community-posting terms, each of four weeks as a part of clinical posting for under graduates. Community posting can be planned and scheduled in a way that the desired objectives of under graduate studies to be attained at UHTC/RHTC may be achieved.

Andragogy:

UG teaching may be carried out in six ways.

1. Field visits: Visiting the community, social and health care institutes within UHTC/RHTC areas.
2. Family study: In depth study of the families by history taking and family case presentations.
3. Case studies: Individual or small groups of students may be assigned to prepare case studies about specific social-environmental factors in the community, element of primary health care or health programs.
4. Health Education: Health education sessions at schools or in the community by the students.
5. Project Works: Small group of three to five students may be assigned various project in specific areas of demography, social studies, environmental study, field epidemiology, health problems, health program performance etc. where student get hand on skill practice of use of principles and techniques of epidemiology, research methodologies.

As a part of their teaching/learning at UHTC/RHTC posting, medical students have to interact with the community, staff and stakeholders for getting information for all of above six approaches. A presentation and discussions similarly to case presentation and discussion carried out in ward is to be followed at the RHTC/UHTC teaching room or in the community.

Activity guidelines:

Activities, which can be included as a part of UG teaching, are given below.

The first half of the community posting at UHTC/RHTC may be devoted for understanding, community, environment, family, dynamics of disease transmission in the community settings, health related custom and culture.

- a. Community profile of UHTC/RHTC vis-a-vis demography of district/city.
- b. Transect walk in UHTC and RHTC area (to get an overview about the community, housing, environment, basic amenities, general living conditions of people, etc.)
- c. Village stay (indicative agenda given as annexure V)
- d. Case study: Presentation and discussion
 - a. Environment situation of village/slum
 - b. Water and sanitation services and practices in village/slum
 - c. Health related custom and culture
 - d. Family studies (housing and nutrition)

Second half the community posting may be aimed with exposure of student with health care delivery systems from primary health centers to the interaction with the beneficiaries. Activities recommended are as below.

- a. Orientation about general health system with emphasis on primary health care approach.
- b. Case studies, presentation and discussion: To get oriented about structure, functions/services, human resource and facilities.
 - a. Visit to Primary Health Centre (PHC): To get oriented about structure, functions/services, human resource and facilities.
 - b. Visit to Sub Centre (SC).
 - c. Visit to Anganwadi Centre (AWC).
- c. Visit to Village Health and Nutrition Day (VHND) session
- d. Discussing performance and gap: Reasons and suggestions.
 - a. Maternal health indicators
 - b. Child health indicators
 - c. IDSP indicator
 - d. Malarial indices
 - e. RBSK
- e. Verbal autopsy report discussion.
- f. Health education sessions
- g. Group meeting with beneficiaries (Ante-natal/mothers/adolescents)

b) Internship posting:

During undergraduate teaching, it is expected that medical graduates are oriented about the various aspects about community, their relationship with health outcomes and health care delivery system, while during internship period it is expected that they gain the skills in managing common health problems in community setting by linking their knowledge with field situation. Under internship posting, interneers are posted for two months in the Community Medicine department. During this period, they are to be posted at UHTC/RHTC.

Posting guidelines:

To attain the desired goal and objectives during posting, it is recommended that minimum three weeks posting should be done at the UHTC and RHTC each. Equal number of days may be divided into OPD posting and supportive/supervisory visits along with the faculties/supervisory staff or under the guidance of medical officer.

The intern doctor is expected to carry out his/her duties by six different ways.

1. Assistance (to medical / paramedical persons).
2. Observations (procedures / activities carried out by the health personnel or / field situation and conditions).
3. Actual procedures performance (Under the guidance and supervision of competent persons).
4. Project works (reading, research, discussion, project writing).
5. Problem solving based learning.
6. Exercises like tables, chart and reports preparation calculation of health indices etc.

During internship posting, equal days are to be divided in OPD service and outreach activities. Multiple learning experiences e.g. case studies, project work, exposure to role models, role-play, workshops, seminars etc., should be used.

Activities guidelines:

1. Assisting Medical Officer in running OPD.
2. Make supportive supervisory visits based on predesigned checklist for various health programs/activities and brief to the medical officer.
3. Participate in various outreach sessions organized during their posting tenure.
4. Carry out community projects.

c) PG teaching and training:

UHTC and RHTC postings are the heart of the postgraduate posting for Community Medicine subject. The real gaining of competences can take place at UHTC and RHTC only.

Posting guidelines:

During three years of tenure, depending upon the number of PGs in the department, minimum one and half years must be spent by the PG at the UHTC and RHTC. Out of this one and half year, six months are to be spent at UHTC and one year is to be spent at RHTC. Majority part of these postings are to be carried out during the early part of the postgraduate training so that PGs develop understanding about community, environmental-social-economical-behavioral-cultural factors, field epidemiology, preventive, promotive and primary clinical skills as well as operational aspects of health programs and services on which PGs can build understanding as district/state/national health care. However, during this posting, one day posting per week at department can be arranged for PG discussion/dissertation works without disturbing duties at UHTC/RHTC.

Teaching/learning approaches:

Resident doctor is expected to carry out his/her duties by three different ways.

1. Performing: Preventive, promotive, and primary clinical care through running OPDs, supportive supervisory visits, monitoring and mentoring for health services, inter-sectoral meeting, advocacy meeting, inter-personal communication.
2. Assistance: to Community Medicine faculties in planning, organizing, monitoring and imparting technical support to various health programs/services.
3. Project/Research: Dissertation, operational case studies, situation analysis reports, projects works etc.

Activities guidelines:

1. As a part of PG training, PGs shall work as a shadow medical officer for the UHTC and RHTC. Shadow medical officer means they will be working like a medical officer of PHC and will carry out all activities, which are the job responsibilities of medical officer.
2. Shall assist faculties during their monitoring and technical support activities.

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3. For deeper understanding about the community, environment, and community health problems, program performance etc., PGs shall prepare case studies and make presentation as a part of PG discussion.
 4. Shall participate in various capacities in community based, health system related research in the RHTC/UHTC areas (indicative list is given as annexure VI).
 5. Shall assist faculties in UG teaching at UHTC and RHTC posting.

Capacity Building of staff:

Healthcare being a service-oriented sector, human resource is the most important resource for effective and efficient delivery of the services. The forte of the medical colleges is the training. UHTC/RHTC shall act as training center for imparting training to the human resource working in the UHTC/RHTC as well as other health professionals of the district/city/region.

2) Research and Innovations

It is expected that at UHTC and RHTC, undergraduate and post graduates students get experienced about community based research. UG student and interns can be given the projects or small-scale research to get oriented about the various community-based research and at the same time understand community health issues through it.

Postgraduate students shall be given topics of dissertation/thesis at UHTC and RHTC, which they can carry out along with their duties at the UHTC/RHTC.

Further, faculties shall be promoted to develop research projects in the UHTC and RHTC with the aim to contribute in better understanding community situation, epidemiological situation of the health problems as well as generating evidences for improving effectiveness and efficiency of health care delivery system.

Community Health research

- I. Field epidemiological research
- II. Knowledge, Attitude and Behaviour research
- III. Community interventional research

Health system research

- i. Health need studies
- ii. Operational research: Monitoring and evaluation of various health programmes.

Various thrust areas of research in the community setting (including health care delivery system) are as below.

- i. Custom and culture
- ii. Environmental health study
- iii. Demographic determinants
- iv. Situational analysis of common infectious and non-infectious disease, mental diseases burden, nutritional diseases burden etc.
- v. Behavioral studies (health seeking and others)
- vi. Rural psychology

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- vii. Health awareness and health needs
 - viii. Healthy practice

3) Primary health care related services:

Community Medicine department is responsible to manage the health of community being covered under UHTC and RHTC as per the primary health care guidelines either as direct service provider or as technical support unit to the affiliated PHC. The functioning of and services being rendered by U-PHC and R-PHC as per national/state guidelines are to be implemented as being done everywhere i.e. Medical Officer and other staff as per the guidelines must carry out their duties. However, monitoring, technical support by Community Medicine department will be additional inputs in delivery of preventive, promotive and primary clinical care at the centre.

As a part of teaching and training, a comprehensive picture of the community (overall and village and ward-area wise) must be there with the Community Medicine department. In addition, vulnerability mapping and assessment has to be carried out for better community health management.

Indicator/Measure:

1. Socio-Demographic indicators
2. Health outcomes (morbidity, mortality, disability)
3. Health care service indicators

a) Community health profile

a. Demographic profile

Age, sex, caste and religion wise composition of the community for the UHTC/RHTC area are to be collected, compiled and updated from time to time. This can be done for each village for RHTC. Many of the information can be available with the village Sarpanch office/Panchayat.

b. Environmental profile

- i. Qualitative information about the source of water, methods of collection and storage of drinking water, solid and liquid waste management. Houses with access to safe drinking water, houses with/without toilets etc. This can be collected with qualitative methods i.e. by transect walk, key informant interviews, focus group discussion etc. No need to carry out house-to-house surveys.
- ii. Also, information about the presence of local animals; strays, pets and animal husbandry practices etc.
- iii. Any natural/artificial collection of clean/dirty waters, potential breeding places for vectors etc.

c. Locally prevailing customs, culture, festivals

- i. Local festivals
- ii. Custom and culture especially, nutrition and diet, birth and child rearing, reproductive and sexual health, maternal care

d. Health and diseases related belief and behavior

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- i. Peoples health seeking behavior in general health problems
 - ii. Health related beliefs, myths
 - iii. Preferences for medical care
 - e. Local health, social, education institutes

Brief of all local institutes with address, key persons, areas of work, type of activities and contact person/numbers of all locally present institutes must be gathered and kept as a record/register. They are important stakeholders. Good rapport with them may be developed and they can be roped/their supports can be sought in various health and social activities. Some of the indicative examples are given.

- 1. Health care providers (qualified/unqualified/ faith healers etc.)
- 2. Type of health care services, its distance.
- 3. Social institutes: Formal voluntary organization, Government agencies like Anganwadi centres, Schools, Panchayat office, water supply office, Agriculture cooperatives, Milk cooperatives, Self Help Groups, or informal agencies like youth groups etc.

f. Local leaders

They are the gatekeeper and opinion makers of the community. A good rapport and relationship with them will be a great help in community mobilization and eliciting community participation especially in epidemic situation, community resistance to newer approaches etc. In addition, they can be helpful in organizing various health related community services. Some of the indicative leaders are given below.

- i. People's representatives like Sarpanch,
- ii. Government representative like Talati,
- iii. School principals/teachers, Bank managers
- iv. Community leaders
- v. Religious leaders
- vi. Prominent doctors/health care providers

b) Vulnerability mapping and assessment:

Vulnerability mapping and assessment is the process by which the location, access to basic amenities and the susceptibility of the group of people towards illness can be understood. Vulnerability mapping reflects the health administration's approach to pro-actively reach out and understand the issues of the vulnerable. It is the mechanism by which the inequality in the community can be assessed and addressed. Through vulnerability mapping and assessment, we can not only locate the physical presence of target (needy) population, but also 'map' their needs, barriers, disease profile, social determinants, coping mechanisms and perceptions towards public services.

c) Technical support in health care

1. Preventive, Promotive and Primary Clinical Care:

- a. Running OPD and providing treatment for all common ailments locally prevalent.

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- b. Planning, organizing and implementing preventive care for locally epidemic prone and endemic diseases.
 - c. Community health assessment.

2. Monitoring & Supervision:

Community is the ward for the community medicine department. As in conventional clinical practices, monitoring and review of conditions of patients in ward is carried out, similarly review of the community health is to be carried out in community. Health Management Information System (record, report and register reviews), monthly/weekly review meeting, supervisory field visits and special surveys/studies are four important approaches for monitoring the health situation and delivery of health services.

I) Health Management Information System (HMIS):

Under primary health care/health programs various registers, record and reports are prescribed. These are to be filled up from frontline health workers to Medical Officer. For good monitoring and review, all these record, registers and reports are to be filled up timely, completely and correctly. The monitoring guidelines-checklists prescribed under primary health care/health programs/schemes must be used. Indicators and method, over and above prescribed guidelines can be developed by Community Medicine department and used.

Community Medicine department must

1. Ensure quality and timely reporting of all these formats.
2. Regularly review reports and compare it with expected norms/standards, other comparable centers, district/state/national performance.
3. Identify the gap/problems and give technical inputs for improvement.

II) Monthly review:

Monthly review meeting is one of most cost-effective monitoring methods, if it is carried out meticulously. Performance review; over all at PHC level and health work wise/sub-center wise is to be carried out. It is carried out by use of specified program/epidemiological indicators. All concerned staff has to attend the review meeting. It has to be chaired by the Head of the Department. In the absence of HOD, senior-most from the available faculties may chair the meeting. All faculties involved in the monitoring and technical support of the center/program must also attend the meeting.

Prerequisite for review meeting.

- a) Well drafted agenda
- b) Compilation of information/data from field visits/ HMIS as per agenda.

The objectives of the review meeting should be:

- a. Reviewing the action taken for instructions given in previous meetings.
- b. Identifying the performance gap.
- c. Discussing the factors behind poor performance
- d. Suggesting solutions/solving the issues affecting the performance.

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- e. Giving guidance/direction to health team.
 - f. Disseminating newer direction/information.
 - g. Appreciating the good performing health team members.
 - h. Cross learning from each other for managing health issues.

Every meeting must be properly recorded. For any direction given/decision taken, it has to be recorded clearly with person responsible for action and time frame to be completed, if any.

III) Supervisory visits:

Monitoring by HMIS and monthly review meetings is indirect monitoring but supervisory visits monitors directly. It has tremendous importance in Community Medicine practice. It is expected that every month a good number of supervisory visits are to be carried out by supervisory cadre from PHC and titrated visits from Resident doctors/junior faculties up to the Head of Department. Every month supervisory visits must be planned. It is to be planned in a way that junior faculties may have minimum two visits per UHTC/RHTC and senior faculties may have minimum one visit per UHTC/RHTC besides their clinical posting at UHTC/RHTC. Visit can be planned based on issues/activities/performance gap. Some of the occasions of field visits are listed below.

- a. Village Health and Nutrition Day (VHND)
- b. Anti-Vector borne disease activities
- c. Health education camps
- d. Meeting with beneficiaries.
- e. Meeting with stakeholders
- f. Meeting with special groups of communities.

Purpose of supervisory visits:

- i. Supportive: Supervisory visits must not be meant for fault-finding but it should be used to provide support to the field functionaries in improving her/his performance. The support may be in terms of onsite training/sensitization, problem analysis and solution finding.
- ii. Quality check and improvement: Observing the various knowledge and skills (communication, preventive/promotive care of field functionaries and guiding them for improvement.
- iii. Gaining first-hand information about the field situation and constrains.
- iv. Validation of the information: Field visits should be used to validate the information recorded in HMIS by cross verifying with the field situation.

IV) Special Field visits

- a. Outbreak investigation
- b. Death review (maternal/infant/child/epidemic mortality)
- c. Village Health Sanitation and Nutrition Committee (VHSNC) meeting

V) Health Education

- a. Health Days celebrations
- b. Health talks

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- c. School& out of schoolchildren visits
 - d. School/college& out of school/college adolescent meetings
 - e. Women groups
 - f. Special beneficiary group meetings
 - g. Health Competitions

4) Inter-sectoral coordination and community mobilization:

Inter-sectoral coordination:

Convergence is the process whereby various programme, plans, schemes and departments work in a coordinated way to reach a common goal. For example, to reduce incidence of diarrhoea in the community, families need to learn about hand washing and good hygiene practices. There has to be provision of toilets and safe drinking water in order to prevent diarrhoea. When diarrheal episodes happen, the community needs access to immediate treatment at a facility. In order to address the social determinants, we need to collaborate with the different departments and stakeholders. Various areas of convergence in urban health include prevention of malnutrition, provision of safe drinking water and sanitation, protection from occupational health hazards, and provision of better health education.

Important determinants for good health are

- Adequate food (nutrition)
- Safe drinking water
- Sanitation and housing
- Clean environment
- Healthy living conditions
- Healthy lifestyle
- Access to better health services
- Education
- Social security measures and proper and equal wages
- Freedom from exploitation and discrimination
- Women's rights
- Protected work environment
- Relaxation, recreation and healthy relationships

Example for inter-sectoral coordination:

Organization/ Department	Services	Concerned persons
1. Urban Local Body: Public health engineering department	Water, sanitation, sewage disposal, birth and death registration, epidemic control like dengue, malaria etc.	Mayor/Ward Councilor Municipal Commissioner, Executive Engineer, Executive Health Officer, Public Health Officer, Sanitary Inspector, Sanitary Workers
2. District Urban Development Authority	Housing	Mayor, Municipal Commissioner, DDO,

(DUDA)/ Slum Improvement Board		Collector, Zilla Panchayat Pramukh
3. Women and Child Development department: Integrated Child Development Services (ICDS)	Food and Nutrition	Anganwadi Supervisors, Anganwadi Worker
4. Education Department	Education	School Principal, Teacher
5. Health Department	Health	MO- PHC, ANM, Private health care providers

Water: Drinking water is basic for human survival but not all the water sources are safe and fit for human consumption. Water sources can be broadly classified as Safe and Unsafe depending upon the water quality. It is important for the MAS members to educate the community on safe water. Water intended for consumption should be both safe and wholesome.

Sanitation: Sanitation is a broad term, which includes management of human excreta, solid waste and drainage. In urban areas, especially in slums and slum-like settlements, the status of sanitation is an important concern and a large proportion of urban poor practice open defecation. Sanitation options in urban areas include: Individual household toilets public/community toilets normally constructed by urban local bodies, local groups or private entities (for example, Sulabh International). The primary purpose of such facilities is to provide sanitation facilities in public places or in areas where the population cannot afford individual household toilets or has space constraints.

Living conditions: Unhealthy living conditions in slums and slum like settlements can lead to health problems like respiratory disorders like asthma and bronchitis, TB, skin diseases like scabies, seborrheic dermatitis etc.

Community mobilization:

Community participation in health is important because:

- Communities can play vital role in promotion of healthy behaviours and prevention of diseases.
- People have a right and a duty to be involved in the decisions affecting their lives. The experience of participation in improving their health system makes them more confident and empowers them to act on many other areas that affect their lives.
- Communities possess several resources-human and financial that can be used to enhance the quality of health care and effectiveness of health care services.
- The community is most capable of acting on all the social determinants of health.
- Active community participation leads to correction of the mismatch between people's needs and services delivered; and leads to increased utilization of health services.

Community groups: Community groups like Village Health, Sanitation & Nutrition Committee (VHSNC) in rural areas and Mahila Arogya Samiti (MAS) in urban areas, Self Help Groups (SHGs), youth groups etc. can mobilize communities and work collectively so that coordinated

action between health and other departments like Women and Child Development, Water and Sanitation, Education Boards, Public Works Departments (PWD) etc. takes place.

RHTC/UHTC team shall facilitate their formation and functioning of these SHGs to promote convergent action by the committee on social determinants of health and take action to increase access of vulnerable groups to various public services. With the help of ASHA, ANM and SHGs, RHTC/UHTC team shall mobilize the community for action on gender-based violence, alcohol-drug abuse, mental health issues, and education regarding irrational drug use.

For community mobilization capacity of community are developed in (1) identifying community priorities, (2) designing community development projects (3) mobilizing resource investments and (4) implementation and monitoring of projects.

- a. Participatory appraisal Planning and health priority settings.
- b. Activating Village Health, Sanitation and Nutrition Committee (VHSNC) at village level.
- c. Activating Mahila Arogya Samiti (MAS) at urban slum level.
- d. Stakeholder meetings.
- e. Formation of group of volunteers for supporting health events in community.

Some of the community mobilization initiatives:

- a) Diverse organizations such as women's organizations are to be involved in health affairs.
- b) Ad hoc mobilization in support of some programmes, such as immunization and training of home based newborn care, diet and nutrition. These have been instrumental in making health care accessible
- c) Information sharing and involving communities through area development committees and boards, which are examples of community organizations supporting health action in the locality

VHSNC and MAS are the key interventions under National Health Mission aimed at promoting community participation in health at all levels, including planning, implementing and monitoring of health programmes. MAS and VHSNC as the name suggest are local women's collective. They are expected to take collective action on issues related to Health, Nutrition, Water Sanitation and its social determinants at slum/ward or village level. They were particularly envisaged as being central to 'local community action', which would gradually develop to the process of decentralized health planning. Thus, they are expected to act as a leadership platform for women and focal community group in each slum area for improving awareness and access of community to health services, support the ASHA / front line health worker/ ANM, to develop health plans specific to the local needs and serves as a mechanism to promote community action for health.

Village Health, Sanitation and Nutrition Committee (VHSNC)

The committee is to be formed at the revenue village level and it should act as a sub-committee of the Gram Panchayat. It should have a minimum of 15 members, which should comprise of elected member of the Panchayat who shall lead the committee, all those

working for health and health related services should participate, community members/ beneficiaries and representation from all community sub-groups especially the vulnerable sections and hamlets/ habitations. ASHA residing in the village shall be the member secretary and convener of the committee.

Composition of VHSNC:

- At least 50% members on the Village Health & Sanitation Committee should be women.
- Every hamlet within a revenue villages must be given due representation on the Village Health & Sanitation Committee to ensure that the needs of the weaker sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committees.
- Government employees and honorarium paid staff e.g. teachers, ANMs, Anganwadi workers could be members of the committee. Alternatively, all of them could be special invitees.
- All members of the Village Committee, whether government or non-government, should necessarily be resident in the village.
- Representation to women's self-help group or other development related community based organizations on these committees will enable the committee to undertake women's health activities more effectively.
- ASHA would be members of the committee and it is desirable to make her the member secretary of this committee especially where she has been selected through due process by the community and has her ownership.

Roles and Responsibilities of VHSNC:

- Create awareness about nutritional issues and significance of nutrition as an important determinant of health.
- Carry out survey on nutritional status and nutritional deficiencies in the village especially among women and children.
- Identify locally available foodstuffs of high nutrient value as well as disseminate and promote best practices (traditional wisdom) congruent with local culture, capabilities and physical environment through a process of community consultation.
- Inclusion of Nutritional needs in the Village Health Plan – The committee will do an in-depth analysis of causes of malnutrition at the community and household levels, by involving the ANM, AWW, ASHA and ICDS Supervisors.
- Monitoring and Supervision of Village Health and Nutrition Day to ensure that it is organized every month in the village with the active participation of the whole village.
- Facilitate early detection of malnourished children in the community; tie up referral to the nearest Nutritional Rehabilitation Centre (NRC) as well as follow up for sustained outcome.
- Supervise the functioning of Anganwadi Centre (AWC) in the village and facilitate its working in improving nutritional status of women and children.
- Act as a grievances redressal forum on health and nutrition issues.

Mahila Arogya Samiti (MAS)

In UHTC area, under NUHM it is proposed to facilitate the creation of Mahila Arogya Samiti, which is counterpart to the VHSNC in the village. The main purpose of MAS includes demand generation, ensuring optimal utilization of services, establishing referral linkages, increasing community ownership and sustainability and establishing a community based monitoring system.

The major objectives of MAS are to:

- Provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
- Provide a mechanism for the community to voice health needs, experiences and issues with access to health services.
- Generate community level awareness on locally relevant health issues and to promote the acceptance of best practices in health by the community.
- Focus on preventive and promotive health care activities and management of untied fund.
- Support and facilitate the work of community service providers like ASHA and other frontline workers who form a crucial interface between the community and health institutions.
- Provide an institutional mechanism for the community to be informed of various health programmes and other government initiatives and to participate in the planning and implementation of these programmes, leading to better health outcomes.
- Organize or facilitate community level services and referral linkages for health services.

Formation of MAS:

- Constitution of a team at slum level: The ASHA, ASHA facilitator/Community organizer with support of NGO field functionary (if any), AWW and ANM will constitute a team for selecting the MAS members. Each ASHA will supervise the formation of two to five MAS.
- Meetings with slum women: The team (ASHA and others) conduct a series of meetings with women from the slum to understand the health conditions and to sensitize the women to work towards improving the health of the men, women and children in the slum
- Identification of active and committed women: Active, interested and committed women will be identified and over a period, encouraged to work collectively on community issues to form the base of the Mahila Arogya Samiti.
- Formation of MAS and selection of its office bearers: Once the women decide to work as a local collective, a resolution is passed for formalizing the MAS formation. The newly constituted MAS is oriented about its roles and responsibilities and the names and details of MAS members are recorded in the MAS registration sheet. Thereafter, ASHA facilitates the selection of the Chairperson of the MAS unanimously by the group members.

The MAS is to be formed at slum level. It will approximately cover approximately 50-100 households. However, this can be modified based on the ground realities in each slum area, e.g. small slum of less than 50 families or presence of disparate groups within each slum. In case of existing Anganwadi Centres in the slum, the coverage of each MAS should be aligned with the coverage area of the Anganwadi Centre and has to cover all pockets of the slum.

Composition of MAS

Mahila Arogya Samiti (MAS) should have 10 -12 members, depending on the size of the slum, but the group should not be less than 8 members and not more than 20 members. In case of MAS formed in a slum with different social groups, representation should be ensured from all groups and from all pockets of the slum. The membership in the group would be a natural process, guided by ASHA and others. Therefore, the following parameters not be seen as eligibility criteria but it can be used for preferential inclusion of members

- Woman with a desire to contribute to ‘well-being of the community’ and with a sense of social commitment and leadership skills.
- Woman’s age is not being kept as a barrier as the role of the woman in the house and the community is either as a target beneficiary or as an influencing force.
- If a group is being formed over a number of pockets of different communities, membership from all such pockets shall be ensured.
- If the slum has a presence or history of collective efforts (as a self-help group, Development of Women and Children in Urban Areas (DWCUA) group, neighbourhood group under SJSRY, thrift and credit group), women involved in these efforts should be encouraged to be part of MAS
- Service users like pregnant women, lactating mothers, Mothers with children of up to 3 years of age and patients with chronic diseases who are using the public services should also find place in the MAS
- ASHA will be the Member secretary of MAS

Functions of the MAS:

1. Mapping and listing of slum households; also, preparation of resource map in the communities for identifying vulnerable and socio-economically disadvantaged group.
2. Monitoring and facilitating access to essential public services: ensuring that all the people in the community or geographical area of MAS, particularly marginalized, vulnerable groups and disabled are receiving the services related to health, water, sanitation nutrition and education
3. Organizing local collective action for preventive and promotive health activities: MAS serves as an inspiring organization and bring the community together for collective action on health. This could be done by motivating for community mobilization and utilizing support for organizing cleaning drives, improving sanitation. It will promote convergent and community action in partnership with all other urban area initiatives for vector control, environmental health, water, sanitation, housing.
4. Facilitating service delivery and service providers in the community
5. Community health planning
6. Community monitoring of health care facilities.
7. Maintenance of records
8. Management of untied funds

Other Community Groups:

Self-help groups (SHG) are small voluntary association of people from the same socio-economic background with a purpose of solving their common problems through self-help and mutual help. It is a community based financial intermediary committee usually composed of 10–20 local women or men. A mixed group is generally not preferred. Members also make small regular savings contributions over a few months until there is enough money in the group to begin lending. Funds may then be lent back to the members or to others in the village for any purpose. In India, many SHGs are 'linked' to banks for the delivery of micro-credit. It is a group which help every needy.

The functioning of SHGs has essentially been viewed only from an economic perspective. The existing approach encourages the economic development of women, with SHGs a mechanism to achieving this. However, how these economic benefits are being translated into the change in women's status, particularly their health status is important. Self-help group is a useful platform to enhance women's health through increased knowledge and awareness on health issues, and financial security during health emergencies etc. It is very active in providing income-generating activities. Since women empowerment and health are interrelated, women's empowerment cannot be achieved by ignoring issues related to health of women. Over the last couple of decades, the concept of Self Help Groups (SHGs) and its potential, as an effective tool to alleviate poverty and empower women has garnered considerable interest worldwide.

Community Medicine department can facilitate formation of SHG with the support of the Medical Social Workers and Government department/NGOs working for SHG. Wherever SHGs are available, agenda of health can be mainstreamed and they can be supported to take it further.

Section III:

Collaboration Model to strengthen medical education and primary health care by developing mutually beneficial relation at UHTC and RHTC.

India is a welfare state committed to create a situation where its citizens attain highest level of health. For the same, India as a country is setting National Health Goals. These goals can be attained through holistic health care delivery system inclusive of preventive, promotive, curative and rehabilitative services. All players, public and private health care system, are having social and moral responsibility to contribute in attainment of National Health Goals. It is expected that all health care providers working in any role; as medical practitioners, health managers, planners; have to contribute in attaining National Health Goals.

India has a large network of medical colleges run by the Government, Corporation and Private sectors. Medical colleges and other institutes of higher learning and training in medical and health sciences play a critical role in shaping the mindset of future generations of medical practitioners who form an integral part of country's healthcare system. Goal of medical education and role of medical colleges have to be in the consonance of needs of country. For the same, some of the key objectives for Indian Medical Graduates are as below.

1. To train medical graduates in preventive, promotive and rehabilitative services besides curative care for common health problems
2. To teach them about socio cultural and demographic factors and their roles in health outcomes
3. To orient them about national health program & health care services and sensitize them about health care activity for preventive, promotive, curative and rehabilitative services in the country under primary health care.

And for the same, some of teaching approaches recommended are:

- a. Educational experience should emphasize health and community orientation instead of only disease and hospital orientation or being concentrated on curative aspects
- b. The importance of the community aspects of health care and of rural health care services is to be recognized.
- c. The importance of social factors in relation to the problem of health and diseases should receive proper emphasis throughout the course and to achieve this purpose, the educational process should be community based rather than only hospital based.
- d. The graduate medical education in clinical subjects should be based primarily within the community including peripheral health care institutions along with outpatient department emergency departments.

For fulfillment of above objectives and facilitating teaching approaches cited above, it has been made mandatory that every medical college must have an Urban Health Training Centre and a Rural Health Training Centre.

UHTC & RHTC are the link point for involving medical colleges with general health system. To have synergistic benefits a good collaborative mechanism can be developed. However, this collaboration required clear-cut guidelines, role of different stakeholders. For the realization and smooth execution an administrative mechanism for transfer of U-PHC & R-PHC, operational and technical guidelines for UHTC and RHTC is most vital step. This has to be

prepared in a way that smooth administrative and financial management be there and all primary objectives of all the stakeholders i.e. general health system and medical college management can be protected. More than 60% of them are being run by private management.

Government is playing greater role in health care delivery in India, especially in preventive and promotive health care through primary health care approach. It has huge network of primary health care delivery system, implementing numerous health programs/schemes. This network has large number of Rural Primary Health Care (R-PHC) and Urban Primary Health Centre (U-PHC) catering assigned community. For effective community based teaching about preventive, promotive and primary health care and orienting about health programs/schemes to medical graduates, U-PHC and R-PHC area to be integral part of the UHTC and RHTC.

Looking to the responsibilities of primary health care system and medical education system towards attaining the National Health Goals and commitments towards health of citizen, they have to develop collaboration mechanism at U-PHC and R-PHC level.

This collaboration will bring goods from both the systems. Besides contributing towards attaining National Health Goals; at one end medical education system will have good functioning primary health care setting with community for teaching, primary health care system will have an upgraded U-PHC and R-PHC which can along with health care delivery system can act as training, research and health resource center.

For the same, collaboration between medical colleges and National Health Mission (general health system) need to be established with the aim to strengthen NHM and medical education. For achieving this aim, following two activities are proposed.

1. Upgrading U-PHC/R-PHC to UHTC/RHTC with long-term goal to develop Centre of Excellence.
2. Technical support to District/City by Community Medicine Experts from the medical colleges.

For developing effective collaborative mechanism following are key recommendations:

1. Complete administrative and financial control of identified U-PHC and R-PHC must be under the Dean. For the same, identified U-PHC and R-PHC are to be handed over to medical colleges with staff or with financial provision for recruiting staff, or affiliated with Government owned Health Centers. Alternatively, affiliation with the U-PHC and R-PHC where medical college will provide technical support to the U-PHC and R-PHC and U-PHC and R-PHC will support and facilitate teaching and training of Under Graduate and Post Graduates at the center.
2. Regularly releasing of the fund for running as per the NHM/PHC norms.
3. Carry out Memorandum of Understanding (MOU) with medical colleges e.g. in case of private medical colleges or an order may be issued from the State Government. (Ministry of Health & Family Welfare may issue directives/instruction to State government for the same).
4. A well-drafted Memorandum of Understanding with clear-cut roles and responsibilities of each stakeholders, i.e. Government/local self-government and medical college management should be prepared.

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5. NHM (NRHM & NUHM) is a good opportunity in supporting strengthening the UHTC & RHTC, which can be utilized.

Role of Ministry of Health & Family Welfare/NHM:

Central Government is having guiding role for health topics like medical education and health problems touching entire country. It can take a lead by developing a detailed framework for collaboration between medical education and general health system.

1. Form the policy and guidelines for effective collaboration.
2. Provide additional financial support for human resources infrastructure, equipment, vehicle, drugs etc.
3. Provide additional support for capacity building/operational, health system research/innovations etc. on urban and rural health.
4. Sensitize State/local self-government and medical college authorities through regional/state workshops.
5. Training of Community Medicine Head and one faculty on health and financial management

Role of state/Local Self Government (LSG):

Role of State Government/District Health team/Local Urban Body

1. Shall give affiliation with the assigned U-PHC and R-PHC and issue the order/resolution to transfer U-PHC and R-PHC with its infrastructure, human resources or support faculties to facilitate teaching and training of Medical students (as per the MOU)
2. Shall construct and maintain additional infrastructure for special OPDs, training/teaching rooms, staff rooms etc. within Primary Health Centre premises.
3. Allocate all sanctioned funds as per the norms under U-PHC and R-PHC prevailing in the state/LSG/NHUM from time to time.
4. Shall ensure the recruitment/deputation, training and monitoring of the all staff both for primary health care delivery.
5. Shall provide additional requirements for infrastructure, human resources, equipment, instruments, mobility support etc. with justification for need and mutual agreement.
6. Shall ensure availability of funds, infrastructure, human resources, equipment, instruments, mobility support etc. to help it in developing as "Centre of Excellence".
7. Shall ensure regular availability of the staff of the U-PHC and R-PHC
8. Shall provide additional mobility support required for providing technical support to district/city and to U-PHC/R-PHC.
9. Involving medical college faculties in all related training and capacity building along with other U-PHC and R-PHC staff.
10. Inviting appropriate staff from medical colleges for attending meetings and monthly/quarterly review of functioning of centers and implementations health services/health programs at district/city or block level.

Role of Medical Colleges

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1. Shall look after overall administrative, financial, health care services and programmatic activities of handed over U-PHC and R-PHC or provide technical support to affiliated health center.
 2. Shall follow the norms for all financial related activities as per the Government/Local Self Government/NHM (in case of full control only).
 3. Shall recruit and ensure availability of human resource, teaching/training instruments for medical students and medical college faculty as per the MCI norms
 4. Shall construct and maintain hostel and mess related facilities
 5. Shall ensure availability of a dedicated vehicle for the staff for field activities and supervision at UHTC/RHTC as per MCI norms.
 6. Shall identify Community Medicine Department as nodal department on the behalf of the medical college management for teaching/training and technical support.
 7. Shall depute the staff for attending the trainings and meeting under primary health care as per the requirement

Expected outcomes:

1. MBBS UG graduate will understand about urban-rural health (Community Health) situation, demographic and social factors influencing health.
2. Undergraduate medical students will be oriented about health care services and various activities under National health programs.
3. Capacity of human resources of U-PHC & R-PHC, from Medical Officer to ASHA, will be increased due to direct mentoring from the Community Medicine experts of the medical colleges.
4. Coverage and quality of preventive, promotive and curative care under urban and rural health center will be increased due to receiving direct technical support from the experts from the Community Medicine Department.
5. Various models of initiatives and community interventions can be generated which can be adopted as strategy under general health system and health programs.
6. Operational health research/Health system research may provide evidences to improve the effectiveness and efficiency of the Health system.
7. A Centre of Excellence will develop at UHTC/RHTC for teaching/training, health care and research.
8. Improved service coverage for RMNCH+A and diseases control programmes.
9. Greater health literacy/ health seeking behavior in the community.
10. Improved quality of all health programmes and health care services.
11. Communities are better aware about the health and social services and be well connected with them (e.g., BPL schemes, JSY, social welfare schemes etc.)
12. Improved environmental health i.e. safe and adequate drinking water, waste disposal system
13. Activate and functional health and Village Sanitation Committee/ Mahila Arogra Samiti/ Self Help Groups.
14. A well functional and model health and wellness center.

Concept note for Centre of Excellence at UHTC/RHTC (U-PHC/R-PHC)

Overall National and Institutional goal of medical graduates for India is that they should be a competent basic doctor at the end of MBBS course. To support teachings in community settings and for fulfillment of objectives related with preventive, promotive and health care services, it is recommended availability of mandatory field level service units in urban and rural areas as UHTC and RHTC. These should be under full financial and administrative control of medical college. Hence, to attain the National and Medical Education goals/objectives for medical graduates, every medical college is having tertiary care hospital for supporting teaching. Medical college must have functional UHTC/RHTC. A good functional UHTC/RHTC are nothing but an upgraded U-PHC and R-PHC (where all preventive, promotive, curative and rehabilitative activities, preventive control of common public health problems and implementation of national health programs are going on) with additional resources (i.e. human, infrastructure, instrument, equipment, vehicle, drugs and consumable etc.) as per the MSR, MCI 1997 to function as UHTC & RHTC.

In order to achieve goals and objectives of medical education, under MCI guidelines it is instructed that State Government and Institution bodies are required to ensure adequate financial and technical inputs under Medical Council of India guidelines. Also, it is a mandate for Government to provide a primary health care in the assigned area through U-PHC and R-PHC. UHTC and RHTC is a mechanism to link medical education and public health care.

It is proposed that this opportunity can be used to develop a “Centre of Excellence” with the aim make it a knowledge hub with focus on following five domains.

Five domains of Centre of Excellence

1. Model Primary Health Centre
 - Improved performance: Quantity and Quality.
 - Greater community participation and development
 - Better inter-sectoral coordination
2. Training site
 - UG/PG students
 - Nursing and ANM students.
 - Front line health workers of the city/district
3. Community Research Centre
 - Longitudinal study of the community
 - Epidemiological/managerial studies
 1. Case studies, Projects, Research
 - Operational/implementation research
 - Community Interventional Trials.
4. Incubator for Innovations
 - Implementation of newer ideas and initiatives
5. Health Resource Centre
 - Epidemiological information centre on various local health problems to guide the management it.

ANNEXURES

Annexure: I:

Goal and objectives as per Medical Graduates Education Regulation, MCI 1997

(1) NATIONAL GOALS:

At the end of undergraduate program, the medical student should be able to:

- (a) Recognize 'health for all' as a national goal and health right of all citizens and by undergoing training for medical profession fulfill his/her social obligations towards realization of this goal.
- (b) Learn every aspect of National policies on health and devote himself/herself to its practical implementation.
- (c) Achieve competence in practice of holistic medicine, encompassing promotive, preventive, curative and rehabilitative aspects of common diseases.
- (d) Develop scientific temper, acquire educational experience for proficiency in profession and promote healthy living.
- (e) Become exemplary citizen by observation of medical ethics and fulfilling social and professional obligations, so as to respond to national aspirations.

(2) INSTITUTIONAL GOALS:

In consonance with the national goals each medical institution should evolve institutional goals to define the kind of trained manpower (or professionals) they intend to produce. The undergraduate students coming out of a medical institute should:

- a. Be competent in diagnosis and management of common health problems of the individual and the community, commensurate with his/her position as a member of the health team at the primary, secondary or tertiary levels, using his/her clinical skills based on history, physical examination and relevant investigations.
- b. Be competent to practice preventive, promotive, curative and rehabilitative medicine in respect to the commonly encountered health problems.
- c. Appreciate rationale for different therapeutic modalities; be familiar with the administration of the "essential drugs" and their common side effects.
- d. Be able to appreciate the socio-psychological, cultural, economic and environmental factors affecting health and develop humane attitude towards the patients in discharging one's professional responsibilities.
- e. Possess the attitude for continued self-learning and to seek further expertise or to pursue research in any chosen area of medicine, action research and documentation skills.
- f. Be familiar with the basic factors which are essential for the implementation of the National Health Programs including practical aspects of the following:
 - i. Family Welfare and Material and Child Health(MCH)
 - ii. Sanitation and water supply
 - iii. Prevention and control of communicable and non-communicable diseases
 - iv. Immunization
 - v. Health Education
 - vi. IPHS standard of health at various level of service delivery,
 - vii. Medical waste disposal.
 - viii. Organizational institutional arrangements.

-
- g. Acquire basic management skills in the area of human resources, materials and resource management related to health care delivery, General and hospital management, principal inventory skills and counseling.
 - h. Be able to identify community health problems and learn to work to resolve these by designing, instituting corrective steps and evaluating outcome of such measures.
 - i. Be able to work as a leading partner in health care teams and acquire proficiency in communication skills.
 - j. Be competent to work in a variety of health care settings.
 - k. Have personal characteristics and attitudes required for professional life such as personal integrity, sense of responsibility and dependability and ability to relate to or show concern for other individuals.

Goal and objectives of Internship:

(1) General

Internship is a phase of training wherein a graduate is expected to conduct actual practice of medical and health care and acquire skills under supervision so that he/she may become capable of functioning independently.

(2) Specific Objectives

- a) At the end of the internship training, the student shall be able to:
- b) Diagnose clinical common disease conditions encountered in practice and make timely decision for referral to higher level;
- c) Use discreetly the essential drugs, infusions, blood or its substitutes & laboratory services.
- d) Manage all type of emergencies-medical, surgical obstetric, neonatal and pediatric, by rendering first level care;
- e) Demonstrate skills in monitoring of the National Health Program and schemes, oriented to provide preventive and promotive health care services to the community;
- f) Develop leadership qualities to function effectively as a leader of the health team organized to deliver the health and family welfare service in existing socio-economic, political and cultural environment;
- g) Render services to chronically sick and disabled (both physical and mental) and to communicate effectively with patient and the community.

Key General Consideration and Teaching Approach:

1. Graduate medical curriculum is oriented towards training students to undertake the responsibilities of a physician of first contact who is capable of looking after the preventive, primitive, curative & rehabilitative aspect of medicine.
2. Educational experience should emphasize health and community orientation instead of only disease and hospital orientation or being-concentrated -on-curative -aspects. The importance of social factors in relation to the problem of health and diseases should receive proper emphasis throughout the course and to achieve this purpose, the educational process should be community based than only hospital based. The graduate medical education in clinical subjects should be based primarily on outpatient teaching, emergency departments and within the community including peripheral health care institutions. In order to implement the revised curriculum in Toto, State Government and Institution bodies must ensure that adequate financial and technical inputs are provided.

Annexure II:

Learning objectives of Community Medicine for undergraduate and internship as per Graduate Medical Education (MCI)

Learning objectives for medical graduate:

a) Knowledge

The student shall be able to:

1. Explain the principles of sociology including demographic population dynamics.
2. Identify social factors related to health, disease and disability in the context of urban and rural societies.
3. Appreciate the impact of urbanization on health and disease.
4. Observe and interpret the dynamics of community behavior.
5. Describe the elements of normal psychology and social psychology.
6. Observe the principles of practice of medicine in hospital and community setting.
7. Describe the health care delivery system including rehabilitation of the disabled in the country.
8. Describe the national health programmes with particular emphasis on maternal and child health programmes, family welfare planning and population control.
9. List epidemiological methods and describe their application to communicable and non-communicable diseases in the community or hospital situation.
10. Apply biostatistical methods and techniques; outline the demographic pattern of the country and appreciate the roles of the individual, family, community and socio-cultural milieu in health and disease.
11. Describe the health information systems.
12. Enunciate the principles and components of primary health care and the national health policies to achieve the goal of 'Health for All'.
13. Identify the environmental and occupational hazards and their control.
14. Describe the importance of water and sanitation in human health.
15. To understand the principles of health economics, health administration, health education in relation to community.

b) Skills

At the end of the course, the student should be able to make use of

1. Principles of practice of medicine in hospital and community settings and familiarization with elementary nursing practices.
2. Art of communication with patients including history taking and medico-social work.
3. Use epidemiology as a scientific tool to make rational decisions relevant to community and individual patient intervention.
4. Collect, analyze, interpret and present simple community and hospital based data.
5. Diagnose and manage common health problems and emergencies at the individual, family and community levels keeping in mind the existing health care resources and in the context of the prevailing socio-cultural beliefs.
6. Diagnose and manage maternal and child health problems and advise a couple and the community on the family planning methods available in the context of the national priorities.
7. Diagnose and manage common nutritional problems at the individual and community level.

-
8. Plan, implement and evaluate a health education programme with the skill to use simple audio-visual aids.
 9. Interact with other members of the health care team and participate in the organization of health care services and implementations of national health programmes.

c) Integration

Develop capabilities of synthesis between cause of illness in the environment or community and individual health and respond with leadership qualities to institute remedial measures for this.

Teaching of Community Medicine should be both theoretical as well as practical. The practical aspects of the training programme should include visits to the health establishments and to the community where health intervention programmes are in operation. In order to inculcate in the minds of the students the basic concepts of community medicine to be introduced in this phase of training, it is suggested that the detailed curriculum drawn should include at least 30 hours of lectures, demonstrations, seminars etc. together with at least 15 visits of two hours each.

Learning objectives for internship:

Interns shall acquire skills to deal effectively with an individual and the community in the context of primary health care. This is to be achieved by hands on experience in the district hospital and primary health Centre. The details are as under: -

- I) Community Health Center/ District Hospital/ Attachment to general practitioner:
 - 1) During this period of internship an intern must acquire
 - a. Clinical competence for diagnosis of common ailments, use of bed side investigation and primary care techniques;
 - b. Gain information on 'Essential drugs' and their usage;
 - c. Recognize medical emergencies, resuscitate and institute initial treatment and refer to suitable institution.
 - 2) Undergo specific Government of India/Ministry of Health and Family Welfare approved training using Government of India prescribed training manual for Medical Officers in all National Health Programmes (e.g. child survival and safe motherhood-EPI, CDD, ARI, FP, ANC, safe delivery, Tuberculosis, Leprosy and others as recommended by Ministry of Health and Family Welfare: -
 - a. Gain full expertise in immunization against infectious disease;
 - b. Participate in programmes in prevention and control of locally prevalent endemic diseases including nutritional disorders;
 - c. Learn skills first hand in family welfare planning procedures;
 - d. Learn the management of National Health Programmes;
 - 3) Be capable of conducting a survey and employ its findings as a measure towards arriving at a community diagnosis.
 - 4) (a) Conduct programmes on health education, (b) gain capabilities to use audiovisual aids, (c) acquire capability of utilization of scientific information for promotion of community health.

-
- 5) Be capable of establishing linkages with other agencies as water supply, food distribution and other environmental/social agencies.
 - 6) Acquire quality of being professional with dedication, resourcefulness and leadership.
 - 7) Acquire managerial skills, delegation of duties to paramedical staff and other health professionals.

II) Taluka Hospital:

Besides clinical skill, in evaluation of patient in the environment and initiation of primary care, an intern shall;

- 1) Effectively participate with other members of health team with qualities of leadership.
- 2) Make a community diagnosis in specific situations such as epidemics and institute relevant control measures for communicable diseases;
- 3) Develop capability for analysis of hospital based morbidity and mortality statistics.
- 4) Use essential drugs in the community with the awareness of availability, cost and side effects;
- 5) Provide health education to an individual/community on:
 - a. Tuberculosis;
 - b. Small family, spacing, use of appropriate contraceptives;
 - c. Applied nutrition and care of mothers and children;
 - d. Immunization;
 - e. Participation in school health programme

III) Primary Health Centre (PHC)

- 1) Initiate or participate in family composite health care (birth to death), inventory of events.
- 2) Participation in all of the modules on field practice for community health e.g. safe motherhood, nutrition surveillance and rehabilitation, diarrhea disorders etc.
- 3) Acquire competence in diagnosis and management of common ailments e.g. malaria, tuberculosis, enteric fever, congestive heart failure, hepatitis, meningitis acute renal failure etc.
- 4) Acquire proficiency for Family Welfare Programmes (antenatal care, normal delivery, contraception care etc.)
- 5) A village attachment of at least one week to understand issues of community health along with exposure to village health centres, ASHA sub-centres should be added.

Annexure III

Reforms in Medical Education

**National Consultative Meet
on
Defining Norms for RHTC and UHTC of Medical Colleges in
India**

12- 14 October, 2016
King George's Medical University, Lucknow, UP

Draft Report

Conveners:

Indian Association of Preventive & Social Medicine
King George's Medical University, Lucknow
National Health Systems Resource Centre, Govt. of India

National Consultative Meet on Defining Norms for RHTC and UHTC of Medical Colleges in India

1. Preamble:

RHTC and UHTC are integral part of department of Community Medicine of a medical college and provide learning opportunity to medical students, interns and postgraduates. The MCI documents provide a working guideline for its functioning but do not clearly define its organizational infrastructure and functioning. The Assessment Form used by the Assessors during MCI inspection, focuses on a number of parameters which do not go with the ongoing activities and causes lot of problem to the college and may even become cause of de-recognition.

2. Need for consultation/Background:

- Lack of clarity in guidelines for physical establishment of RHTC/UHTC
- Lack of clarity in relationship between RHTC and PHC
- Lack of clarity in the services to be delivered – Clinic Vs Family care
- Lack of clarity on quantum of work load of the RHTC/UHTC Vs staff available
- Lack of clarity in the prescribed qualifications of paramedical staff
- Lack of clarity in the prescribed services V/s data being recorded in the Assessment Form
- Lack of clarity on the residential requirement of staff/students/interns/PGs at RHTC/UHTC
- Lack of clarity as how to avoid overlap of preventive services being delivered by RHTC/UHTC Vs health staff of State Govt.
- Lack of clarity on need of 3 PHCs to be adopted as RHTC is only at one PHC
- Lack of clarity on the ownership of RHTC/UHTC
- Lack of clarity in area/population to be covered

3. Objectives:

- To review the existing MCI guidelines
- To review the existing set up of RHTC/UHTC in various colleges and their functioning
- To review the need for 3 PHCs
- To review the justification of the information being collected by Assessors
- To debate on the areas lacking clarity, and
- To come out with realistic recommendations on establishment of infrastructure, staff and functioning of RHTC/UHTC

4. Members of the Consultative Group:

Chairperson: Vice Chancellor, KGMU

Members: IAPSM Governing Council members-

MCI Representatives-

MCI Assessor-

Health & Family Welfare, Govt. of India-

State Health Officials-

Representatives from Govt. & Private Medical Colleges-KGMU-

Select HODs of Community Medicine/ Deans of Medical colleges

Convenor: IAPSM through:

Dr VK Srivastava, Past president, IAPSM/

Dr Uday Mohan, Past Vice President

5. Process of Consultation:

5.1 Current Status of RHTC/ UHTC

5.2 Group Work

5.3 Group Recommendations

6. Annexures:

- i. Standard requirements for the setting up of College/ Dept. of Community Medicine
- ii. Requirements as prescribed in LOP/Renewal of colleges
- iii. MCI guidelines on functioning
- iv. MCI Standard Assessment Forms – UG/PG
- v. Research publication by Dr Pradeep Kumar

Group Recommendations:

GROUP -I

RHTC:

- For the admission capacity of 100 students, it is suggested that there should be one RHTC and one PHC. For the admission capacity of 200 and more students, the no of PHCs should be increased to TWO.
- The group strongly recommends that one CHC should be adopted and converted to RHTC. It is suggested that the PHC should have outreach activities.
- Community Medicine Department shall be responsible for all OPD, IPD and outreach services as per the National Health Programs for the designated community of the RHTC and PHC area. For the same administrative and financial control of the RHTC should be with the Head of Department of Community Medicine.
- There should be an MOU between the Department of Health Services and medical college for the smooth functioning of the RHTC.
- The distance of RHTC should be 30 km from the outer boundary of the municipal corporation
- The infrastructure of the existing adopted CHC can be utilised. The additional infrastructure required for RHTC can be constructed in the CHC campus or in and around CHC.
- The human resource of the CHC can be utilised in addition to the mandatory required human resource for RHTC.
- In addition to the available transport services at CHC, there should be one 30-seater bus and one 7-8 seater SUV (both air-conditioned) along with drivers.

-
- Training and field area: There would be specific population of 5000 for training and fieldwork. Family folders for the above 5000 population will be maintained by the RHTC.
 - Hostel facility along with mess facility should be available for the interns and postgraduate students. The minimum rooms should be 10 (5 rooms for girls and 5 rooms for boys). In addition, the number of rooms can be modified as per the strength of the batch of interns and PGs.
 - Residential quarters for the RHTC staff in addition to the CHC staff should be available.

UHTC:

- Any Sub-divisional Hospital, Dispensary, and Urban Health Centre can be adopted as the Urban Health Training Centre.
- The distance of the UHTC should be within 20 kms from the institute.
- Community Medicine Department shall be responsible for all OPD and outreach services as per the National Health Programs for the designated community of the UHTC area. For the same administrative and financial control of the UHTC should be with the Head of Department of Community Medicine.
- There should be an MOU between the Department of Health Services and medical college for the smooth functioning of the UHTC.
- The infrastructure of the existing UHC can be utilised. The additional infrastructure required for UHTC can be constructed.
- The human resource of the UHC can be utilised in addition to the mandatory required human resource for UHTC.
- In addition to the available transport services at CHC, there should be one 30-seater bus and one 7-8 seater SUV (both air-conditioned) along with drivers.
- Training and field area: There would be specific population of 5000 for training and fieldwork. Family folders for the above 5000 population will be maintained by the UHTC.

GROUP -II

RHTC/UHTC- Infrastructure – building - numbers of room, space, staff etc.

TERM OF REFERENCE

RHTC – For 100 students there should be one PHC with one RHTC for population of 30,000 (IPHS standards) should be in synergistic control with government. Population that should be covered by family folder methodology should be minimum 5000.

- To be located at a distance of 30 kms/ 1-hour commuting distance, but this may not apply for metropolitan cities.
- Transport facilities for
 - Students and interns 30-40seater bus for 100-student batch.
 - Staff 7+1 capacity vehicle.
 - Supportive staff- 12-14 seater multipurpose vehicle
 - One ambulance for patient.
 - Control of vehicle with department.
- Hostel- 1 hostel for interns/ residents 10 room on twin sharing basis separate for boys and girls total 20 rooms. With one room for warden, quarters for staff.

-
- Mess facilities should be there.
 - Staff
 - 1 medical officer cum lecturer, 1 lady medical officer, 1 PHN, health inspector and health educator- not needed, 2 ANMs, 1 LHV, 2 medical social worker, 1 Technician, 1 technician assistant, 1 peon, drivers according to vehicle number, 1 store keeper, 1 record clerk/worker, 2 sweeper, other category (2 cook, 1 helper, 1 pharmacist, security guard on 8 hrs duty)
 - 1 or 2 desktop with Wi-Fi connection with few books and journals for resident and intern
 - Demonstration room-1, size as per 40 students
 - Laboratory
 - Accommodation size 300 sq. ft capacity 30-40 students
 - Rooms for OPD 1 for specialist, 1 for lab, 1 for OT, 1 labor room, 1 doctors' duty room, immunization room.
 - IPD facilities one male ward and one female ward.
 - Audio-visual aids with LCD projector with speaker.

UHTC - One UHTC for 5000 population within city limits may be own or take up adopted health posts

- Vehicle same as RHTC under the departmental control
- Hostel / mess facilities not needed
- OPD facilities

Suggestion - PHC should be under Government control and have all functional National Health Programs.

GROUP -III

TOR: - RHTC/ UHTC – staff, functioning and services.

Group members: -

1. Staff

References:

1. MCI Document - Form B
2. NUHM Document
3. IPHS Standards for PHC

The members of the group suggested that for determining the number of staff members for RHTC, the additional manpower may be sanctioned in addition to what is prescribed for PHC as per IPHS standards.

RHTC

Sr No.	Existing Manpower for PHC (IPHS Std)	No.	Additional Manpower	No.
1.	Medical Officer- MBBS	01	Asst. Professor (MD)	01
2.	Medical Officer- AYUSH	01	MBBS/ LMO	01
3.	Accountant/ Data Entry Operator	01	Medical Social Worker	02
4.	Pharmacist	01	PHN	01
5.	ANM	03	Health / Sanitary Inspector	01
6.	Health Worker (Female)	01	Lab Assistant	01
7.	Health Worker (Male)	01	Driver	01
8.	Health Assistant (Female)/ LHV	01	Store keeper	01
9.	Lab Technician	01	Sweeper cum Chowkidar	02
10.	Multi Task Worker (Group D)	02	Hostel Matron	02
11.	Sanitary/ Watchman	01	Guards	03
			Cook	02
			Helper/ Cleaner	02
Total		14	Total	20

UHTC

Sr No.	Existing Manpower for U-PHC (NUHM) for 50,000 population	No.	Additional Manpower	No.
1.	Medical Officer- MBBS	02	Asst. Professor (MD)	01
2.	Medical Officer- AYUSH	00	MSW	01
3.	Nurse	03	PHN	01
4.	LHV	01	Health / Sanitary Inspector	01
5.	Pharmacist	01	Lab Assistant	01
6.	ANM	3-5	Lab Technician	01
7.	Public Health Manager cum Community Mobilizer	01	Driver	01
8.	Support staff	03	Peon	02
9.	M/E Unit	01	Clerk/ Data Entry Operator	01
Total		17	Total	10

The following activities are suggested for RHTC/UHTC.

Apart from the regular service delivery to the patients, following activities are suggested by the participants of the group:

1. Teaching and training of the undergraduate students, interns as well as postgraduate students should be the base of the entire curriculum to be adopted at the centers. The

teaching should be based on the National Health programs, functioning of the PHC as well as the U-PHC. In the UHTC, the focus should be on the marginalized as well as the vulnerable populations.

2. Students should be involved in the need assessment of the community through Community Need Assessment Approach (CNAA).
3. The efforts should be made to engage the specialty departments of the medical college.
4. Few departments, which should be actively engaged, include Community Dentistry also.
5. At UHTC, Geriatric care must be included as an important component of the service delivery.
6. The efforts should also be made for the inter-sectoral coordination, including the Municipal Corporations as well as the Public Health Engineering departments.
7. For the intake capacity of 100 students, it was suggested that the minimum population for which the family folders to be prepared is 5000, each for UHTC and RHTC.
8. A mechanism should be developed to have a continuous/ monitoring of the family folder.
9. Participants also suggested that for maintaining uniformity minimum information to be filled in the family folder should be developed in collaboration with IIPS Mumbai as well as IAPSM National body. This information will act as a good resource for the demography as well as disease load for the population.
10. Participants also suggested that the minimum qualification for the posts like PHN/ Health inspector/ Health Educator etc. should be defined along with the job responsibilities.

National Consultative Meet on Defining Norms for RHTC and UHTC of Medical Colleges

List of Participants

Sl. No.	Name	Institution
1.	Prof. Ravi Kant	Vice Chancellor, KGGMU, Lucknow
2.	Dr. RK Srivastava	Former Chairman, Board of Governors, MCI & DGHS
3.	Dr. RM Tripathi	EC Member, MCI
4.	Dr. AK Agarwal	Ex. Dean, MAMC, ND & MCI Assessor
5.	Dr. Sanjiv Kumar	ED, NHSRC
6.	Dr. Ashok Mishra	President, IAPSM
7.	Dr. Pradeep Kumar	Chief Editor, IJCM
8.	Dr. AM Kadri	Secretary General, IAPSM
9.	Dr. Ashutosh Kumar	Dean, KGMU, Lucknow
10.	Dr. Bhupinder Singh	Principal, CIMS, Lucknow
11.	Dr. Bina Ravi	Principal, HIMs, Sitapur, UP
12.	Dr. RP Sharma	Prof. & Head, Community Medicine, GSVM, Kanpur
13.	Dr. ParamitaSen Gupta	Professor, CMC, Ludhiana
14.	Dr. Shashi Kant	Professor & Incharge, RHTC, AIIMS, ND

15.	Dr. CP Mishra	Professor, PSM, IMS, BHU, Varanasi
16.	Dr. Lalit Sankhe	Professor of PSM, Grant Medical College, Mumbai
17.	Dr. Surya Bali	Faculty, CFM, AIIMS, Bhopal
18.	Dr. Chhaya Rajguru	Incharge RHTC, Grant Medical College, Mumbai
19.	Dr. Pankaj Bharadwaj	Dept. of Community Medicine, AIIMS Jodhpur
20.	Dr. Ajit Sahai	Consultant (Research), KGMU
21.	Dr. SK Singh	Professor SPM, KGMU
22.	Dr. Muksh Shukla	Asstt. Professor, HIMS, Barabanki
23.	Dr. VP Srivastava	Incharge, UHTC, CIMS, Lucknow
24.	Dr. RP Misra	Consultant Biostatistician
25.	Dr. VK Srivastava	Prof. of SPM & Past President, IAPSM

Annexure: IV

Staffing pattern at Primary Health Center (PHC) under IPHS, 2012

From Service delivery angle, PHCs may be of two types, depending upon the delivery caseload – Type A and Type B.

- Type A PHC: PHC with delivery load of less than 20 deliveries in a month,
- Type B PHC: PHC with delivery load of 20 or more deliveries in a month

Select PHCs, especially in large blocks where the CHC is over one hour of journey time away, may be upgraded to provide 24-hour emergency hospital care for a number of conditions by increasing number of Medical Officers, preferably such PHCs should have the same IPHS norms as for a CHC.

The work force that should be available at PHC is given in the table below:

Staff	Type A		Type B	
	Essential	Desirable	Essential	Desirable
Medical officer MBBS	1		1	1#
Medical officer AYUSH		1^		1^
Accountant cum data entry operator	1		1	
Pharmacist	1		1	
Pharmacist AYUSH		1		1
Nurse midwife (Staff Nurse)	3	+1	4	+1
Health Worker (Female)	1*		1*	
Health Assistant (Male)	1		1	
Health Assistant (Female)	1		1	
Health Educator		1		1
Laboratory Technician	1		1	
Cold Chain and Vaccine Logistic Assistant		1		1
Multi-skilled Group D worker	2		2	
Sanitary worker cum watchmen	1		1	+1
Total	13	18	14	21

* For Sub-Centre area of PHC.

If the delivery case load is 30 or more per month, one of the two medical officers (MBBS) should be female.

^ To provide choices to the people wherever an AYUSH public facility is not available in the near vicinity.

Annexure V: Village Orientation Programme

For First Year Medical Students

Objectives of village visit in 1st MBBS:

1. To make them aware about village conditions, income generation among villagers and administrative structures in general to support livelihood.
2. To have some hands-on experience of health facilities available locally and informal discussion with the nearby families regarding their perception of health facility.

Methodology:

Students are divided into the three groups in three different villages accompanied with one faculty/resident and one social worker as follows –

Overall Co-ordinator:

Students Roll No	Village Name	Faculty & Social Workers Name
01 -35		
36 -70		
71 -100		

Day wise schedule for Village Orientation Program followed in all the visited villages.

Sr. No.	Date	Activities
1		Orientation about village activities and perform in-house activities.
2		Village walk through, sanitation and drainage system of village, tobacco household process, visit to Panchayat, PDS ration shop and visit to dairy.
3		Visit – health facilities available in village i.e. Anganwadi, Subcentre etc. and family interaction regarding their feeling about health and well-being.

First day Activities

- First a pretest to be conducted for the assessment of knowledge before visiting the village.
- In-house orientation program to discuss about importance of village visit.

Second day activities

Introduce student about objectives of the session.

1. **Walk through village** and preparing the map of the village

➤ **Objectives-**

- To know environmental and living conditions of the people
- To know various wastes produced in the village
- To know about water supply in the village whether chlorinated or not
- To get aware the problems arising by improper disposal of waste
- To see the difference between life styles of the high and low socioeconomic people

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- To know about the landmarks of the village
 - 2. **Gram Panchayat visit** where students met Sarpanch and Talati and gather information about basic administration at village level.
 - **Objectives-**
 - To know about administrative system in the village
 - To know about the staff and the function of Sarpanch and Talati.
 - 3. **Ration Shop visit**
 - **Objectives-**
 - To know about PDS in India
 - To know the items being provided to BPL and APL card holders and the price of the items
 - 4. **Visit to Dairy**
 - **Objectives-**
 - To know the concept of co-operative dairy and relation with income generation for villagers
 - To know about the collection, storage, transportation of milk.
 - 5. **Visit to Tobacco Khali** - Students visited tobacco khali situated in their village and interacted with the laborer and the owner of the khali.
 - **Objectives-**
 - To know about health hazards to the workers in tobacco khali and relation with income generation
 - To know about personal protective measures followed by them.

Third Day Activities

- 1. **Visit to Anganwadi-** Students visited the Anganwadicentre in the village and interacted with the anganwadiben to know about her appointment and services and the beneficiaries of Anganwadi center.
 - **Objectives-**
 - To know about the staff at Anganwadi center
 - To get an idea about the services
 - To know about the beneficiaries
- 2. **Visit to PHC/Sub center** - Students visited PHC/Subcenter whatever is in their visiting village.
 - **Objectives-**
 - To know about the staffing pattern of PHC
 - To know about the services provided at PHC
- 3. **Visit to families of the village in group of two student –**
 - **Objectives-**
 - To know about their perception of health care services available and problems in the family and village
 - To know about the ways of care and protection they follow to keep healthy.

After coming back to the department, a verbal feedback and post-test to be conducted.

Village Stay for IV Semester
One-week schedule (Monday to Saturday)

Objectives: What, specifically, will be achieved?

1. To expose the students to identify socio-environmental factors that can affect human health
2. To study various health related issues among primary school children
3. To observe the Indian primary health care approach at village level in practice
4. To practice mode of health education & awareness generation on health related behaviour
5. To sensitize the medical students for identification of health-related problems and apply community based intervention through locally feasible solutions, on important health issues

Schedule for village visit & stay:

1st day

- **9.00 - 1.00:** Pre-test and orientation about the various forms to fill up and group discussion
- **2.00 p.m.** Jigsaw method of T-L technique for strengthening of learning

Note: During village stay, every day:

Breakfast will be served during 8 to 9 hours; the lunch will be available between 13.30 to 15 hours and the dinner will be during 20 to 21 hours.

There will be summary of the learning of the day, informal games during 21 to 22 hours followed by retiring for the day.

2nd day:

- 08.30 – 09.00: Assemble in front of parking area
- 09.00 – 09.45: Loading of luggage & boarding the vehicle
- 09.45: Depart for respective villages
- 10.30 – 11.00: Settle in the respective accommodations
- **Divide students in four groups to take lead for each day's activities and report. A, B, C, D.**
- 11.00 to 1.30: Visit to **PHC** to observe elements of primary health care practices and discussion with health functionaries regarding their job assignment and performance of national health programs.
- 3.00 – 6.00 pm: A walk through all corners of the village for familiarization & observation of environmental conditions and to identify group of **families with low and high socio-economic status. Village map** would be prepared by students, based on important landmarks. **Information on demographic profiles of the village.**
- 6.00 - 8.00 pm: (Group activity) In two groups

1. **A & B groups:** Clinics for villagers in **lower socio-economic group area** – Basic history taking and health education on diagnosed cases by the students; morbidity and nutritional survey in 20 families

2. **C & D groups:** **Informal talk with elderly villagers** among subgroup about basic strength, weakness, threat and opportunities of village. This would be helpful in **knowing the villagers and their problem** in details.

3rd day:

- 9.00 - 10.00: Discussion on activities of Subcentre and Anganwadi
- 10.00 - 12.30: Visit to **Subcentre and Anganwadi Centre** to observe, 'Mamta Divas'.

Student would learn about **primary level care practices** at village & sub center level. They would get the opportunity to talk health care personnel & learn about assigned jobs carried by health staff.

- 12.30 - 1.30: Local **tobacco factory** visit, if available or any agriculture based factory to show effects on labourer.
- 3.00 – 5.00 pm: **Para-clinical subjects**
- 6.00- 8.00 p.m.: In two groups

1. **C & D: Clinics for villagers in higher socio- economic group area:** Basic history taking and health education on diagnosed cases by the students; morbidity and nutrition survey in 20 families.

2. **A & Informal talk with elderly villagers** among subgroup about basic strength, weakness, threat and opportunities of village. This would be helpful in **knowing the villagers and their problem** in details.

4th Day:

- 9.00 – 10.00: Group discussion about administrative pattern at village level
- 10.00 – 12.00: Visit the local "**Panchayat Bhavan**" and introduction to the local authorities available e.g., Sarpanch, Talati, Gram sevak, four different Mitras including Arogyamitra identified by Govt. and have a talk on their activities and assigned work.
- 12.00 - 1.30: Visit to **water distribution system, solid and liquid waste** including animal dung & sewage disposal mechanism of the village. Technique of chlorination of water will be demonstrated. **Breeding** sites for mosquitoes & flies will also be shown (**Environmental health**).
- 3.00 – 5.00: **Para-clinical subjects**
- 6.00-8.00 p.m.: **Clinic in old age home** and **health education activity** for village community in the form of "Role play" for awareness generation on an important identified problem

5th day:

- 9.00 – 12.00: Visit to **primary and secondary** schools situated in the village. Observe school health activities, identify school health problems, mid-day meal program, examine student in groups and counsel students for healthy activities.
- 12.00 – 1.30: Visit to the **nearby store** to demonstrate various pesticides available in the market then visit a farmland for demonstration of **pesticide spraying** by farmers & observe possible hazards.
- 3.00 pm: Thanksgiving to the villagers then departure

6th day: 11/09/10, Saturday

- 9.00-11.00: Presentation in groups about lesson learned in village stay
- 11.00-13.00: Assessment for internal marks, Post-test based on learning in village stay, feedback etc.

Note:

Forms to be filled up in-group:

1. Village Mapping
2. Collection of morbidity and nutrition data from low and high socio-economic group family, analysis & conclusion.
3. Occupational hazard during tobacco farm visit
4. School services

5. PHC, Subcentre & Anganwadi

III MBBS – Administrative village visit

Objectives:

1. To supervise, monitor, evaluate, & observe administrative and health care activities in Primary Health Centre (PHC).
2. To study general planning and implementation of important national health programmes.
3. To develop skills of leadership to organize and administer community health programmes in villages.
4. To complete family/case studies as per the guidelines given in the family survey journal.

Schedule:

1st day

- **9.00 - 1.00:** Pre-test and orientation about the various forms to fill up and group discussion
- **2.0 pm:** Jigsaw method of T-L technique for strengthening of learning

Note: During village stay, every day:

Breakfast will be served during 8 to 9 hours, the lunch will be available between 13.30 to 15 hours and the dinner will be during 20 to 21 hours.

There will be summary of the learning of the day, informal games during 21 to 22 hours followed by retiring for the day.

Performa Discussion:

1. NVBDP 2. NCD screening 3. Immunization & School health 4. TB & 5. General admin.

Day -2

- 8.30 - 9.00: Assemble in front of parking area
- 9.00 - 9.45: Loading of luggage & boarding the vehicle
- 9.45: Depart for respective villages, settle in the respective accommodations
- 11.30 - 14.00 & 15.00 - 17.00: Visit to PHC: Provide overview of the program and complete **one of the broad area** required as per design. Students are supposed to take complete round of village to prepare a village survey and map required to complete family journal.

Areas identified for study are:

1. PHC administration 2. Immunization & Family planning 3. Malaria 4. TB 5. School health 6. IDSP 7. Family/case study based on record journal: one complete family & case study along with three family study.

Activities for day 2 to day 5:

All the batches will be divided into 5 groups viz. A,B,C,D and E. Each group will be assigned a particular activity every day in cyclical order as per plan depicted below.

1. Supervision 2. Monitoring 3. Evaluation 4. Leadership 5. Observation

Day/Session/ Activity	Group - A	B	C	D	E
2/ Forenoon & afternoon (Area1)	1	2	3	4	5
3/ Forenoon (Area 2)	2	3	4	5	1
3/ Afternoon (Area 3)	3	4	5	1	2
4/ Forenoon (Area 4)	4	5	1	2	3
4/ Afternoon (Area 5)	5	1	2	3	4
5/ Forenoon (Area 6)	1	2	3	4	5

Brief notes on these six activities:

1. Supervision:

Observe the process, the practice, the attitude for correctness, effectiveness and aptitude.

Following are few examples:

- 1) Immunization: Storage, cold chain, asepsis, dose, route of administration, counseling, instructions, disposal of used material, record keeping, reporting
- 2) Family Planning: selection of the beneficiary, history taking and physical examination, instructions, counseling, follow up procedures, record keeping, reporting
- 3) Slide for MP: History taking, counseling for the test, site selection, asepsis, prick, smear preparation, smear preservation, follow up procedure, recording, reporting,
- 4) Sputum for AFB: History taking, counseling for the test, instruction for the collection, asepsis, sputum collection, follow up procedure, recording, reporting,
- 5) School health: observing a school health session in terms of team members present, clinical examination being done, health education provided, involvement of teachers.
- 6) IDSP: Overview and method of conduction.

2. Monitoring:

Assess whether the activities are going as per plan.

- 1) Immunization: Target for each method, achievement, quality of achievement (acceptors), strengths, weaknesses, guidance
- 2) Family Planning: Target for each method, achievement, quality of achievement (acceptors), strengths, weaknesses, guidance
- 3) NVBDCP: ABER and API
- 4) RNTCP: Case Detection, cure rate and case maintenance for RNTCP
- 5) School Health: No. of schools covered as against micro plan
- 6) IDSP

3. Evaluation:

- 1) To assess the achievements of each programme as against set targets /objectives in terms of inputs, process and outputs.
- 2) To assess the overall impact of particular health programme in PHC area.
- 3) To assess the perceptions of health functionaries and beneficiaries about impact of programme.

4. Observation:

The observer group shall be the group responsible for coordinating the entire activity. They shall go through the planning of the activity on previous day, designate one student each to observe the supervision, monitoring, evaluation, leadership activities and document their observation and **make presentation at the end of the day**. The group shall also ensure that other groups document their observations. They shall provide all the information required for

the final presentation regarding the particular programme assigned to them for the final presentation.

5. Leadership:

On day 2, the leadership group in discussion with the other groups, faculty will decide and plan one community based activity. The leadership groups on subsequent days carry forward the plan and carry out the activity.

Day -6

- **9.00-9.30am:** Getting ready for presentation. All groups will have to upload their final presentation before 9.30am. Once the presentation session starts no further uploading will be allowed.
- **9:30 – 11:30 am:** Group presentations
- **11:30 – 13.00 pm:** Internal assessment (written test) followed by feedback & Viva-Voce if not conducted in field.

Annexure VI:
Indicative list of activities/project work for PGs

1. Developing Annual Action Plan for UHTC/RHTC
2. Planning & organizing Village Health and Nutrition Day (VHND) activities
3. Planning and monitoring pre-monsoon anti malaria plan
4. Monitoring and evaluation of one Health Programs
5. Supply & logistic plan
6. Micro-planning of Immunization campaign
7. Validation of performance/reports
8. Capacity building plan for different health workers on RCH
9. Developing communication strategies for one of health problems for UHTC/RHTC areas
10. Preparing for the monthly review meeting and making minutes for the same
11. Plan and organizing screening and health promotional activities for NCD
12. Outbreak (Epidemic) Investigation (minimum three in three during tenure)
13. Maternal/Child death review and response
14. Death audit/verbal autopsy of any death due to TB/Malaria/Dengue
15. Process evaluation of VHND/NID/SNID/MI sessions
16. Malaria situation analysis report: Epidemiological and programmatic.
17. Child morbidity & mortality situational analysis: Epidemiological and programmatic
18. Maternal care & mortality situational analysis: Epidemiological and programmatic
19. Contraceptive utilization situational analysis: Epidemiological and programmatic
20. Planning and participating in advocacy meetings
21. Planning and participating in health education session
22. Planning and participating in group meeting with special groups

Note: Above list is not exhaustive and it is not necessary that disciple should have prepared projects on all topics. By and large it is expected that s/he should have done around 15 project works during the MD course individually. Interpretation of various common laboratory reports

Indicative list of Medical Microbiology:

1. Staining & culture for malaria.
2. Staining & culture for Mycobacterium Tuberculosis
3. Staining & culture for other organisms
4. Sample collections and transport

Indicative list of the Family with cases:

1. Tuberculosis
2. Malnutrition (PEM, obesity, anaemia, vitamin A deficiency, IDD etc.)
3. Drug addiction
4. STD & AIDS
5. Handicapped person
6. Antenatal / postnatal woman, etc.
7. Hypertensive
8. Diabetes

-
- 9. Malaria**
 - 10. Typhoid /Hepatitis/Diarrheal diseases**
 - 11. Leprosy/Filariasis**
 - 12. Newborn/Infant**

Note: Above list is not exhaustive and it is not necessary that disciple should have done family study on all the above topics. By and large, it is expected that s/he should have done around 7-10 family studies during the MD course individually.
