Guidelines
For
Multipurpose
Health Worker (Male)
2010

Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi

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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
API	Annual Parasite Index
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CHC	Community Health Centre
DOTs	Directly Observed Treatment-Short course
DTC	District Training Centre
HFWTC	Health & Family Welfare Training Centre
IPHS	Indian Public Health Standards
MCH	Maternal and Child Health
MPW	Multipurpose Health Worker
NGO	Non Governmental Organisation
NIHFW	National Institute of Health & Family Welfare
NLEP	National Leprosy Eradication Programme
MPHW (Male)	Multi Purpose Health Worker (Male)
NRHM	National Rural Health Mission
NSPCDR	New Sputum Positive Case Detection Rate
NVBDCP	National Vector Borne Disease Control Programme
ORS	Oral Rehydration Solution
PHC	Primary Health Centre
PRI	Panchayat Raj Institutions
RCH	Reproductive and Child Health
RDT	Rapid Diagnosis Test
RHS Bulletin	Rural Health Statistics Bulletin
RNTCP	Revised National Tuberculosis Control Programme
SHC	Sub Health Centre
SIHFW	State Institute of Health & Family Welfare
STD	Sexually Transmitted Diseases
VHSC	Village Health & Sanitation Committee

1. Background

1.1 The concept of Multipurpose Health Workers (Male and Female) was introduced in 1974 for the delivery of preventive and promotive health care services to the community at the level of Sub-Health Centres (SHCs), the most peripheral health facilities, covering 5000 population in plains and 3000 population in hilly/ tribal/ difficult areas. The Multipurpose Health Worker (Male) is the grass root health functionary for the control of communicable diseases including Malaria, TB, Leprosy, Water Borne Diseases, as well as Environmental Sanitation, detection of disease outbreaks and their control, health education etc. The non availability of MPHW (Male) across the states has been one of the critical issues in implementation of national programmes including National Vector Borne Disease Control Program (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP), and National Leprosy Eradication Programme (NLEP). The worst impact has been on malaria control. The malaria workers were originally supported by the Central Government, and the States had to take them over once the National Malarial Eradication Programme entered into maintenance phase. These malaria workers and other basic health workers, vaccinators, family planning workers etc. were later on designated as MPHW (Male) on introduction of Multipurpose Health Workers Scheme as per the recommendation of Kartar Singh Committee (1973). They were given a smaller population to meet the community health needs by establishing health linkages with the local community.

1.2 The National Rural Health Mission (NRHM) has a policy of neither substituting state expenditure, nor recruiting against posts created by the states. The states were encouraged to fill up male health worker posts as the conditionality for the support of contractual 2nd ANM under NRHM. Most of the states could not fill up the vacant posts of MPHW (Male), while some States declared the MPHW (Male) as dying cadre and stopped filling of vacant posts mainly due to resource constraints. This led to non availability of both male and female health workers especially at the SHCs in the tribal and other underserved areas. The implementation of public health measures such as collection of drinking water samples, environmental sanitation, school health, adolescent health programs and other National Health Programs etc. have limited success largely due to non availability of male health workers at SHCs. The non availability of health workers (Male) also has been adversely affecting the implementation of maternal and child health programs due to overburdening of the available ANMs. Introduction of several national health programs for non-communicable diseases during 12th five year plan period also required the services of MPHW (Male) for their effective implementation at field level.

1.3 During the past two decades, the availability of MPHW (Male) has dwindled down considerably due to inadequacies in training institutions and non-creations/filling up of posts by the states. Many states have declared the MPHW (Male) as a dying cadre and stopped recruitment as well as creation of posts. A total of 88,344 MPHW (Male) were trained till 1987 and 84,993 positioned at SHCs. As per the RHS Bulletin (2008), the sanctioned posts for MPHW (Male) available are 87,835 only and 63,405 MPHW (Male) were in-position for the 1,46,036 SHCs. The State-wise short-fall is detailed in Tables-I

Table I : Health Worker (Male) – Required, Sanctioned, Available and Short Fall (2008)

	States		MPHW (Male) Required		Status of MPHW(Male)				SHCs in High Focus Districts
		Trained Till 1987	As per IPHS for 2010 Population	NRHM Time Line	Total Sanctioned 2008	To be Created	In Position 2008	Shortfall	
	India	**88, 344**	**2,73,003**	**1,75,000**	**87, 835**	**87,165**	**63,405**	**11,1595**	**53,544**
1	A.P.	7,421	19,345	12,401	7,340	5,061	6,127	6,274	2,076
2	Arunachal Pradesh	30	351	225	* 23	202	156	69	175
3	Assam	3,224	6,815	4,369	*2,705	1,664	2,383	1,986	529
4	Bihar	5,183	21,411	13,725	2,135	11,590	1,074	12,651	8,858
5	Chhattisgarh	***	6,170	3,955	4,741	+786	2,514	1,441	3,754
6	Goa	170	347	222	150	72	135	87	0
7	Gujarat	4,980	13,347	8,556	6,206	2,350	4,456	4,100	1,528
8	Haryana	1,857	5,648	3,620	2, 44	1,076	2,031	1,589	111
9	Himachal Pradesh	973	1,603	1,028	2,008	+980	1,270	+242	239
10	J&K	364	2,599	1,666	*381	1,285	*377	1,289	475
11	Jharkhand	***	7,785	4,990	*5,438	+448	2,320	2,670	2,881
12	Karnataka	8,301	13,548	8,685	5,009	3,676	3,762	4,923	1,713
13	Kerala	3,212	7,362	4,719	2,672	2,047	2,654	2,065	0
14	Madhya Pradesh	7,060	17,573	11,265	7,170	4,095	4,030	7,235	6,486
15	Maharashtra	7,763	25,053	16,059	12,210	3,849	9,956	6,103	903
16	Manipur	315	602	386	420	+34	420	+34	206
17	Meghalaya	381	817	524	273	251	273	251	309
18	Mizoram	341	324	208	366	+158	398	+190	0
19	Nagaland	142	708	454	276	178	300	154	0
20	Orissa	4,457	10,156	6,510	4,911	1,599	3,392	3,118	3.080
21	Punjab	3,678	6,528	4,185	2,858	1,327	1,983	2,202	454
22	Rajasthan	3,763	16,002	10,258	3,968	6,290	2,528	7,730	4,115

	States		MPHW (Male) Required		Status of MPHW(Male)				SHCs in High Focus Districts
		Trained Till 1987	As per IPHS for 2010 Population	NRHM Time Line	Total Sanctioned 2008	To be Created	In Position 2008	Shortfall	
23	Sikkim	100	138	88	147	+59	147	+59	0
24	Tamil Nadu	3,202	15,189	9,736	5,062	4,674	3,278	6,458	0
25	Tripura	397	946	606	*449	157	436	170	1,020
26	Uttarakhand	***	1,983	1,271	771	500	616	655	185
27	Uttar Pradesh	11,939	45,030	28.865	980	27,885	2,097	26,786	11,610
28	West Bengal	8,899	21,103	13,527	6,543	6, 984	4,215	9,312	2,723
29	A&N Island	84	101	65	*26	39	22	43	0
30	Chandigarh	7	305	196	8	188	14	182	0
31	Dadra & NH	0	96	62	9	53	9	53	0
32	Daman & Diu	***	56	36	22	14	19	17	0
33	Delhi	0	3,643	2.335	0	2,335	0	2,335	0
34	Lakshadweep	0	24	15	14	1	13	2	114
35	Puducherry	101	295	189	0	189	0	189	0

*National Health Profile 2008 *RHS 2006 (Data not Available in RHS 2008) PIP 2010-11*

**** New States*

1.4 As per the RHS Bulletins (1987, 1996, 2006 and 2008), the availability of MPHW (Male) declined over the years from 84993 (1987) to 71053 (2001), 65511 (2006) and 60247 (2008). In many States the reduced availability of MPHW (Male) led to repositioning one each at PHCs covering 4 to 6 SHCs. As per the IPHS norm of two MPHWs (Male & Female) at SHCs, over 2,73,000 MPHW (Male) need to be provided for the projected populations of 2010. The time line for NRHM activities includes the provision of 1,75,000 SHCs as part of the service guarantees under IPHS (Framework for Implementation 2005-2012).

1.5 As an interim measure, the Government of India provided 100 % support for engaging 9,655 contractual MPHW (Male) in 16 states for the 200 high malaria endemic and the Kala-Azar affected districts. This led to restarting of the MPHW (Male) course in state such as Karnataka. The filling up of the vacant posts of MPHW (Male) has been successful in some states notably Assam and West Bengal.

1.6 The Indian Public Health Standards (IPHS-2007) stipulates the availability of one MPHW (Male) and two ANMs for implementation of public health programmes and maternal & child health care respectively. As per the cabinet decision of 2002, the Government of India took 100% responsibility of provision of 1st ANM through

treasury route and the 2nd ANM is provided through NRHM funding to the states. The sustained efforts during the past few years led to enhanced availability of ANMs in all the states and increase of ANM schools from 271 (2007-08) to 662 (2009-10).

2. High Focus Districts

2.1 The Government of India has identified high focus districts on the basis of burden of malaria, TB, and leprosy as well as performance of districts in relation to institutional deliveries and immunization coverage of children under five years against vaccine preventable diseases. The 235 districts identified as high focus includes 99 of the 243 districts with NSPCDR of < 60% for TB, 102 districts with API > 1.9 for malaria or with confirmed kala-azar cases (during the 5 year period of 2003-2007), 53 Leprosy endemic districts as well as the 216 of the 485 districts with < 80% Institutional deliveries and 177 of the 358 districts with < 85% coverage of full Immunization in children as detailed below in Table-II. Of the 235 high focus districts, 3/4th of these districts are from the states of Uttar Pradesh (44): Bihar (35); Madhya Pradesh (31); Jharkhand (18); Rajasthan (15); Orissa (15); and Chhattisgarh (14).

Table II : High Focus (HF) Districts – Health Care Outcomes

	States	Total Districts	High Focus Districts	Tuberculosis NSPCD Rate <60%		Malaria API >1.9 & Addl. Dist. With Kala Azar cases		Leprosy Annual NCDR >20		Maternal and Child Health (DLHS - 3)			
				Total Dist.	HF Dist.	Total Dist.	HF Dist.	Total Dist.	HF Dist.	Institutional Deliveries<80 %		Immunization Children<85 %	
										Dist.	HF Dist.	Dist.	HF Dist
	India	**643**	**235**	**243**	**99**	**200** (142+ 58 *)	**102** (65+ 37*)	**53**	**53**	**485**	**216**	**348**	**177**
1	Andhra Pradesh	24	4	0	0	0	0	0	0	14	2	5	2
2	Arunachal Pradesh	16	3	2	1	14	3	0	0	NA	NA	NA	NA
3	Assam	27	5	4	1	9+1*	2+0*	0	0	27	5	25	5
4	Bihar	38	35	29	27	0+33*	0+28*	13	13	37	35	37	35
5	Chhattisgarh	16	14	12	11	8	8	9	9	16	14	0	0
6	Goa	2	0	2	0	2	0	0	0	0	0	0	0
7	Gujarat	26	6	0	0	3	0	5	5	22	4	17	4
8	Haryana	21	1	9	0	5	0	0	0	21	1	16	1

9	Himachal Pradesh	12	3	1	1	0	0	0	0	12	3	0	0
10	J&K	22	6	11	6	0	0	0	0	12	6	5	3
11	Jharkhand	24	18	1	1	17+3*	11+3*	4	4	22	18	17	17
12	Karnataka	30	7	14	2	7	1	0	0	18	5	8	1
13	Kerala	14	0	3	0	0	0	0	0	0	0	5	0
14	M. P.	50	31	30	23	10	9	1	1	43	29	42	30
15	Maharashtra	35	3	34	1	2	1	2	2	26	3	9	1
16	Manipur	9	4	6	4	1	0	0	0	NA	NA	NA	NA
17	Meghalaya	7	5	1	1	6	5	0	0	7	5	5	5
18	Mizoram	11	0	2	0	6	0	0	0	7	0	7	0
19	Nagaland	11	0	4	0	7	0	0	0	NA	NA	NA	NA
20	Orissa	30	15	14	2	23	15	5	5	30	15	19	15
21	Punjab	20	4	7	0	0	0	0	0	20	4	6	0
22	Rajasthan	33	15	8	3	5	3	0	0	32	15	29	13
23	Sikkim	4	0	0	0	0	0	0	0	4	0	0	0
24	Tamil Nadu	32	0	10	0	2	0	0	0	1	0	0	0
25	Tripura	4	2	3	2	4	2	0	0	4	2	4	2
26	Uttarakhand	13	2	8	1	0+1*	0	11	11	13	2	9	2
27	Uttar Pradesh	71	44	22	11	3+9*	2+4*	3	3	70	42	70	41
28	West Bengal	19	6	1	0	4+11*	2+2*	0	0	17	6	7	0
29	A&N Island	4	1	0	0	3	1	0	0	NA	NA	NA	NA
30	Chandigarh	1	0	0	0	0	0	0	0	0	0	0	0
31	Dadra & N	1	0	0	0	1	0	0	0	1	0	1	0
32	Daman & Diu	2	0	1	0	0	0	0	0	1	0	0	0
33	Delhi	9	0	3	0	0	0	0	0	8	0	4	0
34	Lakshadweep	1	1	1	1	0	0	0	0	0	0	0	0
35	Puducherry	4	0	0	0	0		0	0	0	0	1	0

*Districts with confirmed Kala-Azar cases during 2003 to 2007

NA: DLHS-3 data Not Available

NB: DLHS data available for lesser districts (MCH) due to bifurcation of former states / districts – Bihar 35 of 38, J&K 13 of 22, Mizoram 8 of 10, MP 43 of 50, Rajasthan 32 of 33, Tamil Nadu 30 of 32 & UP 70 of 71 districts).

3. Engagement of MPHW (Male) in High Focus Districts

3.1 Considering the need for MPHW (Male) for the disease control programs, the Government of India decided to provide financial assistance to states for contractual remuneration of the MPHW (Male) at 53,544 PHCs in 235 high focus districts for a period of three years. The remuneration will be paid at a rate of Rs 6000 per MPHW per month. The expenditure will be on sharing basis, 85% by NRHM and 15% by State Governments for the first year followed by 75% and 25% for the second year and 65% and 35% for the third year.

3.2 The request for financial assistance should be included in the annual Project Implementation Plan of NRHM by the states. The state wise number of MPHW (Male) in the high focus districts for which financial assistance may be provided is given in Table III below:

Table III : State-Wise Proposed MPHW (M)

	State/UT	Proposed no. of MPHW (M) (for SHCs of High Focus Districts)
1	Andhra Pradesh	2,076
2	Arunachal Pradesh	175
3	Assam	529
4	Bihar	8,858
5	Chhattisgarh	3,754
6	Goa	0
7	Gujarat	1,528
8	Haryana	111
9	Himachal Pradesh	239
10	J & K	475
11	Jharkhand	2,881
12	Karnataka	1,713
13	Kerala	0
14	Madhya Pradesh	6,486
15	Maharashtra	903
16	Manipur	206
17	Meghalaya	309
18	Mizoram	0
19	Nagaland	0
20	Orissa	3.080
21	Punjab	454
22	Rajasthan	4,115

	State/UT	Proposed no. of MPHW (M) (for SHCs of High Focus Districts)
23	Sikkim	0
24	Tamil Nadu	0
25	Tripura	1,020
26	Uttarakhand	185
27	Uttar Pradesh	11,610
28	West Bengal	2,723
29	Andaman	0
30	Chandigarh	0
31	Dadra& Nagar	0
32	Daman & Diu	0
33	Delhi	0
34	Lakshadweep	114
35	Puducherry	0
	Total	**53,544**

3.3 The State Governments need to create the requisite number of posts and fill up on regular basis within next three years so that the continuity of these workers is maintained after the initial period of three years during which the Government of India is to provide financial assistance.

4. Eligibility & Selection Criteria

4.1 The minimum qualification should be class XII pass with biology or science. In the event of non-availability of XII class pass applicants in the notified tribal areas, the minimum educational qualification may be relaxed to Class X pass with science.

4.2 The applicants should be below 25 years age. Relaxation in age limit be provided to SC,ST, OBC and other categories as per rules.

4.3 The applicant should be resident of any of the villages within the Gram Panchayat and in the event of non-availability of such local candidates, the applicants from any of the villages in the adjoining Gram Panchayat and failing which from the block may be considered in that order.

4.4 The selection committee may be constituted at the Block PHC level by the state government. The committee should inter-alia include Chairman/President of Block Panchayat Samiti, Block Development Officer, and medical officer in charge of the Block PHC.

4.5 The selection of the candidate should be on merit basis taking into account the total marks (including languages) obtained in XII Board Examination. In case of notified tribal areas, where class XII pass candidates are not available, merit list should be prepared on basis of total marks obtained in Class X examinations.

4.6 The selected candidates must execute a bond for serving in the Gram Panchayat/Block area for a minimum period of 5 years failing which he will be liable to remit back a fixed amount as determined by the State Government.

4.7 Where the existing Recruitment Rules for MPHW(male) prescribe different eligibility criteria, the state governments should review them to suitably incorporate the eligibility criteria recommended above.

5. Job Responsibilities of MPHW

5.1 The DMPW (Male) course envisages to adequately train the MPHW (Male) to carry out the responsibilities assigned to him. He should make a visit to each family once a month. MPHW (Male) will mainly focus on activities which are related to disease control programs, detection and control of epidemic outbreaks, environmental sanitation, safe drinking water, first aid in emergencies like accidents, injuries, burns etc., treatment of common/ minor illnesses, communication and counselling, life style diseases and logistics and supply management at sub-centre. In addition he will also facilitate ANM in MCH, Family Welfare, and Nutrition related activities. Due importance should be given in assessment of MPHW (Male) training both at institutional and field level accordingly. The broad areas of job responsibilities of MPHW (Male) would broadly include the following –

5.1.1 **Malaria**

a. Conduct domiciliary house-to-house visits covering all the assigned population as per the schedules approved by the PHC Medical Officer. During his visits, he shall enquire about fever cases in each family and verify the cases diagnosed positive after the last visit.

b. Collect blood smears and perform RDT from suspected fever cases and appropriately maintain records in M-1.

c. Ensure immediate dispatch of collected blood smears for laboratory investigations and provide treatment to positive cases as per the guidelines.

d. Advise all seriously ill cases to visit PHC for immediate treatment and refer all fever case with altered sensorium to the PHC / hospital and arrange funds for transportation of such cases from NRHM/ other funds.

e. Undertake necessary measures to contain the spread of disease as advised by PHC Medical officer.

f. Liaison with ASHA / Village Health Guide / Anganwadi Worker for early detection of malaria, replenish the stocks of microscopy slides, RDKs and / or drugs.

g. Ensure treatment for all diagnosed cases as per the instructions by the PHC medical officer and also take prompt actions for adverse reactions reported.

h. Intimate each house hold in advance regarding date of spraying and other public health activities as well as duly explain the benefits of such activities to the community.

i. Supervise the spraying operations and deploy the two squads in adjoining areas for adequate supervision. Ensure the quality of spraying operations for uniformity in coverage of all the surfaces as well as due precautions regarding water sources and personal hygiene as per the guidelines.

j. Maintain the records of domiciliary visits, blood smears collected, patients given anti-malarials, details of spraying operations etc in the prescribed formats.

5.1.2 **Tuberculosis (RNTCP)**

a. Identify all cases of fever for over two weeks with prolonged cough or spitting of blood and refer to PHC for further investigation. Verify the TB patients self reporting at health facilities.

b. Function as DOTs provider to ensure that all confirmed cases are on regular treatment and motivate defaulters for regular treatment.

c. Improve community awareness on signs and symptoms of tuberculosis and guide the suspected TB cases for referral to the designated microscopy centres and facilitate sputum examinations.

d. Assist and supervise the ASHAs / Anganwadi Workers / Village Health Guides / local health volunteers to function effectively as DOTs providers by ensuring regularity of DOTS, schedule the DOTs as per patient's convenience and collection of empty blister packs.

e. Ensure that follow up smear examinations of sputum are carried out as per the schedules.

f. Maintain the treatment cards and transmit the data weekly to the PHC.

g. Maintain the records of domiciliary visits, records of patients on treatment, sputum examinations etc

5.1.3 **Leprosy**

a. Identify Leprosy suspected cases of skin patches with loss of sensation and refer to PHC.

b. Provide Multi Drug Treatment (MDT) to confirmed cases and ensure completion of treatment including retrieval of defaulters.

c. Guide leprosy patients with deformities for management at appropriate health facilities.

d. Assist and supervise the ASHAs / Anganwadi Workers / Village Health Guides / local health volunteers for early detection of Leprosy cases and treatment.

e. Improve community awareness on signs and symptoms of Leprosy for early detection.

f. Maintain the treatment cards and transmit the data to the PHC

g. Maintain the records of domiciliary visits and records of patients on treatment.

5.1.4 **Preventive Health Care**

a. Surveillance for unusually high incidence of cases of diarrhoeas, dysentery, fever, jaundice, diphtheria, whooping cough, tetanus, polio and other communicable disease and notify PHC.

b. Ensure regular chlorination of all the drinking water sources. Collect water samples regularly, send for testing and undertake appropriate actions for provision of safe drinking water supplies.

c. Generate community awareness regarding safe drinking water, sanitation, waste disposal and personal hygiene and ensure safe disposal of liquid / solid wastes.

d. Assist and coordinate with the VHSC and SHC / PHC Committees as well community leaders for health awareness and preventive health care activities.

5.1.5 **School Health including Nutrition**

a. Visit all the schools in the assigned area and advocate personal hygiene, nutrition, safe drinking water and sanitation and other public health measures.

b. Undertake awareness generation of national health programmes (Malaria, TB, Leprosy etc) for early detection of communicable and non-communicable diseases

c. Ensure completion of immunisation schedules including Inj. TT as per guidelines

d. Assist Ophthalmic Assistant for eye screening of children for detection of visual defects.

e. Identify cases of malnutrition in school children and refer cases to PHC Medical Officer. Guide teachers and parents on nutrition and anaemia. Educate the community about nutritious diet for mothers and children from locally available foods.

5.1.6 **Maternal Health including Family Planning**

a. Assist in ensuring timely referral transport for pregnant women at the time of delivery

b. Provide follow-up services for acceptors of male sterilization and also motivate males for sterilisation and spacing methods based on ANMs eligible couple register.

c. Assist the ANMs and ASHAs in distribution of conventional contraceptives to eligible couples.

6. Training of MPHW (Male)

6.1 The selected candidates will undergo one year training to obtain Multi Purpose Health Worker (DMPW) Diploma. Class X pass candidates selected due to non availability of Class XII pass candidates in notified tribal areas will undergo three months pre-course training in basic sciences.

6.2 The training course for MPHW (Male) was initiated by the Government of India to meet the shortage under 100% centrally sponsored Family Welfare programme. During 1982-85, the course was started at 47 Health & Family Welfare Training Centres (HFWTCs). Subsequently during 1985-87, 77 MPHW (Male) schools were started in 19 States with an annual admission capacities of over 6,700 (Table III) and 88,344 male health workers were made available by the year 1987 (RHS Bulletin 1992). Subsequently several of these institutions have reduced their annual intake or discontinued the course even though infrastructure and staff continued to be available. Their present activities are limited to short term (3 to 6 days) training under RCH Program. As per the information available, the State-wise functional status of these training centres is shown in Table IV below.

Table – IV : Annual Intake Capacities for undertaking MPHW (Male) Course

	States	HFW Training Centres	MPW (M) Schools Functional	Total	MPW (M) Schools / HFWTC Non Functional	Total	Annual Intake (Available/ Earlier)
1	A.P.	4	10	14	-	14	600
2	Arunachal Pradesh	0	0	0	0	0	0
3	Assam	1	0	1	2	3	180
4	Bihar	3	0	3	-	3	180
5	Chhattisgarh	1	4	5	-	5	300
6	Goa	0	1	1	0	1	15
7	Gujarat	2	0	2	-	2	240
8	Haryana	1	2	3	0	3	120
9	Himachal Pradesh	1	1	2	1	3	150
10	J&K	1	0	1	4	5	130
11	Jharkhand	1	0	1	1	2	120
12	Karnataka	2	3	5	0	5	300
13	Kerala	2	0	2	4	6	360
14	Madhya Pradesh	3	10	13	1	14	840
15	Maharashtra	4	7	11	0	11	660
16	Manipur	1	1	2	0	2	120
17	Meghalaya	1	0	1	0	1	30
18	Mizoram	0	1	1	0	1	30
19	Nagaland	0	0	0	0	0	0
20	Orissa	2	3	5	0	5	300
21	Punjab	1	3	4	0	4	240
22	Rajasthan	2	0	2	7	9	540
23	Sikkim	0	0	0	0	0	0
24	Tamil Nadu	3	3	6	0	6	300
25	Tripura	0	1	1	0	1	60
26	Uttarakhand	0	0	0	-	0	0
27	Uttar Pradesh	7	0	7	0	7	420
28	West Bengal	3	5	8	0	8	480
29	A&N Island	0	1	1	0	1	15
30	Chandigarh	0	0	0	0	0	0
31	Dadra & NH	0	0	0	0	0	0
32	Daman & Diu	0	0	0	0	0	0
33	Delhi	1	0	1	0	1	0
34	Lakshadweep	0	0	0	0	0	0
35	Puducherry	0	0	0	1	1	16
	Total	**47**	**56**	**103**	**21**	**124**	**6746**

NB: Several centres have earlier admitted up to 120 candidates per year as per state needs.

6.3 The MPHW (Male) training course duration, which was initially of 1 ½ years, was reduced to one year from 1987. The syllabus revised last in 1991 included four months field training at PHCs. The candidate admitted for the course are bonded for minimum period of 3 years on completion of the course. The examinations are conducted by a State board under the chairmanship of Director of Health and Family Welfare Services. The training included basic health science (anatomy, physiology, microbiology, hygiene), public health including sanitation, primary health care, community health, communicable diseases, national health programmes, maternal and child health (including immunization, family planning, nutrition and nutrition education), and basic medical care, (treatment of minor ailments, first aid, emergency care, health education). The practical training areas included surveillance for diarrhoeal diseases, worm infestations, malnutrition in children and women, typhoid, malaria, filaria, TB, Leprosy, STD/AIDS as well as drug dispensing, dressing of wounds, collection of blood smears, chlorination of drinking water, disinfection, school health, surveys, notification of disease and statistics. Since IX plan, assistance is being provided by the Government of India to the States for strengthening of ANM training schools and 56 MPW training centres/ schools.

6.4 Objectives of Training

The overall objective of the MPHW (Male) training is to impart knowledge and skill sets to equip them to carry out core activities in the field of prevention and control of diseases of public health importance, environmental sanitation, health education detection and control of epidemic prone diseases, First aid in emergencies such as accidents, injuries, burns etc. and treatment of minor illnesses. The specific objectives of the training are indicated below:

a. To impart basic knowledge of environmental sanitation, safe-drinking water and other public health measures

b. To develop competency in early identification and treatment of diseases under national health programs in the community and extend referral services.

c. To enable MPW to take public health action in the event of an outbreak (fever, diarrhea, acute respiratory infections, jaundice etc).

d. To provide first aid in emergencies, accidents and injuries and treatment for minor ailments.

e. To impart health education and health promotion practices in respect of life style diseases.

f. To extend support to the female health worker in regard to maternal and child health, immunization and family planning services.

g. To maintain logistics & supply chain management at SHC level.

h. To maintain proper reports and records & utilizing them in preparation of the annual action plan.

6.5 Revitalizing MPHW (Male) Training Centres/ Schools

6.5.1 The Government of India will provide financial assistance, for a period of three years to states for engaging contractual MPHW (M). Government of India will also consider providing financial assistance to states for rejuvenation of the erstwhile MPHW (Male) training centres/ schools and starting new schools in underserved districts subject to the ceiling prescribed in Table-V below. Stipendiary support of Rs. 500 per trainee per month will also be provided as indicated in Table V.

Table V : Financial Assistance for Strengthening MPHW (Male) Training Centres

	Item	**Upper limit for financial assistance for strengthening MPHW (Male) Training Centres/Schools**
1	Civil Works per centre/school	Rs. 25,00,000
2	Rent for School	0
3	Furniture (Students chairs, tables etc.) per centre/school	Rs. 20, 00,000
4	Teaching Aids per centre/School	Rs. 50, 000
5	Lab. Equipments per centre/School	Rs. 20,000
6	Computer per centre/school	Rs. 25, 000
7	Transportation per centre/ School	Rs. 75, 000/ yr
8	Salaries to staff	0
9	Library Support per centre/School	Rs. 50,000
10	Rent for Hostel (per month/ candidate) per centre/ school (For 60 trainees)	Rs. 7,20, 000/yr (1000 × 12 × 60 / yr)
11	Stipend to students per centre/ school (For 60 trainees)	Rs. 3,60,000/ yr (500 × 12 × 60 / yr)
12	Contingencies per centre/School	Rs. 1, 00,000/ yr
	Total	**Non-recurring: Rs.46.45 lakh Recurring: Rs 12.55 lakh/ yr**

6.5.2 The proposal for providing financial assistance for strengthening MPHW (Male) Training Centres/Schools should be included in the annual Project Implementation Plan of NRHM by the states. The states are required to ensure that MPHW (Male) training centres/Schools are immediately made functional with adequate facility for hostel.

6.6 Faculty in MPW training centre/School

The faculty positions sanctioned by State governments for HFWTC/MPW schools should be in place before the training of MPHW (Male) is taken up. The training centres should also make a list of guest faculty, who may be invited for imparting training to MPHW trainees on specific programmes/ subjects. The programme officers of the respective programmes should invariably be invited for teaching and training in the relevant national health programmes and the activities to be undertaken by the MPHW (Male) in the field. The training centre should also identify one or more block level PHC/ CHC where the trainees will be posted for field training and practice. The medical officer in charge and health supervisors from the identified PHC/CHC should also be included in training of trainers for MPHW training as they will act as mentors of trainees in the field.

6.7 NGOs

The states may also make use of training facilities with NGOs with funding support for recurring expenditure components of items as per ceiling prescribed in Table V.

6.8 Teaching Aids

Imparting quality training requires teaching aids including overhead projector, LCD projector, TV, DVD player etc. The centre should insure that all such equipment are made available and functional.

6.9 Teaching Material

Each trainee should be provided with training manual in local language and workbook for field posting. The Government of India's assistance includes support for library in MPHWTC/ MPW schools, training material related to national health programs etc. These should be made available in the library for easy accessibility to the trainees for acquiring all the requisite knowledge in all the subjects as per the course curriculum.

6.10 Transportation

The training institutions need to provide for the transportation of students for various field trainings to acquire hands on experience on day to day basis. To facilitate this vital component of training, the Government of India may provide assistance upto Rs 75,000 per year per training institution.

6.11 Stipend

During training, a stipend of Rs 500 per month will be paid to each trainee. The states should release fund to the respective training centres for ensuring regular payment of stipend to all the trainees. However, it should be ensured that stipend should be given to the trainees at the end of the month after verification that they have attended all the sessions both theory and practical. If the trainees fail to attend more than 10 percent of the scheduled sessions of theory and practical, the stipend should be reduced proportionately.

6.12 Training Strategy

The National Institute of Health and Family Welfare (NIHFW) will be the nodal agency for overall planning, coordination and monitoring & evaluation of MPHW (Male) trainings in the states through the State Institutes of Health and Family Welfare (SIHFW) and other partner institutions.

7. Role of various stakeholders

7.1 Role of Ministry of Health Family Welfare, Government of India

a. Issue broad guidelines on training and other policy matters.
b. Develop standards for in-service training program implementation.
c. Facilitate implementation of training in states by:
    - Providing support for capacity building at state/ regional level.
    - Providing support through the Nodal Agency.
    - Ensure that training is need based.
    - Ensure emphasis for monitoring, follow up and reinforcement of training.

7.2 Role of NIHFW

The NIHFW will be the nodal institute for the coordination of MPHW (Male) training activities in the states. It will also be responsible for the administrative and technical components of the coordination and will also monitor the training in the country. In order to undertake its role of coordination/ facilitation of MPHW training in the States the following tasks will be carried out by NIHFW –

a. Develop guidelines for identification of peripheral training institutions by the States based on infrastructure, faculty, training load etc and help the States in identification of regional, district and sub district level collaborating MPHW (Male) training institutions.

b. Coordinate: (i) Development of model training curriculum/ training guidelines; and (ii) review and upgrading of manual/ materials currently used, integrating best practice materials produced and used for State specific training programs for MPHW (Male).

c. Conduct orientation courses for master trainers for MPHW (Male) of collaborating agencies/ institutions by the state and also facilitate some training courses of trainers.

d. Develop system of proficiency/ validation for MPHW (Male) training by establishing criteria for proficiency in carrying out various given tasks under national health programs, early detection & control of disease outbreaks and management of emergencies & minor illnesses etc.

e. Develop guidelines for periodic accreditation of training institutions based on facilities and also expertise in skill transfer.

f. Develop a check-list for monitoring of training by State/ District/ Sub-district level training institutions; based on periodic reports by State, course reports as well as field visits and give feedback to State / district to ensure that training is as per guidelines.

g. Evolve guidelines to evaluate the effect of training imparted, by following up the performance of MPHW (Male) trained in the field from time to time.

h. Appraise Ministry of Health and Family Welfare of progress and problems of MPHW training and assist MOHFW in evolving appropriate mid course corrective actions.

i. Evolve guidelines for developing district wise database of trained MPHW (Male) in the State.

j. Assisting States / districts in preparing quarterly data on trained MPHW (Male), utilization by the State and also about the persons being trained and their linkage with operationalisation of SHCs.

7.3 Role of States

The State will have overall responsibility for operationalisation of training program for MPHW (Male) in the respective States. The State should identify the State Institute of Health and Family Welfare as a Nodal Institute for planning, coordination and Monitoring of MPHW (Male) training in the State. The following activities should be carried out by the State for implementation of MPHW (Male) training:

a. Identify all the potential training institutions including those run by NGOs.
b. Collaborate with other States in MPHW (Male) training if the training load is high and the state is unable to complete the training of required number of MPHWs in stipulated period of time.
c. Rejuvenate/ strengthening of HFWTC, DTC, MPHW (Male) school, ANMTC, Nursing school so that they can also be utilized for training of MPHW (Male.)
d. Develop an accreditation mechanism for MPHW (Male) training centers in collaboration with NIHFW/ SIHFW.
e. Ensure that the training of MPHW(Male) is carried out according to the guidelines of the Government of India and the successful completion is certified by a competent authority/Board of state/UT government.

7.4 Role of SIHFW

The State Institute of Health and Family Welfare may be identified as the nodal institute for the coordination and monitoring of the training of MPHW (Male) in the state and will carry out the following activities:

a. Identify Master Trainers for training of MPHW (Male).
b. Arrange training for master trainers in collaboration with NIHFW.
c. Prepare action plan for MPHW (Male) training.
d. Translate training material provided by Government of India in local language and addition of State specific health issues and problems in the manual.
e. Monitor content and quality of training by all participating Centers/ Institutes.
f. Develop mechanism for assessment of trainees in consultation with State Examination Board for MPHW (Male) training

8. Curriculum

8.1 Following curriculum and teaching hours are recommended for one year training course of MPHW(Male)

	Subject/Area	Curriculum	Teaching Hours		
			Theory	Practical	Total
1	Introduction	Primary Health Care - Preventive & Curative. Public Health & Disease Control. National Health Programmes. National Rural Health Mission. Maternal & Child Health. Health Care Vision and Goals. Health Care Infrastructure in the State and district.	8	-	8
2	Safe Drinking Water and Environmental Sanitation	Methods of water purification including chlorination of wells /tanks and domestic water purifiers. Safe water storage and handling practices. Collection of drinking water samples, despatch for testing and remedial measures to eliminate water borne diseases. Identification of stagnant water sources and their elimination Activities for the promotion of environmental sanitation including disposal of solid and liquid wastes and construction of toilets) Health education on safe disposal of wastes, safe hygiene practices inc (drinking water, dietary & personal hygiene and smokeless chulas etc).	12	24	36
3	Malaria	Malaria transmission, detection of malaria parasite, disease surveillance, vector control measures and usage of long lasting insecticide treated nets (LLIN) Case definition, signs and symptoms, early detection of cases, referrals and follow up of confirmed malaria cases Supervision of spraying operations Health education and counselling for early reporting, completion of treatment, containment of mosquito breeding places, usage of insecticide treated bed nets and insecticidal spraying in the households	24	40	64

4	Kala-Azar	Kala-Azar transmission and surveillance (house to house). Signs & symptoms, early detection of cases, Rapid Diagnostic Kit (RK39), referrals and follow up of cases Supervision of spraying operations Health education and counselling containment of mosquito breeding sources, usage of insecticide treated bed nets and insecticidal spraying in the households.	8	20	28
5	Japanese Encephalitis (JE) / Acute Encephalitis Syndrome (AES)	JE transmission, disease surveillance and vector control. Signs and symptoms of JE /AES, early detection, timely referrals, radical treatment and follow up of cases. Enumeration of children and JE Vaccinations. Health education and counselling.	8	12	20
6	Dengue & Chikungunya	Dengue & Chikungunya transmission, surveillance (house to house), signs & symptoms and follow up of cases. Control of mosquito breeding and supervision of sprayings. Health education and counselling of the community.	8	12	20
7	Lymphatic Filariasis	Filaria transmission, organisation of surveys for night blood slides, assessment of micro filarial (MF) Rate. Signs & symptoms, identification of cases. Home based management of lymphodema cases and referrals of hydrocele cases for surgery.	8	20	28
8	Tuberculosis (RNTCP)	RNTCP programme, TB scenario in state & district. Types TB infections (pulmonary &extra-pulmonary), signs & symptoms, referrals, treatment protocols, complications, side effects of treatment, detection of drug resistance cases and follow ups including defaulters. Coordination with DOT providers, STS, STLS, NGOs etc. Awareness generation in the community for early detection, ATT adherence and tracking of TB cases. Health education & Counselling including concurrent risks of AIDS &TB	20	32	52
9	Leprosy	Leprosy transmission, types of cases and Leprosy control. Signs & symptoms, types of leprosy cases, early detection of people with skin patches & loss of sensation, referrals, follow up and management	8	16	24

		of leprosy reaction cases. Leprosy associated disabilities and their management including referral to specialized institutions. Health education and counselling on early case detection, prevention of deformities & disabilities and rehabilitation			
10	Disease Surveillance	Integrated Disease Surveillance Programme (IDSP). Surveillance for disease outbreaks, investigations & control. Analysis of preliminary data including threshold values of disease outbreaks and reporting all unusual events. Signs & symptoms of epidemic prone diseases, reporting of cases (hepatitis, gastro-entities, fever with/ without skin rashes, ARI etc,) and measures to prevent epidemics.	16	24	40
11	School Health	School health programme and its implementation including co-ordination with school authorities for health check up and preventive health care Booster Immunisation schedules and techniques of immunisation. Health education and counselling techniques.	8	20	28
12	Adolescent Health	Adolescent health programme, physiological and behavioural changes in adolescents, nutrition, personal hygiene, healthy life styles.	8	12	20
13	Treatment of Minor Ailments	Assessment & treatment of minor ailments (mild fever cases, diarrhoeas, vomiting, body aches, deworming etc. Identification of danger signs & symptoms and referrals.	20	8+24	52
14	First Aid including Traffic Accidents	Nature of the accidents and types of injuries (invisible & visible), First aid for burns, wounds, fractures, drowning, respiratory distress, electric shock and animal / snake bites. Transport of seriously injured. Risks and precautions in handling of pesticides & sprayers and referrals. Techniques of artificial ventilation and cardiac massage.	16	20	36
15	Dog Bites and other Animal bites	Risks of animal bites, preventive measures, first aid and treatment requirements. Types of animal bites, signs & symptoms, immediate local treatment of wounds, first aid, referrals and follow up. ARV, ASV and other post exposure treatments.	4	8	12

16	RTI/STI & HIV/AIDS	Signs & symptoms, risks and precautions for RTI/STI/HIV. High risk populations, referrals to ICTC and follow up Coordination linkages with sputum microscopy centre Health education & counselling for RTI/STI/ HIV control.	4	12	16
17	Blindness Control	Causes of blindness, signs & symptoms and referrals of cases of visual impairment including cataract. Abnormal Vision and referrals including glaucoma. Screening of children for visual defects and testing of vision Minor eye problems and their treatment. Health education for eye care and protection of eye sight.	4	12	16
18	Iodine Deficiency Disorders	IDD programme, iodine deficiency disorders, common manifestations, Iodization of salt, testing of salt for iodine. Iodine rich and deficient food materials.	4	8	12
19	Mental Health	Types of disorders and referrals	2	4	6
20	Flurosis	Source of fluorine in environment, hazards of excessive content of fluorine in water, hazards of fluorine deficiency and their prevention	4	4	8
21	Oral Health	Oral health problems, oral hygiene and referrals.	2	8	10
22	Deafness	Deafness hazards, causes of deafness, prevention & control of deafness, detection of deafness cases and appropriate referrals to PHC/CHC	4	4	8
23	Health care of elderly	National programme for health care of elderly and camps for the screening of elderly. Health education of elderly and families for healthy aging.	2	4	6
24	Maternal Health including Family Planning	Maintenance of registers - households, eligible couples & family planning MTP& PNDT Acts. Male sterilisation techniques and organising NSV camps. Health education of male populations.	8	16	24
25	Child Health Immunization	Vaccine preventable diseases and Immunisation. Immunisation schedules, cold chain maintenance including ILRs & deep freezers, logistics of vaccines, alternate vaccine delivery, disinfection of equipments, disposal of syringes	12	20	32

		and other waste, side effects of vaccines and complications of immunisations and their management. Organization of Immunisation sessions including Village Health Nutrition Days (VHNDs). Early detection and reporting of vaccine preventable diseases including Acute Flaccid Paralysis (AFP) and neonatal tetanus. Health education dissemination of key messages.			
26	Diarrhoeas in children	Causes of diarrhoea, sign and symptoms and referrals. ORS preparation and use. Health education and counselling of parents regarding early consultation, ORS usage and safe practices in child care.	8	16	24
27	Acute Respiratory Infections	Causes, prevention, signs & symptoms, treatment and timely referrals. Health education and counselling of parents.	4	16	20
28	Nutrition	Diet and nutrition including micronutrients, types of diet (diabetic, high /low protein etc), balanced and healthy diet and exclusive breast feeding of children and weaning. Nutritional needs of children, adolescents, pregnant women, elderly & sick. Causes of underweight, malnutrition and obesity. Growth charts, measurement of height & weight. Identification of growth faltering cases and referrals to AWW for supplementary nutrition and to appropriate facilities for management of children with growth faltering with supplementary nutrition Health education and counselling on nutrition.	12	16	28
29	Logistic & Supplies	Estimation of requirements, procedures of indenting, receipt of supplies, maintenance of stock registers, bin cards & expiry calendar for drugs / supplies , issue of supplies, insecticides etc.	8	8	16
30	Health Statistics	Health Statistics, indicators, medical records, international classification of diseases (ICD-10) and health facility data. Demography, characteristic of the population, growth rate, life expectancy, vulnerable populations (Tribal etc), CBR, CDR, still birth rate, IMR, neonatal mortality, under 5 mortality,	12	8	20

		health status indicators, measurement of morbidity, disability rates and disease specific death rates. Sources of health statistical data including registration of births & deaths, Sample Registration Systems (SRS), NFHS, DLHS, Notifiable diseases and regulations. Data collection, analysis, presentation and identification of problems. Statistical and medical ethics			
31	Maintenance of Records	Record maintenance at SHC and, PHC/ CHC levels. Record maintenance for the control of communicable & non-communicable diseases under national health programmes (malaria, TB, leprosy, blindness control etc.). Health Management Information Systems (HMIS) and computer literacy.	18		18
32	Household Surveys & Mapping	Design, planning, data collection & analysis of health investigations and surveys.	8	24	32
34	Communication & Counselling	Interpersonal and group communications, participatory approaches of communication, framing of messages and effective means of messaging, methods of counselling.	8	20	28
35	Working with Community & Working as a Team	Role of Health worker in the community including assessment of health needs of the community, working with the local communities, NGOs & local leaders. Working as a team member, coordination of activities with other health workers including ANMs, Anganwadi health workers and ASHAs	4+4	12+12	32
36	NCD	National Programmes - Control of diabetes, cardio-vascular diseases, stroke, cancer and tobacco. Risks and prevention of non-communicable diseases. Identification of suspected cases diabetes, heart diseases, stroke, cancer and obesity and referrals to PHC/CHC for advice. Risk factors associated with Non-communicable Diseases. Investigations for non-communicable diseases. Urine testing for sugar and albumin	12	16	28

9. Assessment

9.1 There should be regular assessment of the trainees to ensure progressive learning and acquisition of required knowledge and skill-sets. Total marks for the assessment would be 1500. Assessment would be in three parts, concurrent assessment, internal assessment and final examination. Out of the total marks, 600 should be assigned to concurrent assessment, 300 to internal assessment and 600 to final examination. Due weightage should be given to each unit in the curriculum. Within each unit, the weightage should be given to the field assessment and theory. The final examination of 600 marks should also include viva-voice examination.

9.1.1 **Concurrent Assessment:** The main objective should be to assess the trainees whether they have developed skills related to their day to day performance of tasks assigned to them. The concurrent assessment should consist of the following -

a. **Maintenance of Work Book: T**he purpose of maintaining the workbook is to ensure that activities carried out by them during their field posting under each unit of the curriculum are recorded and supervised by the health assistant (male), who will be the local mentor of the trainees assigned under his supervision. At the end of completion of the respective units, work book should be assessed by training in-charge of DMPW course as well as other medical officers of the block level PHC/ CHC who are nominated for training of MPHW (Male). Besides, viva-voice examination should also be conducted at the end of the each unit field posting.

b. **Written- Theory Examination**: After completion of each unit, the training centre should conduct unit examination including viva-voice. The trainee should separately pass in theory and field assessment. In case, a student fails in the unit examination, he has to repeat the unit. Extra classes should be arranged by the training centres for such trainees and he should be re-examined at the end of that particular unit. The purpose of re-examination is to ensure that the trainee completes the training course within the stipulated time frame but without compromising with the quality of skill which he is expected to develop at the end of the training.

9.1.2 **Internal Assessment:** The purpose of the internal assessment by the training centre is to make trainees serious about the training course. The assessment should include regularity of the trainees, class participation, presentation in seminars, and overall discipline maintained by him.

9.1.3 **Final Examination:** At the end of the training course, final assessment should be conducted by the training centre which should include both theory and viva-voice examination. The purpose of the final assessment is to assess that the trainee has acquired requisite knowledge and skills in tasks that he would be performing as a MPHW (M).

9.1.4 **Final Assessment:** The final assessment would include adding up of the marks secured by the trainees in concurrent assessment, internal assessment and final examination. Unsuccessful candidate has to repeat the course and will not be entitled for any stipend during this period. The final certificate of completion of the course will be issued to the successful candidates by the competent authority/Board constituted by the state government.

9.2 Follow Up of MPHW (M) training:

It is envisaged that after one year quality training of DMPW (M) course, the trainees should be able to perform his job responsibilities adequately. Therefore, it is essential that the respective training centres should also follow up the trainees in the field on half yearly basis to make an independent assessment about their proficiency. The observations made should be conveyed to respective district CMO/DHO, SIHFW and NIHFW for further improvement.

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