

**Operational Guidelines
for
Implementation of Integrated Management of Neonatal and Childhood
Illness (IMNCI)**

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Operational Guidelines for Implementation of Integrated Management of Neonatal and Childhood Illness (IMNCI))

SECTION A : The package

1. Introduction

Bringing down Infant and Child Mortality Rates and improving Child Health & Survival has been an important goal of the Family Welfare Programmes in India. During the period 1977 to 1992 programmes like universal immunization programme; oral rehydration therapy (ORT) programme and programme for prevention of deaths due to acute respiratory infections (ARI) were implemented as vertical programmes. These programmes were integrated in 1992 under the Child Survival and Safe Motherhood Programmes and have continued to be a part of the Reproductive & Child Health Programme implemented since 1997.

As a result of these efforts, the Infant Mortality Rate (IMR) has come down significantly over the years from 114 in 1980 to 58 in 2004. It has, however, been seen that the decline has not been uniform across all States over the years. The IMR and child mortality in some States such as MP, Orissa, UP, Rajasthan, Bihar, Gujarat, Assam and Haryana continue to be unacceptably high. Besides this, it has been seen that the IMR decline which during the period 1980 to 1990 was 34 points (114 to 80), an annual decline of 12 (80 to 68) during the period 1990 to 2000, with Rajasthan, Assam and Haryana showing only a negligible fall. The major reason has been as a very slow decline in the neonatal mortality rate. A large number of children continues to die during the first month of life (neonatal period) and efforts have to be made to tackle this situation in a very focused manner. At the same time efforts have to be continued to bring down deaths due to diarrhea and acute respiratory infections by implementing the related interventions.

It has to be remembered that malnutrition and low birth weight (LBW) are contributors to the about 50% deaths among infants and children under 5 years of age. It is obvious that for preventing deaths due to low birth weight, the health and nutritional status of mothers during pregnancy has to be taken care of. It is well established that care during or immediately after birth plays an important role in preventing deaths in the early neonatal period. Visiting the children at homes has been found to be a critical intervention which helps in preventing deaths. However, unfortunately post natal care has not received adequate attention until recently. According to NFHS-II Survey only 6% women were visited by a health worker during the first week of life. Efforts have therefore to be made during the coming years to ensure that the numbers of home visits during the post natal care are increased significantly.

2. What is Integrated Management of Newborn and Childhood Illnesses (IMNCI)

WHO/UNICEF have developed a new approach to tackling the major diseases of early childhood called the Integrated Management of Childhood Illnesses (IMCI). Studies show that children presenting with any illness often suffer from more than one disease. For instance, a child presenting with diarrhoea may also be malnourished and may not have received the immunization as per the National Immunization schedule. The integrated approach ensures that all relevant needs of the child are looked at and attended to during the contact of the child with the health workers.

3. The IMNCI Package

The IMNCI package has been developed by experts including the Child Health Researchers, academicians the Indian Academy of Pediatrics (IAP) and the National Neonatology Forum (NNF) to adapt it for the specific requirements of children in India. Since newborn care is an important issue for bringing down the infant mortality rate in India, this aspect has been included in the package adapted by India. This

package includes the following interventions:-

Care of Newborns and Young Infants (infants under 2 months)

- Keeping the child warm.
- Initiation of breastfeeding immediately after birth and counseling for exclusive breastfeeding and non-use of pre lacteal feeds.
- Cord, skin and eye care.
- Recognition of illness in newborn and management and/or referral).
- Immunization
- Home visits in the postnatal period.

Home visits are an integral part of this intervention. Home visits by health workers (ANMs, AWWs, ASHAs and link volunteers) help mothers and families to understand and provide essential newborn care at home and detect and manage newborns with special needs due to low birth weight or sickness.

Three home visits are to be provided to every newborn starting with first visit on the day of birth (day 1) followed by visits on day 3 and day 7. For low birth weight babies, 3 more visits (total of six visits) are to be undertaken before the baby is one month of age. The details of these visits are given in the training package.

In addition the opportunity of home visit is to be used for the care of mothers during the post-partum period. This will help mothers and families on how to recognize and manage minor conditions and will ensure timely referral of severe cases.

Care of Infants (2 months to 5 years)

- Management of diarrhoea, acute respiratory infections (pneumonia) malaria, measles, acute ear infection, malnutrition and anemia.
- Recognition of illness and at risk conditions and management/referral)
- Prevention and management of Iron and Vitamin A deficiency.
- Counseling on feeding for all children below 2 years
- Counseling on feeding for malnourished children between 2 to 5 years.
- Immunization

After neonatal period, IMNCI package is accessed by the family for their newborns/children from the health workers in the community (ANM, AWW, ASHA or link volunteer) or providers at the facility (PHC/CHC/FRU).

4. Components of IMNCI

Training

IMNCI is a skill based training. The training is based on a participatory approach combining classroom sessions with hands-on clinical sessions in both facility and community settings.

Broadly, two categories of training are included, one for medical officers and a second for front-line functionaries including ANM's and Anganwadi Workers (AWW's).

For ASHA and link volunteers if any, a separate package consistent with IMNCI focusing on the home care of newborn and children is in preparation keeping in mind their educational status.

While training is an important input for implementation of IMNCI, this is not the only one. Effective

implementation of IMNCI in a district also involves the following components.

□ **Improvements to the health system.** The essential elements include:

- ❖ Ensuring availability of the essential drugs with workers and at facilities covered under IMNCI.
- ❖ Improve referral to identified referral facility.
- ❖ Referral mechanism to ensure that an identified sick infant or child can be swiftly transferred to a higher level of care when needed. Every health worker must be aware of where to refer a sick child and the staff at appropriate health facilities must be in position to identify and acknowledge the referral slips and give priority care to the sick children.
- ❖ Functioning referral centres, especially where healthcare systems are weak, referral institutions need to be reinforced or private/public partnerships established
- ❖ Ensuring availability of health workers / providers at all levels
- ❖ Ensuring supervision and monitoring through follow up visits by trained supervisors as well as on-the-job supportive supervision

□ **Improvement of Family and Community Practices** Counseling of families and creating awareness among communities on their role is an important component of IMNCI. This includes

- Promoting healthy behaviors such as breastfeeding, illness recognition, early case seeking etc.
- IEC campaigns for awareness generation.
- Counseling of care givers and families as part of management of the sick child when they are brought to the health worker/health facility.
- During Home Visits- Home Visits provide an opportunity for identification of sickness and focused BCC for improving newborn and child care practices.

□ **Collaboration/coordination with other Departments, PRIs, Self Help Groups, MSS etc**

Implementation of IMNCI in an effective way in any district would be possible only with the total involvement of ANM and Anganwadi workers of ICDS, and grassroot functionaries of other sectors. Community ownerships and participation is of paramount importance. Therefore active involvement of PRI, self help groups and women's groups is a must. Special effort will thus be required on the part of the district CMOs to involve the concerned departments.

For training of health staff and follow-up and supervision of IMNCI activities in the district, the involvement of pediatrics units/departments of District Hospitals will be necessary. The involvement of the Departments of Pediatrics and Preventive and Social Medicine of the local or regional medical colleges should be sought. This may need decisions at State level.

Implementation of IMNCI in the districts has to be seen as part of the Child Health Strategy under the National rural health mission/Reproductive and Child Health Programme- Phase II. ***“While training of the staff and workers will need special efforts, the Coordination mechanisms, improvement in the health systems and improvement in family and community practices is to be undertaken as part of the ongoing efforts in these areas under the National Rural Health Mission and RCH Programme-Phase-II”.***

The referral care for sick children and newborns is to be provided at the upgraded PHC's and FRU's which are being developed as a part of the RCH programme phase-II. The guidelines for services at these facilities have been developed.

SECTION B: Institutional Arrangements

IMNCI is a Child Health Intervention to be implemented as part of NRHM/RCH-II. Training for IMNCI will therefore be part of the overall training plan under RCH-Phase II.

1. State Level

- **Appoint a nodal officer for IMNCI.** IMNCI is a Child Health Intervention to be implemented as part of NRHM/RCH-II. Training for IMNCI will therefore be part of the overall training plan under RCH-Phase II. However, implementation of IMNCI within the districts will need a lot of coordination with other Departments of the State Government as workers from these Departments will not only have to be trained but also involved in the implementation of the programme. It is therefore suggested that at the State level there should be a dedicated officer for looking into IMNCI Implementation. Considering that co-ordination with other Departments is also part of the overall implementation of RCH-Phase II/NRHM, the State RCH Programme Director could take up the responsibility himself. The nodal officer will be responsible for the institutional arrangements listed below.
- **Set up a co-ordination Group.** IMNCI is a major intervention for bringing down IMR. It is therefore necessary that a coordination mechanism is built at the State level by including the donor agencies, other Departments like ICDS, Panchayati Raj, department of medical education are important as medical colleges will be involved not only in IMNCI implementation but also education of medical and nursing students. The coordination committee should be linked to the State Health Mission of the NRHM. Meeting quarterly, the role of the coordination group would be to (i) provide any technical support needed for state and district level implementation, (ii) coordinate financial inputs, (iii) review logistics and drugs supply and (iv) review progress in the implementation of IMNCI training and implementation activities. Involvement of departments like ICDS, Panchayati Raj, Medical Education will all have essential and specific contributions to make in scaling up IMNCI.
- **Arrange translation, printing and supply of training material.** Training materials have already been developed at the central level. The modules, charts, booklets, videos and facilitators guides will be made available to states for facilitating the training under IMNCI. Translations are currently available in Hindi, Marathi, Oriya, Gujarti, Karnatak, Telugu, Tamil and Bengali. Materials would need to be printed depending on the needs of each state. A thorough review of the quality of the translation by experts in medicine and IMNCI is strongly advised before moving for printing. Requirement of funding for these activities may be reflected as part of State PIPs.
- **Create pool of State level trainers.** Depending on the number of districts selected and the availability of medical colleges/other Regional Training Centres in the districts, State are to work out their requirement for State level trainers. These trainers are required for training of trainers (TOT) of district trainers as defined earlier and also to monitor quality of training in the districts. These trainers will be trained at the National Institutes at Delhi. In case any State feels that they have the capacity to develop some institutions as National Training Centres, they can approach the Central Government for assistance in this regard.
- **Select priority districts for IMNCI implementation**^[1]. IMNCI will have to be implemented in a well planned manner as it requires a great deal of time and resources. It is therefore suggested that initially only in a few districts and then taking up more districts based on the initial experience. The selection in the first phase may therefore be restricted to 3-4 districts along with regional training centers (preferably medical colleges) in the first phase. Each state should however, strive to complete implementation of

IMNCI in at least 25-30% of the districts over the next 2-3 years.

A number of states have already indicated in their RCH – II Project Implementation Plans the number of districts they are going to take up for IMNCI training. The States may in the light of the guidelines, rationalize the number to be taken up by them during the subsequent years. The states which have not included IMNCI in their earlier PIPs may do so from the next year.

There will be 2 kinds of districts in each state i.e. those implementing IMNCI and those not implementing IMNCI but continuing with existing interventions.

In districts not implementing IMNCI the existing interventions including immunization, diarrheal disease control, ARI control, vitamin A supplementation and essential newborn care including promotion of exclusive breastfeeding for 6 months, and starting optimal complementary feeding from 6 months of age onwards should be vigorously implemented to achieve universal coverage.

☐ **Monitoring, follow-up and review of implementation of IMNCI**

States will need to carefully plan the details of monitoring and follow up visits and periodic reviews of the implementation of IMNCI in the districts. Funds for these activities should be reflected as part of State PIPs .

- ☐ **Identify the state nodal institute for IMNCI training** The institute must have an adequate case load, facilities for training must be present or if not , must be provided before it is formally declared as the state nodal institute. The institute must have a dedicated trained staff. Medical colleges may be used for this purpose as they would generally have all the prerequisites.

☐ **Improvement in family and community practices**

Improving household behaviors for newborn and child care is an important objective of IMNCI. This should be achieved through activities as a part of RCH/NRHM BCC strategy. The messages should be consistent with IMNCI protocols/guidelines. Major emphasis should be laid on seeking health worker contact in neonatal period starting as soon as possible after delivery, and on early care seeking if the child is not well. Involvement of PRI, women's groups, NGOs, TBAs and other self help groups for improving family and community practices will have to be undertaken.

2. District Level

Many of the institutional arrangements at the State level need to be developed at district level, though emphasis is less on overall direction and quality control and more on the day-to-day activities to make IMNCI successful.

- **Appoint District Coordinator for IMNCI.** The district level also benefits from a dedicated officer to oversee implementation of IMNCI. He/She could be the district RCH Officer or the district CMO himself. He will be responsible for overseeing the planning, coordination and monitoring of IMNCI implementation in the district.
District Coordinators may also like to attend the 'orientation course' with the State IMNCI steering committee.
- **Set up an IMNCI Coordination Group.** To foster a day-to-day working relationship between the ICDS and health functionaries in particular, a coordination group should be set up under the Chairmanship of the Chief Medical Officer (CMO), including officers from ICDS, Panchayati Raj, and other departments, representatives of the Departments of Paediatrics and PSM of the regional Training Centres and/or local medical colleges, and development partners involved in implementation such as NGOs, international organization, and/or private medical practitioners. The purpose of the coordination group is to (i) coordinate and plan inputs of each of concerned departments / development partners, (ii) recommend district IMNCI facilitators/trainers, (iii) organize and schedule IMNCI trainings, (iv) review progress of IMNCI training and implementation on a bi-monthly basis. The plans and recommendations of the IMNCI coordination group should be linked to the District Health Mission of the NRHM.
- **Train District Trainers.** Every district will require a clearly identified and committed group of trainers. The nodal officer should identify members of the pool and working with their concerned agency or department devise a level of commitment from each of the district IMNCI facilitators and clinical facilitators. An average district will need to have a pool of about 40-50 facilitators, one third of which being physicians. Identified district facilitators should be trained by State or National level IMNCI facilitators. This is given in detail in section C.
- **Develop a detailed plan for IMNCI Implementation in the District.** Each district will need to formulate a detailed plan and budget for IMNCI implementation for the district. The plan will reflect in detail overall training workload and phasing of the PHC areas to be taken up. In addition, selection of training sites, number of trainers and training materials, training calendar, referral, and monitoring and review arrangements should be addressed.

IMNCI Training is part of RCH-Phase II Training. The funding will be based on the norms of TA/DA and other expenses as applicable under the RCH Programme. The requirement of funds on the basis of the norms will have to be projected as part of budget under the flexi-pool funding for RCH Programme.

As with the State IMNCI plan, the District IMNCI plan should be planned and presented together with the District NRHM / RCH II plan, not in isolation. Before advancing, this plan will need to be approved by the state IMNCI coordination group for IMNCI and will form the basis of implementation as also for monitoring and the periodic reviews to be undertaken at the district level.

- **Ensure timely supplies & logistics, supervision and follow-up**

Uninterrupted timely supply of drugs is an issue which will have to be addressed if implementation of IMNCI is to be ensured. Since the workers acquire new skills in the IMNCI training, it is imperative to provide on-the-job guidance to them. Regular supportive supervision in the form of skill reinforcement, facility support and record review has to be ensured. Supervisors will learn these skills in the IMNCI Follow up Training course. Health and ICDS Supervisors should plan their field visit in consultation with workers with aim to follow-up all workers at least twice or thrice. It is not necessary that health worker

should be supervised by health supervisors only. For convenience and quality, supervisors could divide geographical areas for supervision. After initial support, IMNCI supervision should be integrated into overall programme supervision. Mobility support can be provided to strengthen supervision. It should be ensured that during supervisor visit, supervisor should carry drugs to replenish if required and support workers in implementation. Supervisors should be asked to give feedback to higher authority about their monitoring visits using follow-up forms. Monthly meeting at PHC level provide such opportunity. These information should be used to take corrective steps.

□ **IEC activities for improvement in family and community practices**

This has been detailed earlier under the section Improvement of Family and Community Practices

SECTION C : Training in IMNCI

1. Focus on Skill Development

The training under IMNCI is focused on applied skill development. Around 50% of training time is spent building skills by **“hands-on training”** involving actual case management and counselling, the remaining 50% is spent in classroom sessions, building theoretical understanding of essential health interventions. The hands-on training is undertaken through clinical training sessions in hospitals and in the community. Physicians spend 6 days in hospital and 1 day in community; workers spend 3 days in hospital and 4 days in community settings. The hands on practice is to be undertaken through

- Visits to hospitals and
- In the case of Health workers in addition to hospital based practice, the participants are to be trained through field visits and visits to the homes of sick children.

Skill development is critical to the implementation of IMNCI.

2. Training at two levels

- **Inservice training for the existing staff** – The existing staff in the districts will have to be provided in-service training in a phased manner. The objective of the training effort would be to ensure that all medical officers and health worker are trained in IMNCI.
- **Pre-Service Training** –For including IMNCI in the pre-service teaching of doctors, nurses, ANM's, LHV's and others. ***The State Governments will need to issue instructions in this regard.***

3. Personnel to be Trained

There are 2 types of trainings under IMNCI*

Type of Training	Personnel to be trained	Duration	Package to be used	Place of Training
Clinical skills training	Medical Officer and Pediatricians	8 days	Physicians Package	Medical college /District Hospital
	Health Workers, ANMs, LHV's, Mukhya Sevikas, CDPO's and AWWs	8 days	Health Workers Package	District Hospital
Supervisory Skills Training	Medical Officers, Pediatricians, CDPO's LHV's and Mukhiya Sevikas)	2days#	Supervisory Skills package	Medical college /District Hospital

To be clubbed Preferably with clinical skills training. Where this is not possible the two days training should be conducted within 4-6 weeks of the clinical skills training. Experience has shown that it is difficult to call back people within 6 weeks again for another training.

*** An orientation meeting of 1 to 2 days may be organized in some districts for planners and key personnel such as people from PRI, CDPO's and other senior health functionaries and other stake holders to orient them about IMNCI and its implementation plan.**

4. Training of Trainers

For training of the district staff it would be essential to have adequate number of trainers within the districts. The trainers at district level includes all pediatricians in the district, selected medical officers from CHCs and block PHCs, selected staff nurses and LHVs and CDPO's and

Mukhiya Sevikas from ICDS. **Experience has shown that about 40-50 trainers are required for undertaking training of the health staff on a continuous basis. This is because in every district around 200 doctors and 200 supervisors along with 1200- 1600 workers need to be trained.** All IMNCI facilitators undergo Clinical skills training (physician or worker module) *plus* specific training in facilitation techniques and training on supportive supervision. Total training time is 10 days: 8 days (Clinical skills training) + 2 days for supportive supervision. The TOT for Physicians is facilitated by National IMNCI facilitators; the TOT for Health/ICDS workers is facilitated by State IMNCI facilitators ideally with participation of national IMNCI facilitators. Candidates for the all TOTs and ultimately the district training pool would ideally include all paediatricians in the district, plus selected CHC/Block PHC medical officers, staff nurses, LHVs, CDPOs, and ICDS supervisors. Additional TOT candidates might include faculty of HFWTC, ANMTC, GNMTC, MPW(M)TC, junior faculty of medical colleges, and NGOs. *All candidates should have good communication skills.* Districts with limited manpower might also consider including freelance facilitators.

5. Number to be trained

- It is estimated that in a district of average size about 1800 health staff will need to be trained. The exact numbers will however have to be calculated for each district will be taken up for implementation of IMNCI.
- Since the staff of other departments like ICDS etc is also to be trained, their numbers should be carefully included in consultation with the concerned district officers.
- Since meaningful implementation of IMNCI will need adequate numbers of trained staff, it will be better if the staff belonging to a PHC areas may be taken up fully before moving to another PHC area.

6. Training Institutions

a). State Level

Each state will need to train adequate number of trainers for training the district level trainers. Therefore the state will have to identify a Regional Training Centre. Since training is mainly skill based, choice of the regional or local medical college is obvious. The Departments of Pediatrics and Preventive & Social Medicine in each college will have to take up this responsibility. Another benefit of selecting the medical colleges as regional training centre would be in the pre-service training of undergraduate students. In addition to medical colleges other centres including private centres can also be used for training provided they have the requisite clinical material and facilities for training available.

States may identify one or more medical colleges in the first year depending on the number of districts they wish to bring under IMNCI during year one. The staff of these medical colleges will be trained at the Kalavati Saran Children Hospital, New Delhi and Safdarjang Hospital New Delhi which have been designated as the National level IMNCI Training Centres.

b). District Level

The following issues need consideration before selecting the institutions for training of district staff

- As IMNCI training focuses on building skills by hands on training on cases, the selected institution for training should have sufficient load of inpatient newborns to provide case material for hands on training. The selected institution for training should also have sufficient load of inpatient newborns to provide case material for hands on training. Do not select facilities that are not busy because it will not be possible to show enough number of sick children.
- Health workers have to be given the opportunity for practice on cases in home situations. Therefore at-least 4 visits have to be organized to nearby field areas during their training. This will require

proper administrative and logistic arrangements.

- Class room teaching is also an important component of the training. Classroom training can be done in a place where there are adequate number of class rooms (Preferably two) with sitting capacity of 12-15 participants each. In addition other support facilities liker video etc should be available.
- Since attention is given to individual skill building, each batch of training should not have more than 25 participants with 6-7 facilitators. The facilitators should have sufficient clinical skills to demonstrate signs of illnesses in sick newborns. If necessary, private pediatricians and supervisor level functionaries from NGOs and private sector can be involved.
- HFWTCs/ANM schools can perform this task only jointly with a hospital/health institutions. District hospital will thus be an obvious choice for training of medical officers. For training of health workers CHCs/operational FRUs etc can be considered. Where institutions with enough case load are not available in public sector – involvement of hospitals/health centres of local bodies/public sector enterprises or even private sector. In rare cases even facilities of adjoining districts should be considered

7. Follow-up Training (FUT)

The Follow-up Training is designed to improve supportive supervision skills such as methods for skill reinforcement, records review, and assessment of facility functioning. The intended participants include medical officers/paediatricians and health/ICDS supervisors who will be involved in supervisory, monitoring, and follow-up functions of IMNCI implementation. The duration of the training is 2 days which may either be clubbed with Clinical skills training or conducted within 6-8 weeks of the initial Clinical skills training.

8. Pre-service Training

Following the initial experiences in implementation IMNCI in several districts, States should plan early for the expansion to remaining districts. Pre-service training in medical colleges will need to include training on IMNCI in the training schedules of undergraduate students and interns, during their postings in the Departments of Paediatrics and Preventive & Social Medicine. ANM, AWW, and Staff Nurses' training schools will need to include training on IMNCI in their training schedules. State Governments will need to issue instructions in this regard to be implemented by teaching institutions by respective directorates.

SECTION D: Funding arrangements for IMNCI Trainings

1. National Level training:

For the national level training of the faculty of Medical Colleges of different States at Kalawati Saran Children Hospital and Safdarjung Hospital at Delhi, the States need not provide for budget in their NRHM/RCH-II-Programme Implementation Plans (PIPs) as the funding for this training will be entirely provided by the Government of India. This will include all costs such as TA/DA, stay and other training expenses.

2. State Level training (at the Medical Colleges identified as training centres):

The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs:

- Equipments for imparting training such as:
 - One Computer with in-built CD RW/ROM
 - One LCD Projector with display screen
 - Other miscellaneous training/ teaching accessories.
- TA/DA and honorarium to the trainees and trainers as per RCH norms.
- Vehicle hiring for field visits for trainees as per State Government norms.

3. District Level training:

a). At District Training Cell (in the District Hospital):

The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs:

- Equipments for imparting training such as:
 - One Computer with in-built CD RW/ROM
 - One LCD Projector with display screen
 - Other miscellaneous training/ teaching accessories.
- TA/DA and honorarium to the trainees and trainers as per RCH norms.
- Vehicle hiring for field visits for trainees as per State Government norms.

b). At other Training Centres within the District (Maximum two in identified CHCs/PHCs):

The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs:

- Equipments for imparting training such as:
 - One television (which is CD player compatible)
 - One CD player
 - Other miscellaneous training/ teaching accessories.
- TA/DA and honorarium to the trainees and trainers as per RCH norms.
- Vehicle hiring for field visits for trainees as per State Government norms.

4. Translation, printing and supply of training material:

The modules, charts, booklets, videos and facilitators guides will be made available to the States for facilitating training under IMNCI. These will need to be translated and printed in local languages depending on the needs of each State. The funding requirements for the same may be projected in the State NRHM/RCH-II-PIPs under the flexi-pool funding for NRHM/RCH Programme (Part-A of programme).

5. Field-level Monitoring Support, Follow up and Coordination:

A reasonable budget may be indicated in NRHM/RCH-II PIPs as institutional charges for monitoring and follow up visits/meetings, coordination and other related activities for successful implementation of IMNCI trainings.

^[1] In districts not implementing IMNCI, existing interventions including, diarrhoeal disease control, ARI control, vitamin A supplementation and essential newborn care including infant feeding should be vigorously implemented.